Dr Ross and Partners

Quality Report

Northfield Health Centre
15 St Heliers Road
Northfield
Birmingham,
West Midlands
B31 1QT
Tel: 0121 478 1850
Website: www.northfieldhealthcentre.net

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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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Ross and partners on 1 July 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services for the six population groups (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 and people experiencing poor mental health (including people with dementia). It required improvement for providing safe services.

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

- At the time of our inspection the practice was going through a period of transition. Management arrangements which had formerly been shared with another practice in Northfield Health Centre were being separated and new management was in place.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Processes in place for managing risks were not robust, we highlighted risks associated with infection control, recruitment and the premises that needed to be addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.

Summary of findings

- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment and urgent appointments were available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

The areas where the provider must make improvements are:

- Ensure robust arrangements are in place for identifying, assessing and managing risks to patients including those relating to recruitment, and the premises.
- Ensure risks associated with infection prevention and control are appropriately managed to minimise the risk of cross infection.

In addition the provider should:

- Ensure staff are clear about the purpose and requirements of a chaperone to ensure adequate safeguards for staff and patients during an examination.
- Review systems for maintaining patient confidentiality at reception.
- Review contact information available to patients on the practice website to ensure it remains up to date for example, links for carers support.
- A system should be in place to ensure correspondence is handled appropriately when a patient with no fixed abode registers under temporary addresses.
- Review systems in place to ensure staff have read and understood practice policies and procedures.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. We found that the systems to manage risks to patients were not robust to ensure patients were kept safe. We identified risks relating to recruitment, infection control and the premises. At the time of the inspection the practice was going through a period of transition and the management structures were changing. A new practice manager had been recruited and was in the process of identifying actions that needed to be implemented to manage risks.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were similar to local and national averages. Staff referred to guidance from the National Institute for Health and Care Excellence. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

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 compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect. However arrangements for maintaining confidentiality at reception were not robust.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment when they

Summary of findings

needed one and urgent appointments were available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice was going through a process of change and was able to tell us about its vision for the service. Staff were clear about their responsibilities. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The new practice manager was aware of the need to address risks in relation to the premises and was starting to address these. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people with complex care needs. Vaccination including flu, pneumonia and shingles were available and the practice was above the CCG average for uptake of flu vaccinations in patients over the age of 65 years. There were locally enhanced services for older patients including unplanned admission avoidance and dementia. There was a designated lead for end of life care and systems in place to support the needs of patients at end of life including monthly multidisciplinary meetings. Home visits and same day appointments were available to those who needed them.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Clinical staff (GPs and nurses) took lead roles in the management of chronic diseases management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and structured annual reviews were carried out 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.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. There was close working with health visitors who operated from the same health centre as the practice and follow-up of children who did not attend for immunisations. Immunisation rates were relatively high for all standard childhood immunisations. Services were co-ordinated to make it easier for parents. For example weekly one stop children and mother service enabled patients to see the health visitor at the same time as GP development checks. Appointments were available outside of school hours and the premises were suitable for children and babies. Children under five years would be prioritised for same day appointments.

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 offered services that were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances such as those with a learning disability and carers. Over the last year the practice had sought to identify and increase the number of patients on these registers. The practice confirmed that they had not yet carried out annual health checks for people with a learning disability but were currently working with the CCG priorities to identify and issue health passports to patients with a learning disability to identify needs and preferences should they be admitted to hospital. Carer support and signposting to other support services was also being offered to those identified as carers. Where a need was identified patients at the practice gave longer appointment. There was a general ethos at the practice not to turn people who way that needed support and reception staff were aware of this.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice had a lead GP for the management of patients with poor mental health. Patients experiencing poor mental health were offered annual physical health check and 93% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan in 2013/14. Patients requiring additional support were signposted to various support services including in-house counselling. The practice had systems in place to support safer prescribing of patients on medicines for example shorter or non-repeat prescriptions for patients on antidepressants.

Summary of findings

The practice worked with multi-disciplinary teams in the management of people experiencing poor mental health, including those with dementia. The practice provided locally enhanced services for patients with dementia to support earlier referrals to specialist care.

Summary of findings

What people who use the service say

As part of the inspection we spoke with 9 patients who used the practice. This included two members of the patient participation group (PPG). PPG are a way in which practices can work closely with patients to improve services. We also sent the practice comment cards prior to the inspection inviting patients to tell us about the care they had received. We received 36 completed comment cards. Our discussions with patients and feedback from the comment cards told us that patients were happy with the service they received. Patients told us that they were treated with dignity and respect and felt listened to. Most patients said they could get appointments when they wanted one.

The practice received positive feedback from patients in the latest GP National Patient Survey 2014/15. Patients rated the practice above the CCG and national average in a number of areas including overall experience, access and quality of consultations.

Areas for improvement

Action the service MUST take to improve

- Ensure robust arrangements are in place for identifying, assessing and managing risks to patients including those relating to recruitment, and the premises.
- Ensure risks associated with infection prevention and control are appropriately managed to minimise the risk of cross infection.

Action the service SHOULD take to improve

- Ensure staff are clear about the purpose and requirements of a chaperone to ensure adequate safeguards for staff and patients during an examination.
- Review systems for maintaining patient confidentiality at reception.
- Review contact information available to patients on the practice website to ensure it remains up to date for example, links for carers support.
- A system should be in place to ensure correspondence is handled appropriately when a patient with no fixed abode registers under temporary addresses.
- Review systems in place to ensure staff have read and understood practice policies and procedures.

Dr Ross and Partners

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, practice nurse 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 Dr Ross and Partners

Dr Ross and Partners 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.

Dr Ross and Partners 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 which it shares with another GP practice and community health services. Based on data available from Public Health England, deprivation in the area served by the practice is higher than the national average. The practice has a registered list size of approximately 10,500 patients.

The practice is open 8am to 6.30pm on Monday to Friday. Extended opening hours are available on four mornings each week between 7am and 8am. When the practice is closed during the out of hours period (6.30pm to 8am) patients received primary medical services through an out of hour's provider (Primecare).

The practice has five GP partners (two male and three female) and four salaried GPs. Other practice staff consist of a team of two nurses and a healthcare assistant, a practice manager and a team of administrative staff. The practice is also a training practice for doctors who were training to be qualified as GPs and a teaching practice for medical students.

Prior to March 2015 the management of the practice had been jointly managed with the other practice that shared the premises at Northfield Health Centre. When the practice manager retired the two practices had formally split and separate management arrangements put in place. At the time of our inspection the practice was undergoing this transition.

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 visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 1 July 2015. During our visit we spoke with a range of staff (including GPs, nursing, management and administrative staff) and spoke with 9 patients who used the service. We looked at a range of documents that were made available to us relating to the practice, patient care and treatment. Prior to the inspection we sent the practice a box with comment cards so that patients had the opportunity to give us feedback. We received 35 completed cards where patients shared their views and experiences of the service.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses (for example, a needle stick injury).

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 6 years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of 15 significant events that had occurred during the last 12 months and saw this system was followed appropriately. Significant events were discussed at twice weekly clinical meetings. In one example the clinicians reviewed the management of a patient with an infected pacemaker. Guidance was sought from a cardiologist and a better understanding as to how to manage a similar situation in the future was gained.

Staff told us they used an incident book to record incidents that occurred and these were picked up by the practice manager who completed the relevant reporting forms. Reports seen showed they were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and learning shared with relevant staff.

There was a designated GP who reviewed and acted on national patient safety and medicine alerts received.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their understanding of safeguarding patients from harm. They were aware of their responsibilities if they were concerned that someone may be at risk of abuse and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible to staff.

The practice had a dedicated GP lead for safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern.

Quarterly meetings were held with health visitors, school nurses and midwives to discuss vulnerable children. Health visitors worked from the same premises as the practice which also helped facilitate regular discussions about children they may be concerned about. The management of vulnerable adults would be discussed as part of the monthly multidisciplinary team meetings held with the community matrons and district nurses. Staff told us they followed up children who did not attend for their appointment if they were concerned.

The practice has coded alerts in the problem heading section on the computer record, for patients and families that were vulnerable. Clinical staff knew where this information was to be found, but a computerised alert prompt might help ensure this information was not missed.

There was a chaperone policy in place. Notices were visible on the waiting room noticeboard advising patients that they could request a chaperone if they wanted one. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Chaperone duties were undertaken by staff, including nurses, health care assistants and receptionists. Staff told us that they had received in house training to be a chaperone. We found both clinical and non-clinical staff were not clear about the purpose and requirements of a chaperone to ensure adequate safeguards for staff and patients during an examination. Patients were given the choice as to where a chaperone stood which did not always enable the chaperone to observe the examination.

The practice was unable to provide evidence that all staff undertaking chaperone duties had received Disclosure and

Requires improvement

Are services safe?

Barring Service (DBS) checks or that appropriate risk assessments were in place for this role. (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). We were told that this was because they had been unable to access records that had been maintained by the previous practice manager who had left in March 2015. We spoke with one member of staff whose DBS was missing. They confirmed a DBS check had been undertaken when they first started work at the practice.

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 was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure (cold chain policy). All the medicines we checked were within their expiry dates.

Prior to our inspection the practice had identified concerns with the cold chain in which the temperature range for two of the four medicine refrigerators had been outside the required range by one degree Celsius since January 2015. A significant event had been raised and appropriate action taken including contact with both Public Health England and the CCG for support and to identify any risks to patients. One of the fridges has since been replaced and more robust monitoring of the fridge temperatures put in place. We noticed that fridge thermometers had not been included in latest calibration checks. The practice had identified as part of its action plan to identify the checks required to ensure thermometers were not faulty.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Staff told us that blank prescription forms were locked away securely at night. Although logs were kept of prescriptions received by the practice there was no audit trail as to how or who had used individual prescriptions.

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results. We checked five anonymised patient records which confirmed that the procedure was being followed.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. These were up to date. The health care assistant administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the prescriber. We saw evidence of appropriate training for staff administering medicines under PGDs.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. However, we noticed that clinical rooms with the exception of the minor surgery room were carpeted. This did not allow for infection control standards to be adequately maintained in the case of spills of bodily fluids such as blood. There were no risk assessments in place to assess and mitigate the potential risks of carpets in each of the clinical rooms. There was evidence to show that the carpets and privacy curtains had been deep cleaned prior to our inspection but a lack of records available made it difficult to ascertain how frequently this cleaning took place.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury. A recent significant event involving a needle stick injury had identified issues with staff not following policies and procedures. The practice had identified the need to reinforce the policies and protocols. A follow up date had been identified to review action taken, which was after our visit.

The practice had a lead nurse for infection control who had undertaken training to enable them to provide advice on the practice infection control policy and carry out staff training. We saw evidence that the lead had carried out an infection control audit within the last 12 months but did not raise any major concerns with this. Nursing staff told us the findings from the audits were discussed at the clinical meetings.

Requires improvement

Are services safe?

Notices about hand hygiene techniques were displayed throughout the practice. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice was working on a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). Staff were unable to confirm that legionella risk assessments or checks to reduce the risk of infection to staff and patients were being carried out. Staff told us that they were trying to obtain this information from the property management company and had not received a response and that this was of concern to them.

Equipment

Staff we spoke with had equipment needed to enable them to carry out diagnostic examinations, assessments and treatments. We saw that 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 and displayed stickers indicating the last testing date which was October 2014. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices. However the schedule of testing had not included the fridge thermometers.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at were missing evidence that appropriate recruitment checks had been undertaken prior to employment. The practice manager and GPs explained that the previous practice manager had managed both the practices within Northfield Health Centre but had left in March 2015. The two practices had formally separated and the current practice manager had been appointed to manage Dr Ross and partners practice only. They were still working through the paperwork and had been unable to open previously shared files which contained recruitment information due to password protection.

We saw a spreadsheet which confirmed the date of Disclosure and Barring Service (DBS) checks for clinical and non clinical staff. We saw there were no records of DBS checks for five of the non-clinical staff. We spoke with two members of these staff. Both staff confirmed that the DBS check had been done at the time of recruitment.

Since starting the practice manager was in the process of recruiting a salaried GP. Although the process was not fully completed we saw that appropriate checks were in progress such as proof of identification and registration with professional bodies. We saw records had been maintained to check clinical staff registration with professional bodies were up to date.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Administrative would be offered overtime if needed. Staff told us that locum GPs were rarely used and were unable to recall the last time they had.

Monitoring safety and responding to risk

The practice manager told us that since starting in post in March 2015 they had been working through paper work and identifying what they needed to do. The practice manager showed us a Display Screen Equipment risk assessment they had started to produce. They told us many of the risk assessments were held with the property managers for the building such as those relating to the environment and this was an area of concern that they needed to address. The practice manager told us that they carried out checks of the environment but these were not formally documented. There was a designated member of staff who would follow up any maintenance issues but did not maintain any formal records.

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice, although evidence from significant events showed that these were not consistently followed or understood by staff. The practice also had a health and safety policy. Health and safety information was displayed but was out of date and did not identify any health and safety representative for the practice. The practice manager recognised that this was an issue and needed to be addressed with all the Health Centre occupants.

Requires improvement

Are services safe?

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. Patients were able to obtain same day appointments which enabled the practice to manage urgent cases. The practice A&E attendances and emergency admissions were lower than the CCG average.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date. Practice staff were able to tell us about medical emergencies that they had responded to.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, loss of telephone system and access to the building. The document also contained relevant contact details for staff to refer to. The plan had recently been reviewed to reflect the split between the two former practices but did not include any dates to inform staff that the document was still current.

The practice had carried out a fire risk assessment in 2013 that included actions required to maintain fire safety under the previous management. We saw that a fire inspection had been booked the week after our inspection to update the fire risk assessments. Records confirmed fire equipment had been checked within the last 12 months. Staff told us that the fire alarms were regularly tested but no fire drills had recently taken place. Training records showed that approximately half the staff had undertaken fire training so that they would know what to do in the event of a fire.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. GPs told us they received NICE guidance via email and would discuss any new guidance at weekly clinical meetings.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Regular reviews of patients with long term conditions took place to ensure their treatment remained effective.

The practice had identified patients who were at high risk of unplanned admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patients' age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input and scheduling clinical reviews.

We saw clinical audits that were linked to medicines management information, adherence to best practice guidance and safety incidents. The practice showed us seven clinical audits that had been undertaken in the last 12 months. Five of these were completed two cycle audits where the practice was able to demonstrate the changes resulting since the initial audit. In one audit the practice reviewed its adherence to NICE guidance on stroke prevention in the management of patients with atrial fibrillation. Following re-audit all 153 patients reviewed were found to have been managed according to guidelines. Other examples included audits to confirm appropriate records of checks were maintained for patients receiving contraceptive implants.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. The practice was not an outlier for any QOF (or other national) clinical targets, It achieved 96% of the total QOF target in 2013/14, which was above the national average of 94%. Specific examples to demonstrate this included:

- Performance for diabetes related indicators was similar to the national average.
- The percentage of patients with hypertension having regular blood pressure tests was similar to the national average
- Performance for mental health related indicators was similar to the national average.
- The dementia diagnosis rate was comparable to the national average.

The practice's prescribing rates were also similar to national figures, for example antibiotic prescribing. There was a protocol for repeat prescribing. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP.

The practice had made use of the gold standards framework for end of life care. It had a palliative care register and held regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. The benchmarking data showed the practice had outcomes that were comparable to other services. For example in relation to vaccinations, medicines and patient satisfaction.

Good

Are services effective?

(for example, treatment is effective)

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support and safeguarding. We noted a good skill mix among the doctors with staff having additional training in areas such as palliative care, contraceptive implants and intra uterine devices. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. The majority seen had been undertaken in the last 12 months. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example we spoke with a member of staff who had started as an apprentice and was given both financial assistance and time to train as a phlebotomist. The practice was also a training practice for doctors who were training to be qualified as GPs. Trainees had access to a senior GP throughout the day for support.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles for example seeing patients with long-term conditions such as asthma and diabetes were also able to demonstrate that they had appropriate training to fulfil these roles.

Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. Staff were clear about their individual responsibilities for passing on, reading and acting on any issues arising these communications. Staff told us they were usually seen and actioned on a daily basis.

Emergency hospital admission rates for the practice were relatively low compared to the CCG average. Data available for the practice for April 2014 to December 2014 showed 63 emergency admissions per 1,000 patients compared to the CCG average of 79 emergency admissions per 1000 patients. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract).

The practice held monthly multidisciplinary team meetings to discuss patients with complex needs. For example, those with multiple long term conditions and end of life care needs. These meetings were attended by district nurses, palliative care nurses and decisions relating to patient care were documented on the patient record. Care plans were in place for patients with complex needs.

Quarterly meetings were also held to discuss children at risk with the health visitor, school nurses and midwives. We spoke with health visitors and district nurses who shared the health centre with the practice. They told us that they had a good working relationship with the practice; they confirmed that they regularly met with the practice to discuss patients' needs and would also speak as and when needed.

Information sharing

The practice used electronic systems to communicate with some providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared electronically in a secure and timely manner. We saw a recent example of information that had been shared with the out-of-hours provider for a patient with complex needs. However, the system used was not compatible with that used by the district nurse team to enable easier sharing of information.

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency. The practice had also signed up

Good

Are services effective?

(for example, treatment is effective)

to the electronic Summary Care Record and this was in place. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The system had been in place since 2013 and some staff told us that they had been trained as 'super users' so that they could support other staff. Other staff told us that they had received in-house training. There was scope for practice to better understand the system in place for example the use of template applications to help ensure a consistent approach in the management of chronic diseases.

Consent to care and treatment

We found the GPs we spoke with were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. They understood the key parts of the legislation and were able to describe with examples how they implemented it with terminally ill patients. However, we found the nurses we spoke with were less confident in their understanding.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's written consent was scanned into the electronic patient notes. We saw a copy of a consent form the insertion of contraceptive implants which explained the relevant risks and benefits of the procedure.

Health promotion and prevention

Health checks for new patients registering with the practice and patients aged 40 to 74 years were undertaken by the health care assistant. The practice nurse told us how they used health checks to calculate and identify a patient's health risk. They would notify the patient of the outcome of their health check and risk levels and where appropriate offer a follow up appointment so that they can be appropriately managed.

The practice offered various screening services to patients. They were currently participating in an atrial fibrillation screening programme through the CCG. To date 70% of patients over 65 years had been screened which was exceeding the CCG target of 40%. This enabled patients with irregular pulse to be followed up to help minimise the risk of stroke.

The practice's performance for the cervical screening programme was 78%, which was below the national average of 81%. There was a policy to offer telephone reminders for patients to attend for their cervical screening test. A practice nurse had responsibility for following up patients who did not attend.

The practice also offered chlamydia screening to its patients and provided a range of contraceptive and family planning services. One GP at the practice specialised in children's' health and offered child development checks which incorporated postnatal depression screening and contraceptive advice.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had identified the smoking status of 90% of patients over the age of 16 and signposted patients to a smoking cessation group which operated at the practice one day each week. Data from the practice reported that 83% of these patients had received smoking support and advice. Patients who would benefit were also referred to health weight management and exercise support. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. We saw information in the waiting area advising patients of services available to support them to lead healthier lifestyles and for various long term conditions.

The practice also offered a full range of immunisations for children, travel vaccines (including yellow fever) and flu vaccinations in line with current national guidance. Performance for the majority of immunisations where comparative data was available was similar to the national average. For example:

- Flu vaccination rates (2013/14) for the over 65s were 40%, and 72% for at risk groups. Practice data showed there had been improvement during 2014/15 to 44% and 77% respectively.
- Childhood immunisation rates (2013/14) for the vaccinations given to under twos ranged from 93% to 98% and five year olds from 88% to 97%. These were similar to CCG averages.

Good

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 Patient Survey (2014/15) and a survey of 302 patients undertaken by the practice's patient participation group (PPG). A more recent survey had been undertaken by the practice in June 2015 but the results had yet to be analysed and acted upon. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was also above average for its satisfaction scores on consultations with doctors and nurses. For example:

- 93% said the GP was good at listening to them compared to the CCG average of 88% and national average of 87%.
- 93% said the GP gave them enough time compared to the CCG average of 87% 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%

Patients completed CQC comment cards to tell us what they thought about the practice. We received 35 completed cards and the majority were positive about the service experienced. Patients said they were happy with the care and treatment provided by the practice. They described staff as efficient, caring and helpful. They said staff treated them with dignity and respect. Three comments were less positive but there were no common themes to these. We also spoke with nine patients as part of our inspection. All told us they were satisfied with the practice and said their dignity and privacy was respected.

Consultations and treatments were carried out in theprivacy of a consulting room. Privacy curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Staff were able to describe steps they took to ensure patients' dignity was respected during examinations.

Two of the patients we spoke with told us that they could sometimes overhear personal details at reception. There were notices and reception staff told us that they would use a side window if a patient wished to speak with them in private. However, this window opened out into another waiting area. One PPG member told us that when the electronic book-in had been introduced they had hoped this would free reception staff to take calls away from the front desk but this had not worked. Additionally, 95% said they found the receptionists at the practice helpful compared to the CCG average of 84% and national average of 87%.

The practice ethos was that all patients needing support would be seen. Reception staff were aware of this and told us that they would not turn anyone away that needed help.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example:

- 91% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and national average of 86%.
- 87% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 81% and national average of 82%.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to that information was given to them in a way they could understand to help them make informed choices about their treatment. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language and that they knew how to access these services when needed.

Good

Are services caring?

We saw examples of care plans that had been produced for patients with complex health needs. The GPs told us that patients and their families were involved in agreeing these.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

- 92% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 85% and national average of 85%.
- 95% 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%.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Information in the patient waiting room told patients how to access a number of support groups and organisations. The practice had started to identify carers and over the last 12 months had increased the size of the register from 26 to 118. There was a carers' support policy in place which reception staff were able to give us a copy. This included information about services available to support the carer such as home visits if they were unable to leave the person they were caring for. We saw that that contact information available to patients on the practice website for example links to carer support had not been kept up to date.

The practice had a lead GP for end of life care. They told us how they supported families that had suffered a bereavement including miscarriages. Depending on the circumstances of death the GP would call or send a letter to offer bereavement support to the next of kin. We saw a copy of the letter which signposted them to support services available such as CRUSE bereavement services.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The practice understood the needs of its population and systems were in place to address identified needs in the way services were delivered. For example patients had good access to appointments and clinical staff. The practice had systems to follow up patients with long term conditions and patient outcomes for these patients were generally better than the national average.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. The practice was participating in the CCG led Aspiring to Clinical Excellence (ACE) programme aimed at driving standards and consistency in primary care and we saw a copy of the practice report.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example the installation of televisions in the waiting area and self-check in systems to reduce pressure at reception.

Tackling inequity and promoting equality

The practice had started to recognise the needs of different groups in the planning of its services. There had been recent efforts to establish accurate registers for patients with learning disabilities and carers in order to target specific support to them. This was currently work in progress. The practice was able to show that it had increased the register size over the last 12 months carers from 26 to 118 patients. The majority of the practice's population were English speaking patients. Staff knew how to arrange a translation service if needed and told us they had done so in the past.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence. During our inspection we saw patients entering the premises with mobility scooters, wheel chairs and walking aids. A low level reception desk enabled patients with a wheelchair to speak more easily to reception staff. We found there were no designated baby changing facilities available.

Staff told us that they did not have any patients who were of 'no fixed abode' but would practice policy was to always see someone if they needed assistance. Patients could be registered at temporary addresses although there were no specific systems in place to alert staff if confidential information was being sent to shared or temporary addresses.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor if preferred for their specific health problem.

The practice provided equality and diversity training through e-learning but training records showed that only two members of staff had completed this training.

Access to the service

The surgery was open from 8am to 6:30pm Monday to Friday. Appointments were available on the day for patients that needed to be seen urgently. Patients were also able to book appointments up to four weeks in advance and would be able to see their preferred GP if willing to wait.

Information was available to patients about appointments on the practice website and in the practice leaflet. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring to access out-of-hours service.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and rated the practice well in these areas. For example:

- 86.5% were satisfied with the practice's opening hours compared to the CCG average of 73.7% and national average of 75.7%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 87.6% described their experience of making an appointment as good compared to the CCG average of 68.5% and national average of 73.8%.
- 67.2% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 62.3% and national average of 65.2%.
- 85.7% said they could get through easily to the surgery by phone compared to the CCG average of 63.3% and national average of 74.4%.

Patients we spoke with were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they felt their need was urgent. On the day of our inspection we saw patients booking same day appointments.

The practice offered extended opening hours on four mornings each week between 7am and 8am. It also offered text reminders for appointments and online booking which enabled patients who worked or had other commitments during the day appointment times that were more convenient to them. School children were able to obtain appointments outside school hours. Longer appointments were available for patients who needed them. Staff told us that there was an alert on the system for patients who required longer appointments.

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.

Information was available to help patients understand the complaints system. Details on how to complain were included in the practice leaflet and a complaints leaflet was held behind the reception desk. Information was displayed in the waiting area to alert patients to this but was not easy to find. Only one patient we spoke with told us they had ever made a complaint and were satisfied with the way in which it had been managed.

We looked at the summary of 12 complaints received in the last 12 months. We saw that these were a combination of formal written and verbal complaints. Evidence provided showed the complaints had been appropriately managed.

The practice told us they held an annual meeting to discuss complaints and review any themes or trends and we saw the minutes from this meeting. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on.

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 was going through a process of change in which it was formally separating all management arrangements which had previously been shared with another practice within the same health centre. This was the main priority for the practice and a new manager had been employed to carry this through.

The GPs shared with us their aims for the practice during their presentation which included a desire to provide safe, high quality and accessible services for all of their patients and those with an immediate medical need. As well as reducing health inequalities. A health centre charter was available on the practice's website which set out the level of service patients could expect to receive.

Although, practice staff we spoke with were not aware of any specific visions and values of the practice we saw that they demonstrated values which were caring and in line with what we were told.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. Staff showed us how they accessed the policies and procedures. Policies and procedures were mostly up to date, although some seen did not have dates to ensure staff were referring to the latest version. There were no systems in place to ensure staff had read policies and two recent incidents that had been reported related to staff not following policies and procedures that were in place.

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

The practice used the Quality and Outcomes Framework (QOF) to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing in line with national standards. Individual staff took responsibility for monitoring different areas of QOF in order to meet targets. The practice told us that they wanted to improve the uptake of cervical screening and had undertaken an audit to identify why patients were reluctant to attend for this. Both practice nurses and GPs carried out cervical screening and patients were contacted by telephone to encourage them to come in.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken.

The practice held various staff meetings where governance issues were discussed. We looked at minutes

from these meetings and found that performance, quality and risks had been discussed. However, it was not always clear from minutes seen the remit for the various meetings. The reporting structure of minutes did not make them easily accessible as a source of reference should staff need to refer back to issues discussed and decisions made. The new practice manager was aware of the need to review the management of risks at the practice and was working on this for example in relation to the premises.

We saw a copy of the staff handbook that was given to new starters. This included information relating to sickness absence, performance management and disciplinary procedures. The practice had a whistleblowing policy which was also available to all staff electronically on any computer within the practice.

Leadership, openness and transparency

Staff we spoke with told us they felt involved in discussions about how to run the practice and how to develop the practice. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings, were confident in doing so and felt supported if they did.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), surveys and complaints received. It had an active PPG with 14

Are services well-led?

Good

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

members. The PPG realised that this was not fully representative of the population group and were advertising for further members in the patient newsletter which was available in the waiting area.

The PPG had carried out annual surveys and met every quarter with practice staff. The practice manager showed us data from the latest patient survey which was carried out in June 2015. The results had yet to be analysed and any actions needed identified. The results and actions from the previous survey undertaken in October 2013 were available on the practice website. We spoke with two members of the PPG and they were very positive about the role they played and told us they felt engaged with the practice.

Results from the national GP survey showed the practice as consistently above or comparable to other practices nationally in terms of patient satisfaction with the service.

The practice had also gathered feedback from staff through staff meetings and general discussions. Staff had been asked for feedback to support the appraisal process. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice was very supportive of training and we were given examples of staff that had progressed within the practice. The practice held regular training sessions.

The practice was a GP training practice for qualified doctors training to become GPs and a teaching practice for medical students. Two of the GP partners supported the trainees and there was always access to a senior partner on duty.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings. We saw that the new practice manager had sought to improve the reporting of non-clinical incidents and that this had been discussed at practice meetings and with administrative staff. For example following an incident in which a needle had been found in the car park, the practice was in discussion with the property team to clear and develop the area around the practice.

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 Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The practice did not have robust systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users:** **There were a lack of robust records available to demonstrate risks in relation to fire, the premises and recruitment checks were being appropriately and systematically managed.** Regulation 17 (1)(2)(b)(d)(i)(ii)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **We found the provider had not adequately protected services users against identifiable risks associated with healthcare infections.** **The practice had carpets throughout the practice including clinical rooms but had not undertaken any risk assessments to assess and mitigate the potential risks in relation to this.** **The practice did not have robust cleaning schedules in place to demonstrate that cleaning of carpets and curtains in the clinical rooms took place on a regular basis.** **The practice did not have assurance that legionella risk assessments were in place and actions implemented to safeguard patients from the risks associated with legionella bacterium.** Regulation 12 (1)(2)(a)(b)(h)