

Hollybrook Medical Centre

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Hollybrook medical practice on 26 January 2016. Overall the practice is rated as good.

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.
- Risks to patients were assessed and generally well managed, however, a thorough risk assessment had not been carried out in respect of using some non-clinical staff as chaperones in the absence of a DBS check.
- Some medicines carried by GPs were found to be out of date.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had the skills, knowledge and experience to deliver effective care and treatment.

- Patients told us 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.
- Routine appointments with a named GP were available but patients often had to wait longer to see their preferred GP. Urgent appointments were available the same day.
- The practice had good facilities, including a dedicated baby changing room and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice had a development strategy which had been shared with staff.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as requires improvement for providing safe services.

There was an effective system in place for reporting and recording significant events. Lessons were shared with relevant staff to make sure action was taken to improve safety in the practice.

Although risks to patients who used services were assessed, some of the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. For example,

- Some of the medicines stored in GP's bags were out of date and not fit for use.
- A risk assessment had not been carried out in respect of the use of some non-clinical staff as chaperones in the absence of a DBS check

There was a robust process in place for acting on patient safety and medicines alerts and actions taken were recorded.

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse and staff were clear about what to do if they had a safeguarding concern.

Requires improvement



Are services effective?

The practice is rated as good for providing effective services.

Systems were in place to ensure that all clinicians were up to date with National Institute for Health and Care Excellence (NICE) and other locally agreed guidelines, and clinicians used these as part of their work.

Regular audits were undertaken and improvements were made as a result to enhance patient care. However audits had not been repeated to reflect that improvements had been maintained.

Processes were regularly reviewed and improvements made. For example; SMS messaging was implemented to remind patients about their appointment which had reduced the number of patients who failed to turn up for their appointments.

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.

Good



Summary of findings

Staff worked closely with multidisciplinary teams to plan, monitor and deliver appropriate care for patients. The teams included midwives, health visitors, community matron, district nurses and the mental health team

Are services caring?

The practice is rated as good for providing caring services.

Data from the national GP patient survey published in July 2015 showed that patients rated the practice higher than others for several aspects of care. For example; 91% of patients said their GP was good at treating them with care and concern, compared with the national average which was 85%

Patient survey data indicated patients considered they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment For example; 87% of patients said that their GP involved them enough in decisions about their care

Information for patients about the services available was easy to understand and accessible. We also saw staff treated patients with kindness and respect, ensuring that confidentiality was maintained.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

They were aware of the practice population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

Patients were generally satisfied with the appointment system but told us they sometimes needed to wait for a long time to see their preferred GP. Urgent appointments were available the same day. Telephone consultations and home visits were available by appointment and where required.

The practice had good facilities including a dedicated baby changing room and was well equipped to treat patients and meet their needs. The premises were suitable for patients who were disabled.

Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff on the practices computer system and at meetings.

Good



Are services well-led?

The practice is rated as good for being well-led.

Good



Summary of findings

It had a clear vision and strategy which was shared with staff who understood their responsibilities in relation to this. There was a clear leadership structure and staff felt well supported by management. High standards were promoted and owned by all practice staff and teams worked together across all roles.

The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active and had influenced change within the practice through regular collaborative meetings with the practice management team.

Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities. There was a high level of constructive engagement with staff and a high level of staff satisfaction generally.

Learning and development was encouraged and supported by the partners and management team and dedicated time was assigned for clinical staff to attend development.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

The practice is rated as good for the care of older people and offered proactive, personalised care to meet the needs of the older people in its population. Patients had a named GP and had written care plans that were shared with outside agencies as required. They offered home visits and urgent appointments for those with enhanced needs.

All patients over aged 75 were invited for a health check if they had not visited the practice within the last 12 months and had already achieved health checks for 69% of these patients this performance year.

The practice provided regular scheduled visits to the care homes in their locality so that care could be proactively managed and this reduced the number of urgent visits required.

The practice also has a dedicated nurse for visiting housebound patients, many of whom were elderly, as part of their Annual Care Review (ACR), and to deliver flu vaccines.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions (LTC).

The practice had a systematic and caring approach to managing long term conditions. GPs reviewed all patients with a long term condition annually and where patients had more than one long term condition, they had all of their conditions reviewed in a single appointment. Where more regular reviews were required, these were provided by the nursing staff, who had roles in chronic disease management.

The practice had a diabetic nurse specialist who regularly monitored diabetic patients at the practice so that they didn't have to travel to receive their care.

Longer appointments and home visits were available when needed.

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.

Influenza vaccinations were offered to all patients with a LTC and these were provided in the patient's own home for house bound patients. This enabled the practice to achieve an uptake of influenza vaccinations for 81% of patients registered as having coronary heart disease compared to the national average which was 76%.

Good



Summary of findings

Families, children and young people

The practice is rated as good for the care of families, children and young people.

Immunisation rates were high for all standard childhood immunisations. For example, childhood immunisation rates for the vaccinations given to two year olds ranged between 94% and 99% compared to a CCG range of between 97% and 99%

Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. They ran dedicated influenza clinics for children during the half term holiday.

Appointments were available outside of school hours and the premises were suitable for children and babies. Urgent appointments were always available on the day for children under five.

The practice worked collaboratively with midwives and health visitors and provided post-natal baby checks and influenza vaccination for ladies who were pregnant.

The practice offered cervical smear tests and took this opportunity to consult regarding sexual health and contraception. Patients who did not attend were followed up to ensure they were given every opportunity to attend the clinic. They had achieved 79% attendance rate for providing smear tests for relevant patients which was in line with CCG average and national averages.

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. They had achieved 100% of available points for indicators relating to asthma which was 1% better than the CCG average and 3% better than the national average. There exception reporting rate across the four indicators was between 3% and 19% which was also above CCG and national averages for exception reporting.

The practice offered travel immunisations and advice for people wishing to travel abroad.

Good



Working age people (including those recently retired and students)

The practice is rated as good for the care of working-age people (including those recently retired and students). They had identified the needs of this population group and had adjusted the services they offered to ensure these were accessible, flexible and offered continuity of care. This included access to telephone appointments, and the availability of appointments throughout the day until 8pm.

Good



Summary of findings

The practice offered online services such as electronic prescriptions, and GP appointments were offered through the online booking system which was being proactively encouraged.

Health promotion and screening was provided that reflected the needs for this age group.

Patients were offered a choice when being referred to other services using the NHS e-referral service to take into account the most convenient location for travel.

People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

The practice worked closely with a care coordinator who monitored the attendance and discharge of patients from secondary care. Follow up appointments, including home visits if required, were booked and services from the practice and the community team made available to support patients' rehabilitation following discharge from hospital. The care coordinator also worked collaboratively with the practice, community matron, other attached staff and community services to plan care for people with complex needs and others who needed it. Patients were also able to self-refer to the care coordinator to receive assistance with planning social care.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Staff knew how to recognise signs of abuse in vulnerable adults and children.

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.

The practice held a register of patients living in vulnerable circumstances including those with a learning disability and offered longer appointments. They invited them for an annual health check with the nursing team who had completed training in this area. At the time of our inspection 34% of patients with a learning disability had received their annual health check. They had followed up written invitations with a telephone call to remind them of the appointment.

The practice informed vulnerable patients about how to access various support groups and voluntary organisations.

Good



Summary of findings

The practice had arranged for a local organisation to attend the practice monthly to provide hearing aids and support to patients with hearing loss.

People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia) and had achieved outcomes which were comparable with local and national averages. For example;

- 77% of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months, which is marginally below the CCG and national average (CCG average 85%, national average 84%)
- They had achieved 100% of available points in respect of monitoring patients being treated with the drug Lithium which was 5% better than the CCG average and 9% better than the national average. The exception rate was also slightly higher at 9% to CCG and national averages (5% and 4%)

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia and carried out advance care planning for patients who needed it.

They had told patients experiencing poor mental health about how to access various support groups and voluntary organisations and provided information about these in the waiting area.

Staff had a good understanding of how to support patients with mental health needs and dementia.

Good



Summary of findings

What people who use the service say

We reviewed the national GP patient survey results published on 2 July 2016. The results showed the practice was performing less well compared with local and national averages in some areas. A total of 335 survey forms were distributed and 114 were returned. This represented a 34% response rate

- 57% found it easy to get through to this surgery by phone compared to a CCG average of 74% and a national average of 73%.
- 75% were able to get an appointment to see or speak to someone the last time they tried (CCG average 86%, national average 85%).
- 89% described the overall experience of their GP surgery as fairly good or very good (CCG average 87%, national average 85%).
- 71% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (CCG average 80%, national average 78%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 18 comment cards which were all positive about the standard of care received and the caring, helpful attitude of staff. The five negative comments related to difficulty in getting through to the surgery by telephone and that patients sometimes waited a long time for appointments.

We spoke with five patients during the inspection. All five patients said they were happy with the care they received and thought staff were approachable, committed and caring. They told us that they were given enough time and felt listened to. They also told us that they were able to get appointments when they needed them but that they sometimes needed to wait to see their preferred GP.

Areas for improvement

Action the service **MUST** take to improve

The areas where the provider must make improvements are:

- Ensure that staff carrying out chaperone duties have received a disclosure and barring service check or ensure that any risk assessment that is carried out accurately reflects the risks to patients and how they will be mitigated.
- Ensure that a system is in place to monitor the expiry dates of medicines carried by GPs.

Action the service **SHOULD** take to improve

The areas where the provider should make improvement are:

- Ensure that all staff are aware of the procedures to follow in the event of a fire.

Review the system of clinical audits to ensure all are repeated as part of the continuous improvement in outcomes for patients

Hollybrook Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist adviser, a practice manager specialist adviser and an Expert by Experience.

Background to Hollybrook Medical Centre

Hollybrook medical practice is located in Heatherton, Littleover with a large branch practice in the Sinfin area nearby.

Services are provided from purpose built two-storey premises located in the town centre. The practice has facilities for disabled patients, baby changing facilities and car parking.

The practice provides personal medical services to 1,8040 patients under a Personal Medical Services (PMS) contract. The level of deprivation affecting the practice population is slightly below the national average. Income deprivation affecting children and older people is also slightly below the national average.

The clinical team comprises four GP partners who work full time, four full time salaried GPs, two GP registrars (A registrar is a fully qualified doctor who is training to work as a GP), six nurse practitioners, and a phlebotomist. The clinical team is supported by a full time practice manager, an Information technology manager and a range of reception and administrative staff.

The practice opens from 8am to 8pm Monday to Friday at the main site and from 8am to 6.30pm Monday to Friday at

the branch surgery. We did not visit the branch surgery as part of our inspection. Appointment times are available throughout the day as they do not close for lunch. Telephone lines are open from 8am.

The practice has opted out of providing out-of-hours services to its patients. This service is provided by Derbyshire Health United by telephoning the 111 service.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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 26 January 2016. During our visit we:

- Spoke with a range of staff (GPs, nurses, practice manager, reception and administration staff) and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members

Detailed findings

- Reviewed an anonymised sample of the personal care or treatment records of patients.
- 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 good systems in place for reporting and recording incidents and significant events. Staff told us they would inform the practice manager or the senior partner of an incident or event in the first instance and complete the reporting form which was available on the practice's computer system. The practice recorded all significant events on a central spread sheet and reviewed these at weekly management meetings. Learning was shared with relevant staff and those involved in the event. For example; the practice had reviewed and updated their disaster recovery plan following computer issues caused by a power failure. They also held an annual review of significant events where all staff were invited to attend and discuss outcomes and lessons learned. Staff were able to access information and learning about significant events via the practice's computer system. Where patients were affected by incidents, they were offered a written apology where appropriate.

There was a robust process in place for reviewing and acting on patient safety alerts. Staff were informed of any alerts, acted on these appropriately and recorded the actions they had taken. We followed up two recent safety alerts and found that patients' records had been updated where required to reflect the actions that had been taken to address the issues raised by the alert.

Overview of safety systems and processes

The practice had systems, processes and practices in place and in most areas these worked effectively to protect patients from abuse.

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. GPs were trained to an appropriate level to manage safeguarding concerns.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. For example; carpets in consulting rooms had been replaced with more suitable floor covering, and all consulting and treatment rooms had been de-cluttered
- We reviewed three personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.
- The arrangements for managing medicines, including emergency medicines and vaccinations, in the practice kept patients safe. We checked medicines stored in each of the treatment rooms and medicine refrigerators. We looked at the records which showed all fridge temperature checks were carried out which ensured medicines were stored at the appropriate temperature. Prescription pads were securely stored and there were systems in place to monitor their use. There was a policy to manage repeat prescriptions that was being followed. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.
- The procedure for checking the medicines kept in GPs' bags was not being followed and we found that 11 items of medicines in GP bags had expired by as much as three years. We made the practice aware of the expired medicines and they rectified the problem immediately.
- There was a chaperone policy and a notice in the waiting room advised patients that a chaperone was available, if required. (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 undertake chaperone duties. In addition, all of the administrative and

Are services safe?

reception staff had been trained to act as a chaperone if nursing staff were not available. Appropriate checks had been undertaken via the Disclosure and Barring Service (DBS) for recently recruited staff. (These 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) However, there were some non-clinical members of staff who had not received a DBS check. The practice had asked members of staff whether they had any criminal convictions in the last 12 months and this was recorded on a checklist in their individual personnel file. However, they did not conduct a risk assessment that accurately reflected the risks to patients and how risks would be mitigated.

Monitoring risks to patients

Some risks to patients were assessed and well managed. 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 and staff knew what to do in the event of a fire, however the practice had not carried out any fire drills for the preceding year in line with recommended testing intervals. 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 a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty and the practice ensured that annual leave for GPs was planned throughout the whole year so that sufficient cover was always available. We also saw evidence of a flexible approach to staffing and GPs or nurses would work additional sessions where a need was identified at either of the practices.

Arrangements to deal with emergencies and major incidents

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

- Staff were alerted to an emergency by an instant messaging system on the computers in all the consultation and treatment rooms
- All staff received annual basic life support training and there were emergency medicines available in the treatment room which were in date .
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks which were found to be in place for use.

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.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Practice staff demonstrated they used evidence based guidelines and standards to plan and deliver care for patients. These included local clinical commissioning group (CCG) guidance and National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to ensure all clinical staff were kept up to date. We saw evidence that the practice was using clinical audit to monitor the implementation of guidelines. In addition nursing staff told us they attended clinical training sessions to ensure they kept up to date with guidelines and best practice.

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 95% of the total number of points available, with a 10% exception reporting rate. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/15 showed;

The practice had achieved 100% of available points for some key clinical areas including asthma, heart failure, depression and hypertension. Exception reporting for these indicators varied between 1% and 19%

However, they performed less well in some clinical areas for example;

- Performance for diabetes related indicators was 87% which was 6% lower than the CCG and 2% lower than the national average.
- Performance for mental health related indicators was 89% which was 8% lower than the CCG and 4% lower than the national average
- Performance for peripheral arterial disease was 67% which significantly below the CCG average which was

98% and the national average which was 97%. However, data provided by the practice showed that they had recently improved this outcome and had achieved 79%. (This data has not yet been verified or published)

There had been two clinical audits undertaken in the last two years, one of these was a completed audit where the improvements made were implemented and monitored. For example;

- An audit was conducted to identify whether patients prescribed Citalopram (medicine used in the treatment of depression and anxiety disorder) had been assessed in relation to potential interactions with their other medicines. Following the audit, the practice implemented a reminder system for GPs to conduct an assessment on whether the medicine was the most appropriate. This resulted in a reduction in the number of patients prescribed this medicine.

They carried out regular medicines audits, with the support of the CCG medicines management teams, to ensure prescribing was in line with best practice guidelines for safe prescribing and participated in local audits, peer review and research. The senior partner had completed a Masters degree in information technology and used his expertise to improve processes within the practice.

Effective staffing

We saw staff had a range of experience, skills and knowledge which enabled them to deliver effective care and treatment.

The practice had an induction programme for all newly appointed staff. It covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. This was provided over a four week period for non-clinical staff. Recently appointed staff told us they had been welcomed by their colleagues and felt supported in their roles. We looked at the records for recently recruited staff and found that an induction checklist had been completed.

All staff had received training that included: safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training.

The practice could demonstrate how they ensured role-specific training and updating for relevant staff; for example for staff reviewing patients with long term

Are services effective?

(for example, treatment is effective)

conditions. Staff administering vaccines, taking samples for cervical screening and taking blood samples had received specific training which included an assessment of competence.

Learning needs of staff were identified through annual appraisals, meetings and wider reviews of practice development. Staff had access to a range of training which was appropriate to meet the needs of their role. In addition to formal training sessions support was provided through regular meetings, mentoring and clinical supervision. We saw evidence to demonstrate training needs of staff had been identified and planned for through the appraisal system.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and the computer system. This included care plans, medical records and test results. All relevant information was shared with other services in a timely way, for example when people were referred to other services.

There were systems 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.

All incoming mail including test results was well managed and any amendments to a patient's medicine were made by a GP.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they were discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a monthly basis incorporating reviews of patients at risk of hospital admission, end of life patients, and those who had complex needs. These meetings included community health team representatives, district nurse, health visitor and the community mental health team where required. Care plans were routinely reviewed and updated.

Consent to care and treatment

Staff understood and sought patients' consent to care and treatment in line with legislation and guidance, including the Mental Capacity Act 2005.

When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance, and where a patient's mental capacity was unclear the GP or practice nurse assessed the patient's capacity and recorded the outcome of the assessment.

Staff recorded consent to treatment and procedures in the patient's record. We saw that written consent had been obtained for 100% of surgical procedures and verbal consent was obtained for some procedures carried out by nurses. Staff sought patients' consent to care and treatment in line with legislation and guidance.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet or smoking cessation. Patients were then signposted to the relevant service.

The practice were able to provide some services at both their main site and at the branch surgery, for example, vaccination programmes and dietary advice. Smoking cessation advice and drugs and alcohol advice was available locally and by referral by the practice.

The practice's uptake for the cervical screening programme was 79% which was comparable to the CCG average of 83% and the national average of 81%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 95% to 100% and five year olds from 91% to 97%.

Flu vaccination rates for the over 65s were 73%, and at risk groups 50%. These were also comparable to CCG and national averages.

Are services effective? (for example, treatment is effective)

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

NHS health checks for people aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During the inspection we saw staff treated patients with dignity and respect. Staff were helpful to patients both on the telephone and within the practice. We saw that staff greeted patients as they entered the practice, often knowing each other by name.

Measures were in place to ensure patients felt at ease within the practice. These included:

- Curtains were provided in treatment and consultation rooms to maintain patients' privacy and dignity during examinations and treatments.
- Consultation room doors were kept closed during consultations and locked during sensitive examinations. Conversations taking place in consultation rooms could not be overheard.
- Reception staff offered to speak with patients privately away from the reception area if they wished to discuss sensitive issues or appeared distressed.

All of the 18 Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with two members of the patient participation group (PPG) They also 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 comparable to CCG and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 90% said the GP was good at listening to them compared to the CCG average of 90% and national average of 89%.
- 86% said the GP gave them enough time (CCG average 88%, national average 87%).
- 98% said they had confidence and trust in the last GP they saw (CCG average 96%, national average 95%)

- 88% said the last GP they spoke to was good at treating them with care and concern (CCG average 86%, national average 85%).
- 89% said the last nurse they spoke to was good at treating them with care and concern (CCG average 92%, national average 91%).
- 82% said they found the receptionists at the practice helpful (CCG average 88%, national average 87%)

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 on the comment cards we received was also positive and aligned with these views.

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 in line with local and national averages. For example:

- 86% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and national average of 86%.
- 87% said the last GP they saw was good at involving them in decisions about their care (CCG average 83%, national average 82%)
- 83% said the last nurse they saw was good at involving them in decisions about their care (CCG average 87%, national average 85%)

Staff told us that translation services were available for patients who did not have English as a first language and they also offered sign language for people who required this. We saw notices in the reception areas informing patients these services were available.

Patient and carer support to cope emotionally with care and treatment

The practice was sensitive to the needs of patients at the end of their life and to their relatives. All GPs had received palliative care training and discussed the needs of relatives as well as patients in their weekly meetings. Where patients had passed away unexpectedly, a GP would contact the relatives to check on their welfare.

Are services caring?

Staff told us that if families had experienced bereavement, their usual GP contacted them and offered advice on how to find a support service. Notices in the patient waiting room told patients how to access a number of support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer and they offered influenza vaccinations and

annual health checks. Written information was available to direct carers to the various avenues of support available to them. The practice worked with the PPG to provide annual events for carers and more regular 'carers café' events where carers could meet others in similar situations and access support. There was a dedicated carers champion at the practice.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

- The practice offered appointment times throughout the day without closing for lunch.
- There were longer appointments available for patients with a learning disability and those with complex needs were encouraged to book a double appointment.
- Home visits were available for older patients, house bound patients and patients who would benefit from these.
- Same day appointments were available for children and those who had an urgent need.
- Patients could make appointments by telephone, at reception and online.
- There were sufficient appointments available that enabled patients to obtain a routine appointment within three working days. However, patients sometimes had to wait longer to see their preferred GP.
- Appointment cards were provided and patients were reminded about their appointment via text message. Patients with a learning disability were sent written appointments which were followed up by a phone call to remind them on the day.
- The practice provided a travel vaccinations clinic where vaccines were available on the NHS as well as privately.
- There were disabled facilities and a hearing loop was available. All clinical and consultation rooms were on the ground floor. There was a dedicated baby changing room with good facilities for changing babies.

Access to the service

The practice was open between 8am and 8pm Monday to Friday. Appointments were from 8am to 8pm daily. In addition to pre-bookable appointments that could be booked up to three weeks in advance, urgent appointments were also available on the same day for people that needed them.

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

- 82% of patients were satisfied with the practice's opening hours compared to the CCG average of 76% and national average of 74%.

However, patients found it difficult to make an appointment by telephone and that they often couldn't get to see the GP of their choice unless they waited a long time for an appointment.

- 55% patients said they could get through easily to the surgery by phone (CCG average 75%, national average 73%).
- 41% patients said they always or almost always see or speak to the GP they prefer (CCG average 60%, national average 60%).

We saw in meeting minutes from January 2016 that the practice were working with the PPG to explore ways to address both these issues

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns were in line with recognised guidance and contractual obligations for GPs in England. Information on how to complain was made available to patients in the waiting area and on the website. Leaflets were available explaining the options and signposted patients to advocacy services and to NHS England. There was a designated GP who handled the complaints in the practice.

Patients we spoke with were generally aware of the process to follow if they wished to make a complaint, and told us that they would feel confident to report any concerns should this arise.

The practice had received nine written complaints in the previous 12 months. We looked at a selection of the written complaints received and found that these had been fully investigated and responded to within an appropriate timescale. Patients received a written apology where relevant.

We saw minutes of meetings where a review of complaints had taken place. Learning points were recorded and shared with staff on the practice's computer system.

Lessons were learnt from concerns and complaints and action was taken as a result to improve the quality of care. For example, where it was felt that patient perceptions and

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

expectations had contributed to a complaint theme, an action was put in place whereby education and information was provided to patients to manage their expectations.

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 vision and purpose to deliver high quality care in a friendly, caring and professional manner. We saw that all staff took an active role in ensuring provision of a high level of service on a daily basis and we observed staff behaving in a kind, considerate and professional manner. The practice had a robust strategy and supporting business plans which reflected the vision and values of the practice. For example; discussions had taken place to develop the branch practice into a health hub with a view to being able to offer additional services

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities
- There was a succession planning programme in place for staff
- There was a robust and supportive mentorship programme for trainee GPs
- Practice specific policies were implemented and were available to all staff via the practices computer system. These were updated and reviewed regularly.
- Practice meetings were held that provided an opportunity for staff to learn about the performance of the practice
- There were some arrangements in place for identifying, recording and managing most risks, but these were not robust.
- There was a meeting structure in place that allowed for lessons to be learned and shared following significant events and complaints. Staff groups were invited to specific meetings where relevant, and this included community team

Leadership and culture

The GP partners had the experience, capacity and capability to run the practice to ensure high quality care. They prioritised safe, high quality and compassionate care.

The partners were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. The partners encouraged a culture of openness and honesty.

We were shown a clear leadership structure that had named members of staff in lead roles. For example, there was a nurse practitioner for the infection prevention and control lead, lead GPs for safeguarding, complaints, commissioning, training and medicines management. Clinical staff also had lead roles according to their clinical expertise; for example practice nurses were responsible for an aspect of managing long term conditions.

We saw from meeting minutes that regular team meetings were held. Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and were confident in doing so and felt supported if they did. We also noted that the whole practice team were given time to attend a whole practice meeting every six months which included some training and development. Staff said they felt respected, valued and supported by the management team and that the leadership within the practice was fair, consistent and generated an atmosphere of team working.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

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The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was an active PPG which met monthly, carried out patient surveys and worked with the practice manager to share patients' feedback and to plan improvements for the future. For example, the practice was planning to implement a new telephone information system.

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 Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not fully ensure that care and treatment was provided in a safe way for service users in relation to assessing and mitigating risks by <ul style="list-style-type: none">• Ensuring there was a system in place to ensure that medicines stored in GP bags were in date.• Ensuring that all staff acting as chaperones received a DBS check or a comprehensive risk assessment was in place in the absence of one . Regulation 12 (2)(c)(g)