

NHSTanhouse Clinic

Quality Report

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

Ratings

Overall rating for this service

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Requires improvement



Are services responsive to people's needs?

Good



Are services well-led?

Requires improvement



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Rajiv Chitre on 20 May 2016. Dr Rajiv Chitre has two practices; Dr Rajiv Chitre, 168 Hamstead Road, Handsworth Road, Birmingham and NHS Tanhouse Clinic. The practice has a combined list size of approximately 5000 patients. Patients are able to visit either of the two sites in order to access primary medical services. Both practices are registered individually with CQC and therefore, both sites have individual reports and ratings. However as the practice has one General Medical Services (GMS) contract, a single patient list, a common clinical data system and a shared staff group, the data included in this report reflects both practices. Overall the practice is rated as requires improvement.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- Some systems or processes were not effective to assess, monitor and mitigate the risks relating to the management of hospital communications, the management of medicines and the implementation of actions following audits.
- 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. Improvements were made to the quality of care as a result of complaints and concerns.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a leadership structure in place but at times lacked clarity as to who was responsible for certain tasks.

Summary of findings

- The practice sought feedback which it acted on.

The areas where the provider must make improvement are:

- Introduce robust systems or processes to mitigate the risks relating to the health, safety and welfare of service users. This includes the management of hospital communications, the management of medicines and the implementation of actions following audits.
- A formal strategy must be developed to improve satisfaction scores for GPs in regards to treating

patients with care and concern. Systems or processes must be developed to ensure more carers are identified so they can be offered appropriate support.

The areas where the provider should make improvement are:

- Ensure audit cycles are completed.

Ensure all information regarding safety of practice premises is available to minimise any risks identified.

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?

There was an effective system in place for reporting and recording significant events. Lessons were shared to make sure action was taken to improve safety in the practice. When things went wrong patients received reasonable support and a written apology. The practice had systems, processes and practices in place to keep patients safeguarded from abuse. Most risks to patients were assessed and well managed. However, some the risks relating the management of hospital communications, management of medicines and implementing actions following audits were not effective.

Requires improvement



Are services effective?

Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average. Staff assessed patients' needs and delivered care in line with current evidence based guidance. Clinical audits demonstrated quality improvement. Staff had the skills, knowledge and experience to deliver effective care and treatment. There was evidence of appraisals and personal development plans for all staff. Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Good



Are services caring?

Data from the national GP patient survey showed patients rated the practice below average for some of its satisfaction scores on consultations with GPs and nurses. There was some evidence that the practice was aware of this but no formal plan to address it. Patients we spoke with on the day 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 saw staff treated patients with kindness and respect, and maintained patient and information confidentiality. Carers packs were available at the practice but the number of carers registered by the practice was significantly low.

Requires improvement



Are services responsive to people's needs?

Practice staff reviewed the needs of its local population and engaged with the Clinical Commissioning Group to secure improvements to services where these were identified. For example, the practice was taking part in the primary care commissioning framework (PCCF). As part of this, the practice was expected to offer various services such as end of life care and to improve the

Good



Summary of findings

management of long term conditions. Feedback from patients about accessing the service was mixed. Most patients said they found it easy to make an appointment but not always with the GP of their choice as one of the GPs they preferred were mostly based at the main site in Handsworth. Some patients told us that access was at times difficult. As a response telephone access was now available from 8am instead of 8.30am. Saturday opening had also been offered. The practice was located in a purpose built building. It 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 learning from complaints was shared with staff and other stakeholders.

Are services well-led?

The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. There was a leadership structure but at times there was a lack of clarity as to who was responsible for certain tasks such as handling hospital communications. The practice had a number of policies and procedures to govern activity and held regular governance meetings. However, policies were not always well embedded. For example, for handling communications from other healthcare organisations. Some actions from audits were not implemented. Some risks were not formally assessed such as those related to blind loop cords and infection control. Clinical waste bins were not kept secure..

The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken. The practice sought feedback from staff and patients, which it acted on.

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 provider was rated as requires improvement for safe, caring and for well-led. The issues identified as requiring improvement overall affected all patients including this population group. There were, however, examples of good practice.

The practice offered proactive, personalised care to meet the needs of the older people in its population. The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs. The healthcare assistant undertook home visits to elderly or housebound patients for routine blood tests and blood pressure checks. We saw an example where appointments were offered in a way to suit the needs of an elderly couple. Elderly patients above the age of 75 were offered an annual health check. The practice regularly worked with other health professionals to review patients and to ensure the needs of those with the most complex care needs were being met. For example, patients with end of life care needs or that had an unplanned admission to hospital. The practice was located in a purpose built building and was accessible to patients with mobility difficulties.

Requires improvement



People with long term conditions

The provider was rated as requires improvement for safe, caring and for well-led. The issues identified as requiring improvement overall affected all patients including this population group. There were, however, examples of good practice.

Clinical staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Nursing staff involved in the management of long term conditions had received appropriate training. Performance for diabetes related indicators was 94% which was higher than the CCG average and national average of 90%. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. The practice offered a range of services to support the diagnosis and management of patients with long term conditions such as insulin initiation, electrocardiographs (ECGs) and spirometry.

Requires improvement



Summary of findings

Families, children and young people

The provider was rated as requires improvement for safe, caring and for well-led. The issues identified as requiring improvement overall affected all patients including this population group. There were, however, examples of good practice.

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. The practice's uptake for the cervical screening programme was 82%, which was comparable to the CCG average of 80% and the national average of 82%. Immunisation rates were also similar for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. Priority for appointments was given to sick children. The practice had baby changing facilities and offered a breast feeding friendly service. A prayer room was also available for patients. The practice offered child health surveillance clinics and worked with midwives and health visitors to support and safeguard children and young people.

Requires improvement



Working age people (including those recently retired and students)

The provider was rated as requires improvement for safe, caring and for well-led. The issues identified as requiring improvement overall affected all patients including this population group. There were, however, examples of good practice.

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 and flexible. The practice offered extended opening hours on a Monday until 8pm at the main site and on a Saturday Morning from 9am to 12noon at this site. This was useful for patients who were unable to attend due to work or other commitments during normal opening hours. 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. The practice had used text messaging services for appointment reminders for the past 12 months. However, a new text messaging service had recently been introduced with a smart phone application that enabled two way communications. It was hoped this would reduce the number of missed appointments (DNA's) as patients are able to cancel via this application. The practice offered virtual membership to its patient participation group to encourage feedback from this group of patients.

Requires improvement



Summary of findings

People whose circumstances may make them vulnerable

The provider was rated as requires improvement for safe, caring and for well-led. The issues identified as requiring improvement overall affected all patients including this population group. There were, however, examples of good practice.

The practice offered longer appointments for patients with a learning disability and health checks were offered to them. The practice regularly worked with other health care professionals in the case management of vulnerable patients. A Drugs Misuse Support Worker held clinics (at the main site) to manage and support patients' needs. The practice informed vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Requires improvement



People experiencing poor mental health (including people with dementia)

The provider was rated as requires improvement for safe, caring and for well-led. The issues identified as requiring improvement overall affected all patients including this population group. There were, however, examples of good practice.

National reported data for mental health outcomes (2014/15) was 98% which was 9% above to the CCG average and 6% above the national average. The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health. The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. A Mental Health Counsellor held weekly clinics at this site and offered links to other mental health services.

Good



Summary of findings

What people who use the service say

The national GP patient survey results were published on January 2016. The results showed the practice was performing below local and national averages. However, of the 288 survey forms distributed, only 90 were returned. This represented 0.01% of the practice's patient list.

- 66% of patients who responded found it easy to get through to this practice by phone compared to the national average of 73%.
- 72% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.
- 60% of patients described the overall experience of this GP practice as good compared to the national average of 85%.

- 66% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 29 comment cards which were all positive about the standard of care received. Patients were very satisfied with the service and found staff helpful, caring and efficient.

We spoke with six patients during the inspection. All six patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. However, they also stated that at times they found it difficult to access the service.

Areas for improvement

Action the service **MUST** take to improve

- Introduce robust systems or processes to mitigate the risks relating to the health, safety and welfare of service users. This includes the management of hospital communications, the management of medicines and the implementation of actions following audits.
- A formal strategy must be developed to improve satisfaction scores for GPs in regards to treating

patients with care and concern. Systems or processes must be developed to ensure more carers are identified so they can be offered appropriate support.

Action the service **SHOULD** take to improve

- Ensure audit cycles are completed.
- Ensure all information regarding safety of practice premises is available to minimise any risks identified.

NHSTanhouse Clinic

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 advisor and a practice manager specialist advisor.

Background to NHSTanhouse Clinic

Dr Rajiv Chitre has two practices; Dr Rajiv Chitre, 168 Hamstead Road, Handsworth Road, Birmingham and NHS Tanhouse Clinic, Hamstead Road, Great Barr, Birmingham. The practice has a combined list size of approximately 5000 patients. Patients are able to visit either of the two sites in order to access primary medical services.

The staff group, policies, systems and procedures at Dr Rajiv Chitre are centrally managed and operate across both sites. We inspected the main site at Dr Rajiv Chitre (168 Hamstead Road, Handsworth) on 20 May 2016. We also visited NHS Tanhouse Clinic at Great Barr.

Both practices are registered individually with CQC and therefore both sites have individual reports and ratings. However as the practice has one General Medical Services (GMS) contract, a single patient list, a common clinical data system and a shared staff group, the data included in this report reflects both practices.

The two GP partners (both male) and a long term locum GP (female) work across both sites along with the two practice nurses. There is a practice manager who manages both sites. They are supported by an administration team, who also, when required, worked across both sites.

The practices are both located in a suburban area of Birmingham and the building at the practice is located in a purpose built building leased from NHS Property services.

Based on data available from Public Health England, the practice is located in a more deprived area compared to the national average.

The practice is open from 8am to 6.30pm on Mondays, Tuesdays, Wednesdays and Fridays. On Thursdays it closed at 3pm but patients are able to go to the main site at Handsworth. The practice is also open on a Saturdays between 9am and 12pm.

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. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 20 May 2016. During our visit we spoke with a range of staff including the GP partners, the practice manager, practice

Detailed findings

nurse and administration staff. We also spoke with patients and reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

We also looked at how well services were provided for specific groups of people and what good care looked 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).

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.

Are services safe?

Our findings

Safe track record and learning

The practice had a system in place for reporting and recording significant events. Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The reporting of incidents on the computer system facilitated the sharing of information with the 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. We were told of a recent incident that had been reported by a staff member and where learning was discussed in the staff meeting. Minutes of meetings we looked at showed the discussion had taken place.

We reviewed patient safety alerts and saw that there was a system in place to receive and action safety alerts. Copies of alerts were forwarded by the practice manager to each clinician who then signed to acknowledge receipt and action. We saw copies of alerts were kept in the practice with staff initials.

Overview of safety systems and processes

The practice systems, processes and practices in place to keep patients safe and safeguarded from abuse. Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead GP for safeguarding who had attended level 3 training.

Staff members we spoke with demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. We saw nurses had attended level 2 safeguarding training.

Notices outside the consulting rooms advised patients that chaperones were available if required. All staff who acted

as chaperones had received online training for the role and had received a Disclosure and Barring Service (DBS) check. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

One of practice nurse was the infection control clinical lead who was part of a CCG lead practice nurse forum. This allowed them to keep up to date with best practice including infection prevention and control. There was an infection control protocol in place and staff had received up to date training. We saw that the CCG had carried out an audit in May 2014 where the practice achieved an overall score of 97%. The practice had also carried out an in-house audit in November 2015 and some actions were identified but were not due for completion until November 2016.

The practice maintained appropriate standards of cleanliness and hygiene

Although infection prevention procedures were in place there were some gaps. For example, the practice did not have lever operated taps and the risk assessment did not identify how re-contamination would be prevented. We also saw clinical waste bags were not labelled and were not kept secure.

There were arrangements in place for managing medicines, including emergency medicines and vaccines, in the practice (including obtaining, prescribing, recording, handling, storing, security and disposal).

The practice had a protocol in place for handling repeat prescriptions and a summary flowchart was displayed in the reception area for staff. However, this did not mention the review of high risk medicines. We looked at some records of high risk medicines and found that patients were reviewed appropriately and had appropriate blood tests where required. The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health Care Assistants (HCAs) were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.

Are services safe?

Monitoring risks to patients

There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had up to date fire risk assessments, carried out regular fire drills and records fire alarm checks were available. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health (COSHH). The building was owned by NHS Business Service Authority and the practice manager had been informed that legionella testing had been completed but was unable to get confirmation. Legionella is a term for a particular bacterium which can contaminate water systems in buildings.

The practice had a baby change room and there were two blind loop cords which represented a hazard to children. Although there they were high up and would be out of reach of children normally. However, we saw there were chairs near the loop cords making access easier. This had not been picked up on any risk assessments.

There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. Staff told us that they would cover for each other during periods of absence. The practice was a branch surgery and staff from the main site would cover during unplanned staff absences.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. We were told us that a staff member had accidentally activated the alarm on the computer system at the main site recently but all staff had responded to the alarm which showed staff were aware of the emergency protocol.

All staff received annual basic life support training and there were emergency medicines available in the treatment room. The practice had a defibrillator available on the premises and oxygen with adult and children's masks. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. The practice was a branch site and the plan incorporated this in the plan so that either site could be used in the event of an emergency.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. There were links to NICE guidance on the computer system so that relevant guidance could be accessed. The practice monitored these guidelines were followed.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results showed the practice had achieved 94% of the total number of points available. This was comparable local CCG average national averages. Exception reporting by the practice overall was also higher at 16% compared to the CCG and national averages of 9%. 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. The practice looked into the high exception reporting with the help of the local commissioning support unit and informed us that this was due to a system error. Data from 2014/15 showed;

- Performance for diabetes related indicators was 94% which was higher than the CCG average of 86% and national average of 90%.
- Performance for mental health related indicators was 98% which was higher than the CCG average of 92% and the national average of 93%.

There was evidence of quality improvement including clinical audit. We saw some clinical audits that had been completed in the last 12 months. For example, we saw an audit on oral nutritional supplements where appropriate action was taken following findings. There was another

audit on Non-Steroidal Anti-inflammatory Drugs (NSAIDs). Most of the audits had been conducted recently and some were ongoing but there were no second cycle audits available to show improvement. However, we saw that a current audit had been scheduled for a re-audit at the end of August 2016.

Effective staffing

The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding and fire safety.

The practice could demonstrate how they ensured role-specific training and updating for relevant staff. In-house online training was available and staff were also encouraged to attend CCG training days. There was a training matrix which detailed specific training for each member of staff. The practice nurses were part of the CCG led practice nurses forum which allowed them to keep up to date with best practice.

Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Relevant staff members had attended specific immunisation training courses and told us they had access to online resources such as the green book. They also told us that they attended vaccine updates organised locally by the CCG.

The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. We saw that the practice had carried out a workforce analysis for both clinical and non-clinical staff. This contained details of some of the training they had attended such as safeguarding, basic life support and infection control as well as some developmental opportunities they had requested. Records looked at showed that all staff had received an appraisal within the last 12 months.

Coordinating patient care and information sharing

Staff worked together with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were

Are services effective?

(for example, treatment is effective)

referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

The practice received tests results in electronic format as well as in paper format. The practice had a policy which stated that paper results were to be dealt with by one of the GP partners and electronic results by another partner. However, when we spoke with staff members we received conflicting information on how they were dealt with. We checked the electronic system which showed that 310 hospital communications had not been actioned over the last three weeks although one of the partners was currently processing them. The practice explained that there had been technical problems with the link for four days prior to our inspection and had been resolved a day before our inspection. The practice manager told us that although electronic communication had not been processed, paper based communication would have been dealt with by the other GP partner. We saw all the paper copies of communication received had been processed. However, we were not assured that systems in place were sufficiently robust to ensure important information was not missed.

The practice shared relevant information with other services in a timely way, for example when referring patients to other services. A specific staff member was responsible for actioning referrals. We looked at two example letters which contained the minimum appropriate information but could have been more detailed in regards to the reason for referral.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Training records showed that staff had undertaken Mental Capacity Act training within the last 12 months.

We spoke with one of the GP partners who told us that they sought formal consent for patients undergoing minor surgery. They told us they had conducted an audit to monitor this, but were unable to show us the details of the audit on the day.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Clinical staff members told us they used relevant forms to access other services as well as being able to directly message health visitors through a communication book. The practice also used single point access to manage both routine and urgent referrals for working age adult mental health services.

Specific clinics were held to support patients with diabetes (insulin initiation), respiratory conditions (spirometry testing). A specialist diabetes nurse and consultant held clinics at the practice regularly for more complex patients. This was a CCG initiative.

The practice offered in house support in areas such as weight management. It also offered electrocardiograms (ECGs).

The practice website contained links to health information and support for patients. There was an information screen in the reception area encouraging patients to lead healthier lives with further information and details of other organisations for support.

The practice's uptake for the cervical screening programme was 82%, which was comparable to the CCG average of 80% and the national average of 82%. There was a policy to offer reminders for patients who did not attend for their cervical screening test. We saw examples of letters sent to patients when they had missed their appointments. The practice also had a policy to place a recall date on patients' records as advised by the pathology laboratory. There was a system in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. This was supported by a protocol.

The practice encouraged its patients to attend national screening programmes for bowel and breast cancer screening. Uptake of these national screening programmes was higher than the CCG average and in line with national averages.

Childhood immunisation rates for the vaccinations were similar compared to CCG averages. For example, childhood

Are services effective?

(for example, treatment is effective)

immunisation rates for the vaccinations given to under two year olds ranged from 86% to 100% with CCG ranges from 87% to 94%. For five year olds data ranged from 79% to 95% with CCG ranges from 87% to 94%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and

NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified. The practice was also carried out health checks for patients over the age of 75 without long term conditions and those with a learning disability.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

The practice nurse told us that they locked the treatment with the consent of the patient to maintain patients' privacy and dignity during sensitive examinations, investigations and treatments. Curtains were provided in consulting rooms to protect privacy of patients. We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.

Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs. There was an interview room next to the reception and staff told us they offered this room when needed.

We received three comment cards from this site and 26 from the main site and almost all of the comment cards we received were positive about the service experienced. Patients said staff were lovely, helpful and caring. Patients also felt that the practice offered an excellent service.

We spoke with four patients who told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was below average for some of its satisfaction scores on consultations with GPs and nurses. For example:

- 74% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 84% and the national average of 89%.
- 80% of patients said the GP gave them enough time compared to the CCG average of 81% and the national average of 87%.
- 92% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 93% and the national average of 95%.

- 63% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 80% and the national average of 85%.
- 86% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 80% of patients said they found the receptionists at the practice helpful compared to the CCG average of 81% and the national average of 87%.

The results showed that satisfaction scores for GPs in regards to treating patients with care and concern was significantly lower. We spoke with the practice manager who told us that they were aware of this and had informed GPs to summarise their consultation and ask patients if they understood inviting further questions where appropriate. The practice manager told us that they had discussed this but were unable to provide any formal evidence of this. Patients we spoke with on the day were positive and told us that they were not rushed, and the doctors and nurses listened and always explained any issues to them.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were mostly in line with local and national averages apart from the question related to GP involvement of patients in decisions. For example:

- 76% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 81% and the national average of 86%.
- 63% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.

Are services caring?

- 85% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%.

As mentioned above, the practice was aware of the lower scores and had discussed this with the GPs as an area for improvement. Although there was no evidence that a discussion had taken place we saw evidence that the practice had identified this as an area for improvement.

The practice provided facilities to help patients be involved in decisions about their care. Translation services were available for patients who did not have English as a first language. Many of the staff were able to speak some of the languages spoken by patients. The practice website could be translated into other languages.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. We were told that the practice had identified 19 patients as carers (less than 0.01% of the list). The practice had a carers pack developed by the CCG which was given out to carers for further support. The practice was aware that they needed to improve the number of carers registered and one of the GP partner took on a lead role of 'carers champion' to ensure improvement. The practice had a newsletter which was available in the reception area. We saw that the latest newsletter published in April 2016 encouraged carers to register and to ask at reception for a carers pack. The practice website had further information and had links to support groups.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice 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. For example, the practice was taking part in the primary care commissioning framework (PCCF). As part of this, the practice was expected to offer various services such as end of life care and to improve on management of long term conditions.

The practice offered extended opening hours on a Monday between 6pm to 8pm at the main site for all patients. Extended Saturday opening from 9am to 12pm was offered at this site. This was ideal for working patients who could not attend during normal opening hours.

There were longer appointments available for patients with a learning disability and for certain long term conditions and childhood immunisations. We saw an example where staff offered appointments to suit patient needs.

A Mental Health Counsellor held weekly clinics and offered links to other mental health services. A Drugs Misuse Support Worker also held clinics at the main site to manage and support patient needs. These services were provided by the CCG and held at the practice for all registered patients.

Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice. The Healthcare assistant also visited patients in their home for routine blood tests and blood pressure tests.

Appointments could be made up to two weeks in advance as well as same day appointments. Children and those patients with more urgent medical problems were also seen on the same day. A text messaging service was in place to remind patients of their appointment.

Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.

The practice was located in a purpose built building which ensured that patients who had difficulty with their mobility could access the building with ease.

There was a poster in the reception area that informed that patients that there was a breastfeeding and a prayer room available.

For those that did not speak English as a first language, a translation service was available. Some of the staff spoke other languages spoken by some of the patients and the practice website could be translated in other languages.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday except Thursday when it closed at 3am. However, the main site was open on a Thursday and patients could get access to a GP if needed. Extended hours were provided from 6.30pm to 8pm on Mondays (at the main site). Extended Saturday opening from 9am to 12pm was available at this site.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was below national averages.

- 66% of patients were satisfied with the practice's opening hours compared to the national average of 78%.
- 66% of patients said they could get through easily to the practice by phone compared to the national average of 73%.

Most patients told us on the day of the inspection that they were able to get appointments when they needed them. However, some also stated that access to appointments were an issue at times. This aligned with the comments cards we received. Out of a total of 29 comments cards received, six patients stated that access was at times difficult. To improve this, the practice had extended telephone access from 8am to 6.30pm at the branch site. Previously telephone access had been available from 8.30am. The practice also offered Saturday opening and had lengthened session times for GPs so more appointments could be offered.

The practice had a system in place for telephone triage and home visits were also available. Patients were advised to call before 10am to request these services.

The practice offered a range of online services including making appointments and ordering repeat prescriptions.

Listening and learning from concerns and complaints

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

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

in the practice. We saw that a complaints and comments leaflet was available in the practice and the practice leaflet also informed patients of the process. We saw that the practice had received three complaints in 2016 and they had been responded to appropriately.

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

The practice had a clear vision to deliver high quality care without boundaries and to improve health outcomes for its patient population. The practice aimed to continually improve the quality and flexibility of the service to meet the needs of all population groups. We saw that the practice informed patients in reception that a prayer room and breastfeeding room was available.

The practice also had a charter leaflet which was available for patients to take away. This detailed the practice vision and values as well as what patients could expect. For example, some of these were that patients had the right to be treated with courtesy and respect. To be able to get a non-urgent appointment within 24 hours and to be offered a health check when registering for the first time.

Governance arrangements

The practice had a governance framework to support the delivery of the strategy and good quality care. There were policies in place to ensure appropriate guidance's were being followed. However, we noted that at times this was not robust as we received conflicting information in regards to handling of incoming hospital communication. This was despite there being a clear policy in place.

Risk assessments were not always robust to pick hazards such as those related to blind loop cords and infection control. Clinical waste bins were kept in a lockable room but on the day of the inspection we noted that they were not kept secure and were accessible to patients and members of the public.

One of the GPs carried out minor surgery and told us that they had carried out audits to ensure consent was sought. However, they were unable to show us the audit. The practice also carried out other clinical audits but cycles were not complete to show improvement.

We saw that satisfaction scores for GPs in the national patient survey for some elements of their consultation were significantly below local and national averages

practices. We spoke with the practice manager who told us that they were aware of this and had discussed improvement with the GPs. However, there was no documented evidence in place.

Leadership and culture

There was a leadership structure in place but at times we received conflicting information. Staff were unable to tell us as to who was responsible for certain tasks which lacked clarity such as in the processing of hospital letters and results.

Staff told us the practice held regular team meetings and felt supported by management. Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings or directly with senior staff.

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

The practice encouraged feedback from patients through the virtual patient participation group (PPG). The practice manager ran the virtual group with eight members and had gathered feedback from patients through surveys. We saw that the last survey had been conducted for 2015-16. We saw that three action points were developed from the surveys. One of the actions was to start online appointment booking and another was to inform how the appointment system worked. We saw that the practice proposed to hand out the practice leaflet to explain the appointment system. The latest practice newsletter also explained how patients could book an appointment.

We saw that satisfaction scores for GPs in the national patient survey for some elements of their consultation were below local and national averages. During the inspection and through our discussion with staff we noted that the practice was aware of the issues and had discussed the need to improve. However, there was no formal action plan in place to make improvements.

Staff told us they were always asked for feedback during meetings and they also told us that the management were very approachable and very supportive.

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	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>How the regulation was not being met:</p> <p>Systems or processes were not effective to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. This included the management of hospital communications and implementing actions following audits. A documented plan was not in place to improve satisfaction scores for GPs in regards to treating patients with care and concern. Systems were not in place to ensure carers were identified and registered with the practice in view to offering further support.</p> <p>This was in breach of regulation 17(1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>