Fitzalan Medical Group

Quality Report

Fitzalan Road,
Littlehampton,
West Sussex,
BN17 5JR
Tel: : 01903 735200
Website: www.fitzalanmedicalgroup.com

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

Ratings

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

Summary of findings

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Overall summary

We carried out an announced comprehensive inspection at Fitzalan Medical Group on 13 January 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing, effective, caring, responsive and well led services. However the practice is rated as requires improvement for providing safe services. The practice was also rated as good for providing services to the six population groups.

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

- The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There was evidence that the practice had learned from these and that the findings were shared with relevant staff.
- Patient feedback was positive. Patients said they were treated with compassion, dignity and respect. They said they felt listened to and that they were involved in decisions about their care and treatment.
- The practice had implemented innovative approaches to providing care. For example, by employing a paramedic practitioner.
- The practice responded positively to the needs of its patients. For example by employing staff who could speak Polish, Russian and Lithuanian to meet the needs of the patients from Eastern Europe on its register.
- Staff felt well supported in their roles and had good access to training.
- The practice had an active virtual patient reference group (VPRG).

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

Specifically the provider must:-

- Ensure all nursing staff implement patient group and patient specific directives in line with national guidance.

In addition, the provider should:-

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- Ensure the chaperone policy is visible on the waiting room noticeboard and in the consulting rooms.
- Provide patients with greater flexibility for making appointments.
- Take action to address identified concerns with infection prevention and control practice.
- Provide an opportunity for all practice staff to meet on a regular basis.
- Ensure all staff are familiar with the practice's whistleblowing procedure and that it is included in the staff handbook.
- Provide an opportunity for the VPRG to meet with the practice on a more regular basis.

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 good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe. Practice nursing staff were not always administering vaccines using directions that had been produced in line with legal requirements and national guidance.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed that patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing mental 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 all 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 to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

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 clinical commissioning group (CCG) to secure improvements to services where these were identified. Patients said they usually found it easy to make an appointment with a named GP. Urgent appointments were available the same day. The practice had adequate facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available

Summary of findings

and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared and used to improve services. The patient had an active virtual patient reference group (VPRG) and undertook regular surveys of patient views. Feedback from patients was acted on.

The practice had identified a high number of patients on its register from Eastern Europe. It provided a translation service and had also employed staff who spoke East European languages including Russian, Polish and Lithuanian.

Are services well-led?

Good

The practice is rated as good for being well-led. Although the practice had not articulated a clear vision or strategy staff shared a common ethos for delivering a high quality and caring service to patients. Lead responsibilities in the practice were clearly defined and staff felt supported by management. The practice had a number of policies and procedures to govern activity and had a structure of regular meetings to govern its business. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The virtual patient reference group (VPRG) was active. Staff had received inductions, regular performance reviews and attended staff meetings.

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. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in end of life care and ensuring all patients identified at risk of admission to hospital had a care plan. It was responsive to the needs of older people, and offered home visits and domiciliary flu vaccinations and phlebotomy. All patients over the age of 75 had a named GP.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management. Longer appointments and home visits were available for patients when needed. All these patients had a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP 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. Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice worked closely with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, appointments were available up until 8pm on a Monday and a Wednesday evening. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, and those with a learning disability. It had carried out annual health checks for people with a learning disability. Health checks were carried out at in the person's home if required.

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

People experiencing poor mental health (including people with dementia)

Good

The practice ensured that people experiencing poor mental health received an annual review of their physical and mental health needs. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The GPs made regular referrals to local psychological therapy and counselling services. The practice also made referrals to the local dementia crisis team which provided rapid access to health and social care support for people with dementia and their carers.

Summary of findings

What people who use the service say

We reviewed 27 comment cards where patients and members of the public shared their views and experiences of the service. We also spoke to six patients on the day of the inspection. Most of the patient feedback was positive. Patients told us that staff were helpful, kind, polite and caring and that they were treated with dignity and respect. Some patients commented that they had difficulties with the practice's telephone triage system, in particular, ensuring that they were available when the GP telephoned them back.

We reviewed the most recent data available for the practice on patient satisfaction. Results of the 2013 national GP survey showed the practice similar to the national average in a number of areas. For example, 75% of practice respondents described the overall experience of the practice as good or very good. We noted that 70% of practice respondents to the national patient survey said the GP was good or very good at treating them with care and concern. This was below the national average, however the feedback we reviewed from the comments cards and the patients we spoke with was overwhelmingly positive in relation to how patients felt they were treated. The practice had undertaken its own survey of patient views during 2013/14 in conjunction with its virtual patient reference group (VPRG). This survey had specifically focused on patient views about on-line booking services and the telephone triage system for booking appointments. The survey results showed that of the 73% of respondents who had used the telephone triage service, 93% were happy with the outcome. However, only 64% of respondents said that the telephone call back was convenient for them.

Areas for improvement

Action the service MUST take to improve

- Ensure all nursing staff implement patient group and patient specific directives in line with national guidance.

Action the service SHOULD take to improve

- Ensure the chaperone policy is visible on the waiting room noticeboard and in the consulting rooms.
- Provide patients with greater flexibility for making appointments.
- Take action to address identified concerns with infection prevention and control practice.
- Provide an opportunity for all practice staff to meet on a regular basis.
- Ensure all staff are familiar with practice's whistleblowing procedure and that it is included in the staff handbook.
- Provide an opportunity for the VPRG to meet with the practice on a more regular basis.

Fitzalan Medical Group

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, a practice nurse specialist advisor and a practice manager specialist advisor.

Background to Fitzalan Medical Group

The practice is situated near the centre of Littlehampton and provides general medical services to approximately 14,350 patients. There are eight GPs, five male and three female. The practice also employs seven practice nurses, three health care assistants and two phlebotomists. Opening hours are Tuesday, Thursday and Friday 8.00am to 6.30pm and Monday and Wednesday 8.00am until 8.00pm. The practice also provides nurse and health care assistant appointments from 7.30am on a Thursday. The practice provides a wide range of services to patients, including asthma and diabetes clinics, chronic disease monitoring, cervical screening, childhood immunisations, minor surgery, family planning, smoking cessation and minor illness clinics. The practice has a contract with NHS England to provide general medical services.

The practice has a higher than average percentage of its population over the age of 65, 75 and 85. It also has a higher than average percentage population with income deprivation affecting children. The practice serves a high number of registered patients from Eastern Europe.

The practice provides a service to all of its patients at two locations :-

Fitzalan Road,

Littlehampton BN17 5JR

and,

Wick Surgery

66 Clun Road

Littlehampton

BN17 7EB

Our inspection was undertaken on the practice premises at Fitzalan Road.

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

Why we carried out this inspection

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

How we carried out this inspection

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

Detailed findings

During our visit we spoke with a range of staff including, the GPs, the practice manager, the practice nurses, administrative staff and receptionists. We examined practice management policies and procedures. We spoke with representatives from the practices virtual patient reference group (VPRG) and spoke with six patients. We also reviewed 27 comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

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

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.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. 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. There were records of significant events that had occurred during the last year and we were able to review these. Significant events was a standing item on the practice's monthly clinical meeting agenda where recent significant events were discussed and actions from past significant events and complaints were reviewed. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. S/he showed us the system used to manage and monitor incidents. We saw that records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result of significant events.

National patient safety alerts were disseminated by email to relevant practice staff.

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 most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities 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.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

There was a chaperone policy in place however it was noted that this was not visible on the waiting room noticeboard or in consulting rooms. (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). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

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 clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Requires improvement

Are services safe?

We saw records of medicines management meetings where prescribing data and patterns were reviewed. For example, the prescribing of certain types of asthma inhalers as a percentage of all asthma inhalers.

The nurses and the health care assistants were not always administering vaccines using directions that had been produced in line with legal requirements and national guidance. For example, one of the health care assistants we spoke with was administering vaccines before seeking authorisation from the GP. Although the health care assistant provided GPs with the details of the patients they had administered vaccines to afterwards this was not in line with the national requirements for patient specific directives.

The practice had a prescribing manager who was responsible for overseeing the production of prescriptions in accordance with practice policies and procedures. We saw that all prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

We observed the premises to be clean and tidy although some parts of the building were showing signs of wear and tear. 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.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and had regular updates either on line, from the infection control lead or as part of their on-going professional education. We saw evidence that the lead had carried out an audit of infection control during the last year and that actions for improvement had been identified. There was evidence that some of the actions had been implemented, however some issues still needed to be addressed. For example, the need to replace waste bins in the staff toilet upstairs and the patient toilet downstairs, with foot operated pedal bins. We also noted that whilst the external clinical waste bins were locked they were not secured to a wall or kept in a lockable designated space in line with good practice.

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 and staff knew the procedure to follow in the event of an injury.

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

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, and blood pressure measuring devices.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. 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.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included monthly checks of the building and the environment, annual work place risk assessments for staff and fire risk assessments. The practice had nominated one of its staff members to undertake these tasks and had provided them with additional training on health and safety at work. The practice also had an up to date health and safety policy. Health and safety information was displayed for staff to see.

Arrangements to deal with emergencies and major incidents

There were arrangements in place to deal with on-site medical emergencies. We saw evidence that all staff had received up-to-date training in basic life support appropriate to their role.

Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency).

Emergency medicines were available in the treatment rooms and all GPs and nurses knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

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

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. All staff had electronic access to referral guidelines, practice protocols, patient pathways and links to educational resources.

The GPs told us they took the lead in specialist clinical areas such as diabetes, prescribing and cytology. The practice nurses supported the GPs in the management of patients with long term conditions work. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

.All GPs we spoke with used national standards for the referral of patients with suspected cancers who they referred so they could be seen within two weeks. We saw minutes from monthly clinical meetings where referral management was a regular agenda item. Regular reviews of elective and urgent referrals were undertaken, and improvements to practice were shared with all clinical staff.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. As a consequence of staff training and better understanding of the needs of patients, the practice had increased the number of patients on the register.

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

Management, monitoring and improving outcomes for people

The practice showed us three clinical audits that had been undertaken in the last year. One of the audits was completed audit cycle. The practice was able to demonstrate the changes in outcomes since the initial audit. For example, an audit of GP responses to discharge summaries and whether medication alterations requested by secondary care were being acted on showed that after the results of an initial audit were presented, there was a significant improvement in results when performance was analysed again two months later.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 98% of patients with atrial fibrillation, measured within the last 12 months, were treated with anti-coagulation drug therapy

or an anti-platelet therapy. Where the practice was an outlier for any of the targets it had analysed the reasons for this and taken action where appropriate. For example, QOF data showed that the percentage of women aged 25 or over and who had not attained the age of 65 whose notes record that showed that a cervical screening test had been performed in the preceding 5 years was below the national average. The practice had investigated this and found that this was because women in this age group who were registered with the practice and who were living and working in this country as European Union Citizens returned to their country of birth to have cervical screening undertaken.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. We saw examples of benchmarking data which included planned care activity and A&E attendances.

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. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and 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). The practice also operated its own internal appraisal scheme for its salaried GPs although this was not always done on an annual basis.

Good

Are services effective?

(for example, treatment is effective)

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example one of the practice nurses had attended external training on triage and minor illnesses. The practice also held protected in-house learning sessions for all staff on a monthly basis which included a mixture internal and outside speakers. Recent topics included safeguarding children. Consultants from the local hospitals also attended these sessions to provide staff with updates on clinical topics.

There was evidence that where poor performance had been identified appropriate action had been taken to manage this.

Working with colleagues and other services

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients, for example, those with end of life care needs or people with complex health and social care needs. These meetings were attended by district nurses, social workers, palliative care nurses, and primary care mental health workers to discuss decisions about care planning. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information. The practice had regular meetings with the health visiting service to discuss and families living in disadvantaged circumstances and children identified as at risk.

Information sharing

The practice worked with other service providers to meet patient's 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. The practice had arrangements in place to ensure that all relevant staff understood their responsibilities for passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

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. All staff were fully trained on the system, and commented positively about the system's safety and ease of use.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005. Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions.

The GPs we spoke with demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health promotion and prevention

It was practice policy to offer a health check with the GP to all new patients registering with the practice. All new patients were also asked to complete a questionnaire about their alcohol consumption, so that patients needing advice and support could be identified. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was in line with the national average. Seasonal flu vaccinations were available to at risk patients such as patients aged 65 or over. The practice provided a smoking cessation clinic and offered a range of screening services including cervical screening. There was a range of patient literature on health promotion, prevention and self-help available for patients in the waiting area. The practice website provided patients with health advice and information about healthy lifestyles.

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 2013 national patient survey. The practice had undertaken a survey of patient views in 2014 in conjunction with its virtual patient reference group (VPRG), however this focused on on-line booking and the appointment system. The evidence from the national patient survey showed patients were usually satisfied with how they were treated. For example, data from the national patient survey showed that 70% of respondents stated that the last time they saw or spoke to a GP, the GP was good or very good at treating them with care and concern. Although this was below the national average in all other sources of patient feedback we looked at patients were consistently positive about the way they felt they were treated. The GPs were described as helpful, understanding and listening. The national patient survey showed that 86% of respondents stated that the last time they saw or spoke to a nurse, the nurse was good or very good at treating them with care and concern.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 27 completed cards and they were all positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were polite, helpful and caring. They said staff treated them with dignity and respect. We also spoke with six patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable 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.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private. We noted that the results of the national survey highlighted that only 2% of respondents stated that in the reception area other patients couldn't overhear. The practice was aware of this concern and told us that if necessary patients were offered a private room if they wanted to discuss things in confidence.

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, data from the national patient survey showed 78% of practice respondents said the GP involved them in care decisions.

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 told us they felt listened to and supported by staff. 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. The practice had also appointed members of staff who spoke Russian, Polish and Lithuanian in response to the needs of patients from Eastern Europe on its register. The practices website had a facility to translate all the information provided there in to a number of different languages.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection and the comment cards we received highlighted that patients felt positive about the emotional support provided by the practice. Patients told us that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and on patient website also told patients how to access a number of support groups and organisations. The practice had appointed one its reception staff to take the lead on identifying carers and signposting them to local carers support services. Additional training had been provided for this role. The practice kept a register of carers and the computer system alerted GPs if a patient was also a carer.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had a virtual patient reference group (VPRG) made up of 56 members. A VPRG is one that doesn't necessarily meet but where issues are discussed and communicated with members via e-mail or on the telephone. The VPRG enabled patients to have their say about how services could be improved and how they perceived the surgery and its staff. The practice communicated with the virtual group via e-mail or printed information rather than meetings. The VRPG had input to the design 2014 survey which focused specifically on the appointment system, the practice website and social networks and a practice newsletter. There was evidence that the practice implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the VPRG. For example, in response to patient feedback from the group the practice had moved the blood pressure monitoring machine towards the back of the waiting area to provide more privacy to patients. We spoke with three VPRG representatives on the day of the inspection who told us that they felt the practice did listen to patient views and respond. They told us they would find it useful to have more face to face meetings with the practice.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning and delivery of its services. The practice was situated in a two storey building with most of its services for patients situated on the ground floor with a lift to the first floor. There was automatic door entry to the practice. There were facilities to accommodate wheelchairs and had its own car park with three spaces reserved for disabled visitors. There was also a disabled access toilet on the ground floor.

The practice provided access to translation services for patients who did not speak English as their first language. It had also employed staff who could speak Russian, polish and Lithuanian to meet the needs of the patients on its register from Eastern European countries. The practice website could be translated into over 70 different languages.

Access to the service

The practice's opening hours were Tuesday, Thursday and Friday 8.00am to 6.30pm with extended opening hours on a Monday and Wednesday from 8.00am until 8.00pm. The practice also provided nurse and health care assistant appointments from 7.30 am on a Thursday. The practice offered a variety of on the day and pre-bookable appointments with GPs and practice nurses. All patients who wished to be seen by a GP were assessed by a triage GP before being given an appointment. Patients wanting to make an appointment were required to telephone the surgery before 10.00 am and ask for an appointment, leaving their telephone number for the triage GP to call them back on. Patients were also asked to provide the receptionist with a brief outline of why they would like to be seen so that they could be directed to the most appropriate clinician. The triage GP would then aim to call the patient back within 2 hours of their initial call. The triage GP would speak to the patient and provide advice and if necessary make them an appropriate appointment for them to be seen. Patients who were already seeing a GP for an on-going condition were able to book appointments up to two weeks in advance.

Patient feedback on the appointment system varied. Three of the patients we spoke with on the day of the inspection said they weren't always satisfied with the appointment system and felt there should be more flexibility for patients. For example, being able to book an appointment in person and not having to call before a certain time. They also said that they sometimes had to wait a long time for the triage GP to phone back and that this was not always at a convenient time. The practice's own survey of the appointment system showed that of the 73% of respondents that had used the telephone triage service, 93% were happy with the outcome. However only 64% of respondents said that the telephone call back was convenient for them.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system in leaflet form in the waiting area. Details of how to complain were also set out on the practice website.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We looked at the complaints record and responses to patients over the last twelve months. The practice had received seven complaints during this period. There was evidence that complaints were responded to in a timely way and that action points and learning were recorded and shared with relevant staff. The practice discussed any complaints received at its monthly clinical meetings where they were a standard agenda item.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear set of aims and objectives which it described in its statement of purpose. It was clear that all the staff we spoke with shared a commitment to providing high quality care to patients. There was evidence that the practice was forward thinking and had plans to meet the future needs of its patients. For example, the practice had recently recruited a paramedic practitioner to work as part of the clinical team as an innovative response to overcoming a shortage of GPs.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were easily accessible to staff in their department areas. The policies we looked at were up to date and had been regularly reviewed.

Lead roles within the practice were clearly identified. Specific staff took lead roles in infection control, information and governance, finance, prescribing and safeguarding. The 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. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly clinical meetings and action plans were taken to maintain or improve outcomes.

The practice undertook clinical audits on a regular basis which it used to monitor quality and identify where action should be taken.

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included monthly checks of the building and the environment, annual work place risk assessments for staff and fire risk assessments. The practice had nominated one it staff members to undertake these tasks and had provided them with additional training on health and safety at work. The practice also had an up to date health and safety policy. Health and safety information was displayed for staff to see.

The practice held monthly clinical meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

Staff met regularly within their own teams. The staff we spoke with told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. However, some staff told us that they hadn't met as a whole practice for a while and would like the opportunity to do so.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example disciplinary and grievance procedures and dress and uniform policy which were in place to support staff. These were included in the practice's staff handbook that was available for all staff. Staff we spoke with knew where to find the practices policies if required.

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

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

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

It was noted that none of the staff we spoke with were aware of the practice's whistleblowing policy which was available to all staff in the polices and procedures files located in each department area. It was noted that the whistleblowing policy was not included in the practice's staff handbook.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and appraisal. Staff told us that the practice was very

Are services well-led?

Good

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

supportive of training and they had the skills and knowledge they needed to fulfil their roles. The practice held monthly in-house educational sessions that all staff could attend.

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 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines Staff were not following policies and procedures about managing medicines, in particular patient specific directives in relation to administering vaccines. This was in breach of regulation of 13 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 12 (1) (2) (g) Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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