

Sherwood House Medical Practice

Quality Report

9 Sandon Road
Edgbaston
Birmingham
B17 8DP

Tel: 0121 4200146

Website: www.sherwoodhousemp.co.uk

Date of inspection visit: 22 September 2015

Date of publication: 03/06/2016

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

Ratings

Overall rating for this service		Good	
Are services safe?		Good	
Are services effective?		Good	
Are services caring?		Good	
Are services responsive to people's needs?		Good	
Are services well-led?		Requires improvement	

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	6
What people who use the service say	8

Detailed findings from this inspection

Our inspection team	9
Background to Sherwood House Medical Practice	9
Why we carried out this inspection	9
How we carried out this inspection	9
Detailed findings	11
Action we have told the provider to take	22

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Sherwood House Medical Practice on 22 September 2015. Overall the practice is rated as good.

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

- The practice was clinically well led but management arrangements were not sufficiently robust to manage risks to those who used the service. Information was not always well documented to support the management of the practice. For example in relation to the premises and staffing.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Systems were in place to review incidents that had occurred but the reporting of incidents did not always clear as to what learning had taken place.
- Data showed patient outcomes were above average for the locality. There were robust systems for reviewing patient care and GPs supported each other with this.

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it difficult making routine appointments but could usually get an urgent appointment on the day they were requested.
- The practice had a number of policies and procedures to govern activity, but it was not always clear whether they were up to date.
- The practice proactively sought feedback from staff and patients, which it acted on.

The areas where the provider must make improvements are:

- Ensure risks relating to the premises and patient safety are identified and appropriately managed including, electrical installation checks, control of substances hazardous to health, fire safety, legionella, cleaning of carpets and privacy curtains,

Summary of findings

recruitment checks, emergency equipment and arrangements for business continuity. Improve record keeping to support the monitoring of systems implemented.

In addition the provider should:

- Review systems for the recording of incidents so that any learning can be clearly identified for future reference and to identify any trends from the analysis of reported incidents which might require further action.

- Maintain robust records for recording staff training, appraisals, staff immunisations and fire drills so that the practice can be assured that all staff are up to date.

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 good for providing safe services.

Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses and there was evidence that these were discussed and acted upon. However it was not clear that the reporting was done in a consistent way and what lessons had been learnt to mitigate the risk of future reoccurrence.

Good



Are services effective?

The practice is rated as good for providing effective services.

Data showed most patient outcomes were at or above average for the locality. Staff referred to best practice guidance such as that from the National Institute for Health and Care Excellence and used it to deliver care. Patients' needs were assessed and care was planned and delivered to meet those needs. Staff had received training appropriate to their roles and any were supported to maintain the continuing professional development. There was evidence of appraisals to discuss and identify learning needs. However, the systems in place for monitoring staff training and appraisals did not make it easy for staff to keep track as to whether it was kept up to date. Staff worked with multidisciplinary teams to deliver patient care.

Good



Are services caring?

The practice is rated as good for providing caring services.

Data showed that patients rated the practice higher in relation to consultations with GPs although scores for other staff were lower than other practices in the local CCG area and nationally. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

It engaged with NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services and help meet the needs of the local population. Patients feedback about access to appointments was mixed although patients were satisfied they could get same day appointments if their needs were urgent. The practice had good facilities and was well equipped to treat patients

Good



Summary of findings

and meet their needs. Information about how to complain was available and that the practice responded appropriately to complaints received. Learning from complaints was shared with staff.

Are services well-led?

The practice is rated as requires improvement for being well-led.

The practice was clear in its vision as a clinically led service and the practice performed well in relation to patient outcomes. Staff told us that they felt supported and governance meetings supported the sharing of important information with staff. The practice proactively sought feedback from patients and had an active patient participation group (PPG). However the management side of the practice was less robust. Roles and responsibilities of administrative staff and systems in place for managing risks to patients were not always clear. Information to support the management of the service was not always well organised and documented to support the systems and processes in place. Policies and procedures to govern activity were not all dated to ensure staff were using the most up to date guidance.

Requires improvement



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 this population group.

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. It offered enhanced services in relation to dementia and shingles vaccinations. Seasonal flu vaccinations were being promoted to increase up take. Patients had access to a named GP for the continuity of care. Those at high risk of hospital admission and end of life care needs were identified and reviewed regularly, this included working with other health professionals to provide co-ordinated care. The practice carried out visits to a local care home and were engaging with a new retirement village in the local area to provide services. Home visits and urgent access appointments were available if needed.

Good



People with long term conditions

The practice is rated as good for this population group.

The GPs each had lead roles in chronic disease management and ran various clinics to support these patients. Patients received regular reviews to check that their health and medication needs were being met. For those people with the most complex needs, the GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care. Home visits were available for those who were unable to attend the surgery and urgent access appointments could be obtained on the same day.

Good



Families, children and young people

The practice is rated as good for this population group.

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, staff worked with health visitors to discuss concerns including non attendance for childhood immunisations. Data on immunisation rates available from the practice showed good progress against targets. Various services including baby checks and antenatal checks were available for this population group. Children were able to access emergency appointments when needed. Appointments were available outside of school hours and the premises were suitable for children and babies.

Good



Working age people (including those recently retired and students)

The practice is rated as good for this population group.

Good



Summary of findings

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 was proactive in offering online services as well as a range of health promotion, screening and family planning services that reflected the needs of this age group.

People whose circumstances may make them vulnerable

The practice is rated as good for this population group.

The practice held a register of patients living in vulnerable circumstances including those with a learning disability. There was a designated lead GP for patients with a learning disability and annual health checks had been carried out on 95% of the patients on this register within the last 12 months. The practice also held a carers register which enabled them to target specific services.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people including those at risk and with palliative care needs. 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.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as good for this population group.

Practice data showed that 77% of people experiencing poor mental health had received an annual physical health check since and 65% of the patients had care plans in place. The practice offered open access appointments for those who were most vulnerable in this population group. The practice also worked closely with mental health teams to provide shared care in the management of patients with poor mental health. Counselling services through the local mental health trust were also available on site for patients who would benefit from them.

Good



Summary of findings

What people who use the service say

The national GP patient survey results published on 4 July 2015 showed the practice performance was mixed compared with local and national averages. There were 122 responses and a response rate of 32%.

- 63% found it easy to get through to this surgery by phone compared with a CCG average of 62% and a national average of 74%.
- 77% found the receptionists at this surgery helpful compared with a CCG average of 83% and a national average of 87%.
- 63% with a preferred GP usually got to see or speak to that GP compared with a CCG average of 58% and a national average of 61%.
- 78% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 82% and a national average of 85%.

- 84% said the last appointment they got was convenient compared with a CCG average of 90% and a national average of 92%.
- 59% described their experience of making an appointment as good compared with a CCG average of 67% and a national average of 74%.
- 74% usually waited 15 minutes or less after their appointment time to be seen compared with a CCG average of 62% and a national average of 65%.
- 67% felt they did not normally have to wait too long to be seen compared with a CCG average of 54% and a national average of 58%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 12 completed comment cards which were all positive about the standard of care received. They told us that they received a good service and that they were treated with respect.

Sherwood House 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, a practice manager and an Expert by Experience (a person who has experience of using this particular type of service, or caring for somebody who has).

Background to Sherwood House Medical Practice

Sherwood House Medical Practice is part of the NHS Birmingham Cross City Clinical Commissioning Group (CCG). CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

Sherwood House Medical Practice is registered with the Care Quality Commission to provide primary medical services. The practice has a general medical service (GMS) contract with NHS England. Under the GMS contract the practice is required to provide essential services to patients who are ill and includes chronic disease management and end of life care.

The practice is located in a purpose built health centre. Based on data available from Public Health England, deprivation in the area served is similar to the national average. The practice has a registered list size of approximately 12,500 patients.

The practice is open 8am to 6.30pm on Monday to Friday with extended opening hours on Monday and Tuesday 6.30pm to 8pm. When the practice is closed during the out of hours period (6.30pm to 8am) patients received primary medical services through another provider (Primecare).

The practice has five GP partners (three male and two female) and two salaried GPs. Other practice staff consist of two practice nurses and a healthcare assistant. There is a team of administrative staff which includes a practice co-ordinator who supports the daily running of the practice.

The practice is also a training practice for doctors who are training to be qualified as GPs and a teaching practice for medical students. It also supports the training of physician assistants.

The practice has not previously been inspected by CQC.

Why we carried out this inspection

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

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Detailed findings

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)

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

Before inspecting, 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 inspection on the 22 September 2015. During our inspection we spoke with a range of staff (GPs, a practice nurse, reception and administrative staff) and spoke with 14 patients who used the service (including four members of the practice's patient participation group (PPG)). We also spoke with three health care professionals and the manager of a care home that worked closely with the practice. We reviewed how people were being cared for. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Are services safe?

Our findings

Safe track record and learning

There were systems in place for reporting and recording significant events. These were discussed by the GPs as part of their regular daily meetings and shared where relevant with staff through monthly team meetings as a standing agenda item. The GPs told us that quarterly significant event meetings were also held to discuss incidents that had occurred. We saw evidence of action taken in response to significant events for example, a second oxygen cylinder was procured as back up after an incident in which the practice's oxygen was running low.

Staff were aware of the need to report incidents but we found that this was not always done in a consistent way. For example, we found two reported incidents relating to needlestick injuries but only one was reported in the accident book. Incident reports although well discussed among staff were not always well recorded to show how lessons were learnt or used to identify trends.

National patient safety alerts were forwarded by senior administrative staff to clinical staff to action. The CCG pharmacist would support any audits relating to medicine alerts.

Overview of safety systems and processes

The practice had systems, processes and practices in place to keep people safe. These were generally well embedded although there were some areas identified where systems were not sufficiently robust:

- Arrangements were in place to safeguard adults and children from abuse. Safeguarding policies were in place and accessible to staff on their computers. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. Staff demonstrated they understood their responsibilities and told us that they had received training relevant to their role. There was a lead GP for safeguarding at the practice to provide support who was also a safeguarding lead for the local CCG.
- Patients undergoing an examination or investigation could request a chaperone during their consultation if they wanted one. A notice was displayed in the waiting room, advising patients of this. Nurses and the receptionist who acted as a chaperone had received a

disclosure and barring check (DBS). (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). Staff we spoke with told us that they had not received any specific training to be a chaperone but were aware of their responsibilities and knew where to stand. A chaperone policy was in place to provide guidance to staff

- Systems in place for monitoring and managing risks to patients and staff were not robust. There was a health and safety policy in place and named representative. We found the practice appeared well maintained and appropriate arrangements were in place for the management of clinical and non-clinical waste. However, the practice was unable to demonstrate the arrangements for the routine management of the premises. Risk assessments for monitoring safety of the premises such as control of substances hazardous to health and fire although in place were not dated to ensure they were up to date. There was no evidence of legionella risk assessments or electrical installation checks for the mains electric supply. Fire equipment and alarms were tested regularly and an evacuation procedure was in place but no records of any fire drills to ensure staff knew what to do had been carried out. Following our inspection the practice sent confirmation of bookings and reports for fire, legionella and electrical installation risk assessments carried out at the premises.
- Electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. Records seen confirmed these checks had been undertaken within the last 12 months.
- We observed the premises to be visibly clean and tidy and well maintained. Staff had access to appropriate hand washing facilities and personal protective equipment such as gloves and aprons and cleaning equipment. Cleaning schedules were in place for the cleaning of the practice and equipment. However these did not include the privacy curtains and waiting room carpets, no records were available to show how frequently these were cleaned. We reviewed an infection control audit that had been carried out in June 2015 and staff were able to talk about some of the actions

Are services safe?

they had taken in response. For example lidded containers had been obtained for the storage of loose equipment to protect them from dust. The practice held a list of immunisation status for staff but this was not kept up to date and some of the newer members of clinical staff were missing from it.

- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe. Vaccines and other medicines were checked to ensure they were appropriately stored and fit for use. There were clear processes for staff to follow when issuing prescriptions. GPs told us that medicine reviews took place on a six monthly basis. The practice also worked with local CCG pharmacist to ensure it was prescribing in line with best practice guidelines for safe prescribing. Prescribing data showed that the practice's prescribing rates for antibiotics, non-steroidal anti-inflammatory drugs and hypnotics were comparable to other practices.
- We reviewed the recruitment files for the two newest members of staff. These showed that most recruitment checks had been completed to ensure the suitability of staff employed. We noticed that where a DBS check had been made it was in relation to another previous employer and was not current at the time of employment. No risk assessments had been completed in relation to the roles and responsibilities for non-clinical staff where it was deemed that a DBS check was not necessary.

- Staffing arrangements ensured there was sufficient staff to meet patient need. The GP partners each worked nine clinical sessions and were able to support each other during leave or other absences. Staff told us that they rarely used locums. A daily on-call rota was in place and the GP on call for the day covered any urgent matters that arose. Nurse cover was usually provided by nursing staff doing additional hours.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers which enabled staff to alert other members of staff to any emergency. Staff we spoke with told us that they had received basic life support training within the last 12 months. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. The medicines we checked were in date and fit for use. The practice had oxygen available for use in an emergency but no defibrillator. Staff told us there was a defibrillator in the pharmacy next door if they needed one but were unable to verify whether this was maintained and fit for use.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or incapacity of staff. However the plan had not been reviewed since March 2010 to ensure information including emergency contact numbers for staff and suppliers was up to date.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinical staff we spoke with were able to describe how they accessed and implemented guidelines based on best practice such as National Institute for Health and Care Excellence (NICE) standards and from the CCG. They described how they received updates and alerts and were involved in audits that reviewed the management of patient care against NICE guidance. For example the management of myocardial infarction (heart attack). Patient care was routinely discussed by the GPs to support the sharing of knowledge.

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. The most current published data from 2013/14 showed that the practice had achieved 98% of the total number of points available (higher than the CCG and national averages), with 7% exception reporting (lower than the CCG and national averages). Exception reporting is used to ensure that practices are not penalised where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side-effect. Data from 2013/14 showed;

- Performance for diabetes related indicators was at 100% which was better than both the CCG average of 91% and national average of 90%. Exception reporting for the majority of diabetes related indicators was below CCG and national averages.
- The percentage of patients with hypertension having regular blood pressure tests was at 87% which was better than the CCG average of 83% and the national average of 83%.
- Performance for mental health related indicators was at 99% which was better than the CCG average of 91% and the national average of 90%.
- The percentage of patients with a dementia diagnosis was 0.3% which was lower than the CCG average of 0.5%

and national average of 0.6%. The practice told us that this figure had been externally verified and that the verification process had not highlighted any concerns with reporting.

This practice was aware that it was an outlier for reported versus expected prevalence of Chronic Obstructive Pulmonary Disease (COPD). The GPs told us that this had been subject to external review which did not raise any concerns with the data. The practice was also an outlier for the uptake of cervical screening. Data for 2013/14 showed the uptake of cervical screening for the practice as 74% which was lower than the CCG average of 78% and national average 82%. Cervical screening was mainly undertaken by the nursing staff for which there were 1.15 whole time equivalents. However we were told that there were three GPs who also undertook cervical screening. There was also a designated member of staff who followed up patients who did not attend.

The GPs showed and discussed with us clinical audits they had carried out. These included audits relating to minor surgery and joint injections to assess for complications which were carried out on an ongoing basis. The practice was also participating in a wider CCG led audit to assess the management of patients following a myocardial infarction (heart attack). At the time of the inspection it was not clear from audits seen that they had completed their full audit cycle in order to demonstrate improvements made as a result. The practice subsequently sent further information relating to two of these audits to show that re-audit had taken place.

Effective staffing

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

- The practice had an induction programme for newly appointed members of staff that covered areas such as fire safety, health and safety and confidentiality. Staff told us that induction programmes were tailored to meet the needs of the individual members of staff and showed us copies of these.
- Staff received annual appraisals which enabled them to discuss any learning needs.
- We saw evidence from staff files that they had access to training for the roles and responsibilities they were expected to perform and were allocated protected

Are services effective?

(for example, treatment is effective)

learning time for professional development. For example, we saw certificates relating to the practice nurse's roles. Staff also had access to and made use of e-learning training modules and in-house training.

- The practice had robust systems in place for GPs to share skills and knowledge. The GPs met twice daily to discuss patient information received and discuss options for patient care. The GPs told us that being a training practice also helped keep them up to date.
- Although we were told that all staff were up to date with training such as basic life support, fire awareness and safeguarding we found this difficult to verify. The practice did not have any systems in place to enable management to easily keep track of staff training, for example, when it was next due and to ensure no staff were missed. As a result, managers had to rely on individual files which meant that there was the potential for gaps.

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. Patient information such as test results and treatments were discussed in a supportive environment by the GPs at their twice daily meetings. GPs told us that information received about patients was reviewed daily and that they were up to date. Relevant information was also shared with other services in a timely way, for example special notes were completed for patients who might need to access the out of hours service to support the continuity of care.

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 ongoing care and treatment. Regular formal and informal meetings were held with the district nurses and health visitors to discuss those with complex health needs or at risk of harm. GPs reported that they found it more challenging working with social services as their patients crossed two areas.

The practice supported two care homes and provided monthly reviews of all patients as well as support when required. These were carried out by a dedicated GP for continuity. Feedback received from the manager of one of the homes about the support received was positive.

Consent to care and treatment

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Practice staff were able to show us how they obtained and recorded consent for procedures that were carried out at the practice.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients with long term conditions, end of life care and carers. Clinics for various long term conditions were led by the GPs which enabled staff to keep patients under regular review and identify any changes at the earliest opportunity. The practice told us about additional clinics provided such as a pain clinic including acupuncture, gynaecology clinic, a diabetes clinic in conjunction with a local consultant and sexual health services. Information was available in the waiting area for patients to take away about services including flu clinics and information relating to various health conditions.

Patients had access to health assessments and checks. Letters were sent to eligible patients to invite them to attend. These included health checks for new patients and NHS health checks for people aged 40–74. Any concerns relating to patients were referred to the GP for follow up.

The practice offered cervical screening programmes although uptake at the practice was lower than that of the local CCG and national averages. The practice told us that they had tried to introduce a Friday evening clinic specifically for cervical screening but this had not been successful. The practice was also participating in screening patients for atrial fibrillation (heart condition) and dementia to support earlier diagnosis and care. Travel advice and vaccinations including Yellow Fever were also available at the practice.

Published data for 2013/14 showed flu vaccination rates for the over 65s were 67%, and for at risk groups 52%. The rates for the over 65 years were below the national average of 73% and comparable to the national average of 52% for at risk groups. We saw that the practice was advertising for the current flu season to encourage patients to come in for their vaccination.

We had difficulties in obtaining published data for child immunisations as the practice had been formerly part of a different CCG area. Data from the practice showed

Are services effective?

(for example, treatment is effective)

childhood immunisation for April to June 2015 showed that practice was achieving a 90% overall in both vaccinations for under two year olds and five year olds. We did not have access to any comparative data.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Throughout the inspection we observed that members of staff were polite and helpful to patients attending at the reception desk and that people were treated with dignity and respect. Curtains or screens 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 and that conversations taking place in these rooms could not be overheard. A rope barrier was used at reception to encourage patients waiting to stand back and allow the person in front some privacy. Music was played to minimise the risks of conversations being heard. Reception staff told us that there was an interview room they could use if a patient wanted to discuss anything sensitive or appeared distressed.

Feedback we received from patients through the 12 completed CQC comment cards and our conversations with 14 patients (including 4 members of the patient participation group (PPG)) was positive. Many of the patients had been with the practice for a long time. They told us they were satisfied with the service they received.

Results from the national GP patient survey (published July 2015) showed patients were happy with the service they received from the GPs and that were treated with compassion, dignity and respect by them. The practice was above average for its satisfaction scores on consultations with doctors. However, the scores for nurses and reception staff were lower than the CCG and national averages. For example:

- 91% said the GP was good at listening to them compared to the CCG average of 88% and national average of 89%.
- 88% said the GP gave them enough time compared to the CCG average of 86% and national average of 87%.
- 97% said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and national average of 95%.
- 89% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 84% and national average of 85%.

- 85% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 89% and national average of 90%.
- 77% patients said they found the receptionists at the practice helpful compared to the CCG average of 83% and national average of 87%.

Care planning and involvement in decisions about care and treatment

Most patients we spoke with told us that health issues were discussed with them and that they felt involved in decision making about the care and treatment they received. They also said they felt listened to and had sufficient time during consultations to make informed decisions about their health care. Patient feedback on the comment cards we received was also positive and aligned with these views.

Results from the national GP patient survey (published in July 2015) showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and results were in line with local and national averages. For example:

- 88% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and national average of 86%.
- 85% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 80% and national average of 82%.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations for example, CRUSE bereavement counselling.

There was a practice register of people who were carers. The practice had identified 116 patients on the practice list as carers and this was used to offer support and target services available, for example, flu vaccinations. Information available for carers included a carers corner in the waiting room and a dedicated carers section on the practice website which enabled this group of patients to find out more about support available to them.

Practical advice on what to do in the event of death was available in the practice leaflet and on the practice website. A counsellor was also available at the practice for staff to refer to patients for additional support if needed. We spoke

Are services caring?

with the manager of a care home supported by the practice. They told us that they were happy with the support the practice gave to patients with end of life care needs and their relatives.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice engaged with the local CCG and other practices locally to plan services and to improve outcomes for patients in the area. For example, the practice was participating in the CCG led Aspiring to Clinical Excellence (ACE) programme aimed at driving standards and consistency in primary care.

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

- The practice offered extended opening hours on a Monday and Tuesday evening until 8pm for those who worked or with other commitments which meant they could not attend during normal opening hours.
- On-line booking for appointments and ordering repeat prescription were available for patients' convenience.
- Patients were able to book longer appointments by request if they needed one.
- Home visits were available for patients whose health prevented from attending the surgery.
- Urgent access appointments were available for children and adults via the GP on call.
- The premises were accessible to those with mobility difficulties or used a wheelchair. The premises provided a spacious waiting area with consulting rooms and facilities for disabled patients located on the ground floor.
- Administrative staff told us that they had not used translation services but if needed would encourage patients to bring a family member to translate. This may not be appropriate when discussing sensitive or personal issues. Staff told us that they had members of staff that could speak additional second languages to support patients including a qualified translator who could speak Polish and Slovakian. We were advised that there was a hearing loop available but this was not well advertised to patients and not all staff were aware of it or how to use it if needed.
- Baby changing facilities were available.
- The website provided facilities so that patients who were unable to read the contents could listen to information available.

- Patients had access to both male and female clinicians with which to discuss their health problems.
- Additional services were available including a pain clinic which offered acupuncture to patients as an alternative to medicine, a gynaecology clinic, a diabetes clinic in conjunction with a local hospital consultant.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Appointments were from 8.45am to 11.30 every morning and 3.45pm to 6pm daily. Extended hours surgeries were available 6.30pm and 8am on a Monday and Tuesday. In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available for people that needed them on the day, these were usually with the GP on-call.

Results from the national GP patient survey (published in July 2014) showed that patients' satisfaction with how they could access care and treatment was mixed compared to local and national averages. Six of the 14 patients we spoke with on the day also said they sometimes found it difficult to get a routine appointment but otherwise patients told us they would be seen if it was an emergency. For example:

- 76% of patients were satisfied with the practice's opening hours compared to the CCG average of 72% and national average of 76%.
- 63% patients said they could get through easily to the surgery by phone compared to the CCG average of 62% and national average of 74%.
- 59% patients described their experience of making an appointment as good compared to the CCG average of 67% and national average of 74%.
- 74% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 62% and national average of 65%.

Access to urgent appointments had been a priority area in which the practice's patient participation group (PPG) was working with the practice to try and improve.

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.

Are services responsive to people's needs? (for example, to feedback?)

We saw that information was available to help patients understand the complaints system, including the patient leaflet and website. This ensured patients were aware of the process, where they could get support and who to go to if they were unhappy with the practice's response to their complaint. Information advising how patients could make a complaint was displayed in the waiting area, practice leaflet and website.

We saw that there had been 10 complaints received during 2014/2015. We saw that these had been satisfactorily handled and dealt with in a timely way.

Complaints were discussed at staff meetings as a standing agenda item to ensure any learning was shared.

Are services well-led?

Requires improvement 

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

Our findings

Vision and strategy

At the start of the inspection the GP partners spoke about the practice and their priorities which focussed on clinical care. They told us how they were committed clinically to the practice and each GP undertook 9 clinical sessions a week. They met as a clinical team informally twice a day to discuss patient care.

Governance arrangements

The governance arrangements for the practice focussed heavily on a GP led service. The practice was clinically well led but evidence seen did not support a robust managerially led service

- The GPs were supported by a team of administrative staff under their direction. It was not always evident where responsibilities lay which led to weaknesses in the arrangements for identifying, recording and managing risks within the service.
- Practice specific policies were implemented and were available to all staff on their computers. Some but not all were dated to show when they were last reviewed and to ensure staff were using the most up to date information. Staff told us that the practice administrator had recently been employed to review the policies.
- Staff meetings routinely took place which enabled important information to be shared among staff and attendance at these meetings was recorded.
- There was a clinically supportive culture for the GPs at the practice who held twice daily review meetings in a designated area each with computer access to patient records. This enabled them to easily review clinical activity, patient information and discuss treatment options with colleagues. However, this system of support did not extend to other staff including nursing staff who told us that they did not participate in any supporting networks.
- The GPs were aware of their performance in relation to QOF and overall were performing well. The GPs led on different aspects of disease management.
- There was evidence of staff having received inductions and annual appraisals to discuss development needs and these were acted on. For example the practice

nurse was undertaking a diploma course in diabetes management. However, systems for monitoring staff appraisals and training were not sufficiently robust to ensure staff were up to date with relevant training and appraisals.

Leadership, openness and transparency

The partners were visible in the practice and staff told us that they were approachable and supportive. However, evidence seen throughout the inspection did not suggest that the routine systems and policies involved in running the service were robust. This included:

- Record keeping relating to incidents, staff immunity, staff training and appraisals.
- Risks relating to the premises including electrical installation, legionella, the control of substances hazardous to health, cleaning of curtains and carpets.
- Risks relating to fire safety.
- Risks relating to staff employed.
- Risks relating to the absence of emergency equipment.

We saw that the practice had a whistle blowing policy and staff spoken with knew where to find it but had not had cause to use it.

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 virtual patient group. The PPG consisted of approximately 16 members who met regularly every two months and a virtual patient group of approximately 200 members who participated via email. Information about the PPG was displayed in the waiting area.

We spoke with PPG members who were very positive about the practice and felt valued. Meetings were attended by GP partners who were able to influence change. We spoke with four members of the PPG who felt that the practice was open with them. For example members of the PPG had been invited to attend the appraisal process for the CCG led ACE programme and complaints were shared with them.

Are services well-led?

Requires improvement



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

The latest published data from the friends and family test (July 2015) which asks patients whether they would recommend the service to others rated the practice as in the middle range with a score of 79.3%.

Staff had opportunities through the appraisal process and team meetings to feedback any concerns or issues they might have.

The practice told us that as a practice they participated in research and had been involved in a blood pressure study recently published in a well known medical journal.

The practice was a training practice for doctors who were training to be qualified as GPs and a teaching practice for medical students. The practice also supported training for physician assistants.

Innovation

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 17 HSCA (RA) Regulations 2014 Good governance There were areas in which the practice did not have effective systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. The practice was unable to demonstrate robust systems and policies in place for the running of the service. Regulation 17 (1)(2)(b)(d)(i)(ii)
Family planning services	
Maternity and midwifery services	
Surgical procedures	
Treatment of disease, disorder or injury	