Doclands Medical Centre

Quality Report

Doclands Medical Centre
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Date of inspection visit: 22 April 2015
Date of publication: 28/05/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Doclands Medical Centre on 22 April 2015

Overall the practice is rated as good. We found the practice to be good for providing safe, well-led, effective, caring and responsive services.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered after considering best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients
- The practice had a clear vision that had improvement of service quality and safety as its top priority. High standards were promoted and there was good evidence of team working.

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

The provider should:

- Ensure changes and agreed actions to patient care following discussion at multi-disciplinary team meetings are available to all clinical staff in a timely manner.

Summary of findings

- Ensure patients who are on the 'at risk' register are monitored to identify their use of emergency departments, which may be indicative of potential escalation of risk to that patient.
- Ensure that clinical audits undertaken are recorded, are accessible to the practice to inform and share learning
- Ensure work place risk assessments identify the risk and the control measures in place to minimise any potential risks.
- Ensure the Legionella risk assessment is reviewed and any actions required by the risk assessment are carried out and monitored regularly.

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?

Good

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.

Are services effective?

Good

The practice is rated as good for providing effective services. Patient's needs were assessed and care was planned and delivered in line with current legislation and best practice guidance. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles, 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 some 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. The practice reviewed the needs of their local population. They engaged with other local practices and the local Clinical Commissioning Group (CCG) to secure service improvements where these were identified. The practice had identified the need to improve access to the appointments system and the telephone system. Complaints were responded to appropriately and there was an accessible complaints policy and procedure.

Are services well-led?

Good

The practice is rated as good for providing well-led services. Staff were clear about the values of the practice being patient centred. The practice had a number of policies and procedures to govern

Summary of findings

activity. 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 patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. 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, the avoidance of unplanned admissions scheme. All patients living in care homes had been reviewed and had care plans in place. GPs also followed up any hospital admissions to ensure that patients' needs were met to reduce the risks of patients being re-admitted to hospital. The practice safeguarded older vulnerable patients from the risk of harm or abuse. There were policies in place and staff were trained and knowledgeable regarding vulnerable older people and how to safeguard them.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Patients with long term conditions were supported by a healthcare team that cared for them using good practice guidelines and were attentive to their changing needs. Patients had health reviews at regular intervals depending on their health needs and condition. The practice maintained and monitored registers of patients with long term conditions for example cardiovascular disease, diabetes, chronic obstructive pulmonary disease and heart failure. These registers enabled the practice to monitor and review patient conditions effectively and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Childhood Immunisation rates were good for all standard immunisations. Weekly baby clinics were held and patients praised the health care assistant who ran the clinic. Clinical staff were knowledgeable about the needs of their patient population and ensured children and young people were treated in an age-appropriate way. Staff demonstrated a good understanding and were proactive in safeguarding and protecting children from the risk of harm or abuse. The practice had a clear means of identifying in records those children (together with their parents and siblings) who were subject to a child protection plan. The practice had appropriate child protection policies in place to support staff and staff were trained to a level relevant to their role.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice opened Saturday morning's enabling patients who worked more flexible opportunities to make appointments. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability and it offered longer appointments for people with a learning disability. 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 in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. The practice provided appointments to patients with mental health needs with three mental health and well-being practitioners who worked at the practice on Tuesday and Friday. The practice had medicine prescribing policies in place to assist in monitoring the patient's progress and safeguard them from potential medicine misuse. The electronic patient record system used by the practice also flagged up patients at potential risk of overdose.

Summary of findings

What people who use the service say

During our visit, we spoke with four patients. They told us that the GPs and nurses working at the practice were very good. Three of the patients told us that sometimes it was difficult getting an appointment with their preferred GP. However, these patients had rang on the day of our visit for an 'urgent' appointment and were provided with this within two hours of their telephone call.

A patient representation group (PRG) was newly established so the membership numbers were low. We spoke with both members, they told us that the service they received from the practice was very good and they were looking forward to working with the practice to develop and improve services.

We received 14 completed CQC comment cards. Two responses referred to their dissatisfaction with the reception staff but commented positively on the quality of care they received from GPs and practice nurses. The remaining 12 comment cards all were complimentary about the reception staff and all the GPs and practice nursing staff. They told us staff were helpful, caring, and that they were always treated with dignity and respect. The health care assistant who ran the baby clinics was also praised in the comment cards.

The practice had analysed the results of the returned Friends and Family Test questionnaires for January 2015. (The Friends and Family Test is a NHS England initiative that provides patients with the opportunity to feedback on their experience). The practice received 28 completed questionnaires. 25 of these indicated that patients would be either extremely likely or likely to recommend the practice. Three questionaries' indicated they would be extremely unlikely to recommend the practice. The comments from these three questionnaires were analysed and the outcome reviewed and shared at a team meeting. Actions to improve the service were identified.

The results of the National GP Patient Survey published in January 2015 demonstrated the practice performed well, when compared with the average results for the local Clinical Commissioning Group (CCG), in the following areas: 98% of respondents stating the last nurse they saw or spoke to was good at giving them enough time; 94% of respondents said the last nurse they saw or spoke to was good at explaining tests and treatments and 75% of respondents stating they usually wait 15 minutes or less after their appointment time to be seen.

Areas for improvement

Action the service SHOULD take to improve

The provider should:

- Ensure changes and agreed actions to patient care following discussion at multi-disciplinary team meetings are available to all clinical staff in a timely manner.
- Ensure patients who are on the 'at risk' register are monitored to identify their use of emergency departments, which may be indicative of potential escalation of risk to that patient.
- Ensure that clinical audits undertaken are recorded, are accessible to the practice to inform and share learning
- Ensure work place risk assessments identify the risk and the control measures in place to minimise any potential risks.
- Ensure the Legionella risk assessment is reviewed and any actions required by the risk assessment are carried out and monitored regularly.

Doclands 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 and a specialist advisor who was a practice manager.

Background to Doclands Medical Centre

Doclands Medical Centre is in Preston and is part of the NHS Greater Preston Clinical Commissioning Group (CCG.) Services are provided under a personal medical service (PMS) contract with NHS England. There are 6995 registered patients. The practice population includes a higher number (21.5%) of young people under the age of 18, and a lower number (13.9%) of people over the age of 65, in comparison with the CCG average of 14.9% and 15.9% respectively.

The practice sits at midpoint on the scale of deprivation. Information published by Public Health England, rates the level of deprivation within the practice population group as five on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest.

The practice opens from 8.30 am to 6 pm Monday to Wednesday and Fridays, and opens 8.30 am to 1 pm on Thursdays. The surgery also opens Saturday morning from 8.30 to 11.30 am. Patients requiring a GP outside of normal working hours are advised to contact an external out of hour's service provider Preston Primary Care Centre.

The practice has four GP partners (four male), one female salaried GP, three female practice nurses, one health care assistant, a practice manager, office manager, reception and administration staff. The practice is a GP training practice.

The practice has recently introduced a GP telephone triage service each day to assess the health care needs of patients who request urgent appointments. Both urgent and routine appointments are available each day.

On line services include appointment booking and ordering repeat prescriptions.

Why we carried out this inspection

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

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

How we carried out this inspection

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

Is it safe?

Detailed findings

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 living in vulnerable circumstances

People experiencing poor mental health (including people with dementia)

Before visiting the practice, we reviewed information we held and asked other organisations and key stakeholders to share what they knew about the practice. We also reviewed policies, procedures and other information the practice manager provided before the inspection day. We carried out an announced visit on 22 April 2015.

We spoke with a range of staff including four GPs, a practice nurse, a health care assistant, the medicines co-ordinator, reception staff, administration staff, and the practice manager. We sought views from patients and representatives of the patient participation group, looked at comment cards, and reviewed survey information.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. This included investigating reported incidents, checking national patient safety alerts and sharing 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 and incident reports. The practice manager, clinicians and any other relevant staff investigated and reported on the incidents and events. Documented evidence confirmed that incidents were appropriately reported. Staff we spoke with confirmed this and said that there was an open culture at the practice they were encouraged to report adverse events and incidents.

Minutes of meetings provided evidence that incidents, events and complaints were discussed, and where appropriate actions and protocols identified to minimise re-occurrence of the incident or complaint. Records were available that showed the practice had consistently reviewed and responded to significant events, incidents and complaints and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of significant events that had occurred during the previous 12 months. Significant events were reviewed and discussed at the practice's monthly clinical meeting and where appropriate at the weekly reception team meetings. There was evidence that the practice had learned from these and that the findings were shared with relevant staff.

We saw evidence to confirm that, as individuals and as a team, staff were actively reflecting on their practice and critically looked at what they did to see if any improvements could be made. Staff when interviewed told us about significant events, the outcome of investigations and resultant changes made to minimise future reoccurrence.

We looked at significant events from April 2014 to February 2015. These had been analysed, reported and discussed with relevant staff. Examples included changing procedures for reviewing and reporting on the results of a biopsy or histology reports and similarly the management of 'task' activities on the shared drive computer.

National patient safety alerts were disseminated by the practice manager to relevant staff. Staff confirmed they received these by email. We saw clinical audits had been carried out in response to these safety alerts.

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 that showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their understanding of abuse and their responsibilities when they suspected a patient was at risk of abuse. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. One staff member provided us with an example where they had referred a patients to the children's safeguarding team. Another staff member told us of an incident they observed and reported to the GP who took appropriate action. All staff had access to the practice policy and procedure for safeguarding children and adults. They knew how to share information, properly record safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours.

The practice had one GP as the lead for safeguarding vulnerable adults and children. They had received training to level 3 as required to fulfil this role. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern.

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. Monitoring of patients identified on the 'at risk' register and their attendance at emergency departments was not undertaken. This additional check would highlight any potential of increased risk to the patient, allowing appropriate action to be taken.

There was a chaperone policy, which was visible in the patient waiting room. A chaperone is a person who acts as support and a safeguard and witness for a patient and

health care professional during a medical examination or procedure. All nursing staff, the health care assistant and reception staff were trained to undertake chaperoning duties.

Medicines management

We checked medicines stored in the treatment rooms and fridges. We found that they were stored appropriately. There was a current policy and procedures in place for medicines management including cold storage of vaccinations and other medicines requiring this. We saw the checklist that was completed daily to ensure the fridge remained at a safe temperature and staff could tell us of the procedure in place for action to take in the event of a potential failure of the cold chain. Examples were also provided where the procedure had been used when a breach in the cold chain was identified. A cold chain policy (cold chain refers to the process used to maintain optimal conditions during the transport, storage, and handling of vaccines) was in place for the safe management of vaccines. All medicines that we checked were found to be in date and those vaccines, which were nearing their expiry date, had been marked for easily identification.

GPs reviewed their prescribing practices as and when medication alerts or new guidance was received. Patient medicine reviews were undertaken on a regular basis in line with current guidance and legislation depending on the nature and stability of their condition. The practice employed a medicine coordinator who worked closely with the Clinical Commission Group (CCG) medicine optimisation team to review prescribing practices in line with best practice and national guidance. The medicines coordinator was specifically trained for the role they carried out. They were supported by weekly visits by the CCG pharmacist, who also carried out medicine audits to ensure safe working practices.

The practice had recently installed electronic prescribing which meant that patient prescriptions could be sent automatically to the patient's preferred pharmacist or chemist. This reduced the need to use paper prescriptions. Blank prescription forms were monitored and stored securely.

Medicines for use in medical emergencies were securely stored in the treatment rooms. One practice nurse had lead responsibility for checking stocks of medicines and their expiry dates. We saw these regular checks were recorded.

All staff knew where the emergency medicines were stored. Oxygen and an automated external defibrillator (AED) were kept by the practice for use in an emergency. These were checked regularly. An AED is a portable device that is used to treat cardiac arrest by sending an electric shock to the heart to try to restore a normal rhythm. The practice also had emergency medicine kits for emergencies such as anaphylaxis. Anaphylaxis is a severe, potentially life-threatening allergic reaction that can develop rapidly).

GPs told us that they did not routinely carry medicines in their doctors' bags.

Cleanliness and infection control

We saw the premises were clean and tidy. There were cleaning schedules in place and cleaning records were kept. Comments recorded by patients on CQC comment cards referred to the practice as being comfortable.

We saw that all areas of the practice were clean and processes were in place to manage the risk of infection. We noted that all consultation and treatment rooms had adequate hand washing facilities. Instructions about hand hygiene were available, with hand gels in clinical rooms. We found protective equipment such as gloves and aprons were available in the treatment/consulting rooms. Couches were washable and privacy curtains in the treatment rooms were changed in accordance with a planned schedule. Nursing staff spoken with told us about the cleaning they undertook between patient appointments to reduce the risk of cross infection.

The practice lead for infection control was not available on the day of visit. However records were available of the infection control audit and feedback from this, which was undertaken in January 2015. Minutes of a recent staff meeting referred to the audit and the progress in responding to the action plan. Staff we spoke with confirmed regular checks were undertaken and demonstrated a good understanding of their role in promoting good infection control practices.

Procedures for the safe storage and disposal of needles and waste products were available. Staff had access to spillage kits and policies for needle stick injury and the management of specimens.

Good

Are services safe?

The practice had a risk assessment for the management of Legionella (a bacterium that can grow in contaminated water and can be potentially fatal). However evidence to show the actions taken in response to this and that the risk assessment had been reviewed was not available.

Equipment

Staff we spoke with told us they had sufficient and suitable equipment to enable them to carry out diagnostic examinations, assessments and treatments.

All equipment was tested and maintained regularly and we saw equipment maintenance logs, contracts and other records that confirmed this. Contracts were in place for annual checks of fire extinguishers and portable appliance testing (PAT). We saw that annual calibration and servicing of medical equipment was up to date.

There was an oxygen cylinder, nebulisers and access to an automated external defibrillator. These were maintained and checked regularly.

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).

There was a system in place to record and check professional registration of the General Medical Council (GMC) and the Nursing Midwifery Council (NMC). We saw evidence that demonstrated professional registration for clinical staff was up to date and valid.

Staff told us there were enough staff to maintain the smooth running of the practice. Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness. The staff worked well as a team and as such supported each other in times of absence and unexpected increased need and demand. The practice manager and GP oversaw the rota for clinicians and we saw they ensured that sufficient staff were on duty to deal with expected demand including home visits and chaperoning.

The practice had developed clear lines of accountability for all aspects of care and treatment. Clinical staff had lead roles for which they were appropriately trained. The diversity and skill mix of the staff was appropriate; each person knew exactly what their role was and undertook this to a high standard.

The practice was a teaching practice and the GPs had mentorship roles with the doctors training in their practice.

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. The practice manage undertook a daily work place risk assessment of all areas at the practice to monitor for potential risks. The practice should supplement this visual check with a written risk assessment that identifies potential workplace risks and should include control measures to minimise the potential risks.

All new employees working in the building were given induction information for the building that covered health and safety and fire safety. There was a health and safety policy available for all staff and this was supported by an 'Employee Handbook' and included safety procedures.

There was a fire risk assessment in place and the practice regularly had fire equipment tested. Records of fire equipment safety checks and fire drills to ensure the safety of patients, staff or visitors were available.

Arrangements to deal with emergencies and major incidents

Staff described how they would alert others to emergencies by use of the panic button on the computer system.

An appropriate business continuity plan (Disaster Recovery Plan) was in place. This comprehensive plan covered business continuity, staffing, records/electronic systems, clinical and environmental events. Key contact numbers were included and paper and electronic copies of the plan were kept in the practice. Staff we spoke with were knowledgeable about the business continuity plan and could describe what to do in the event of a disaster or serious event occurring.

Staff had received training in dealing with medical emergencies including cardiopulmonary resuscitation (CPR). This was updated annually. There was suitable emergency equipment. Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of

Good

Are services safe?

cardiac arrest, anaphylaxis and hypoglycaemia and suspected meningitis. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

Weekly fire alarm tests were carried out and equipment maintained by a contracted company.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Once patients were registered with the practice, the health care assistant carried out a full health check. The information covered in a routine health check was comprehensive and included information about the patient's individual lifestyle as well as their medical conditions. The health care assistant referred the patient to the GP or other professionals within the practice when necessary. Patients told us they were satisfied with the quality of care and treatment they received both from GPs and nursing staff.

All the clinicians we spoke with were familiar with, and using current best practice guidance. The staff we spoke with and evidence we reviewed, confirmed that care and treatment delivered was aimed at ensuring each patient was given support to achieve the best health outcomes for them. Each clinician confirmed that they had online access to NICE (National Institute for Health and Care Excellence) guidance.

The practice took part in the avoiding unplanned admissions scheme. All their registered patients living in the 13 care homes within their catchment area had had their healthcare needs reviewed and assessed by a GP and a care plan recorded. The health care assistant checked with the patient and their carers every three months to update the care plan and to ensure any changes in the patients' health or social care needs were recorded and planned. Copies of the care plans were available at the practice. The health care assistant told us that the practice had plans to extend this service further to patients with palliative care needs.

The practice worked closely with the mental health team and three mental health and well-being practitioners worked at the practice on Tuesday and Friday. Patients with mental health needs were referred to these counsellors as part of their treatment. The practice policy was not to automatically repeat prescribe anti-depressant medication to patients. This allowed the GP to review the progress of the patient regularly at face to face appointments. The electronic patient record system used by the practice also flagged up patients at potential risk of overdose.

The GPs and practice nurses had completed accredited training for checking patient's physical health and the management of various specific diseases. The GPs told us they had lead responsibilities in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work.

Clinical staff told us the practice was focused on learning and developing to improve outcomes for patients. Monthly clinical meeting were held and recorded between GPs and nursing staff where clinical needs of patients and the services provided by the practice were reviewed. Nursing staff said that GPs were accessible when they needed advice or support.

The practice had read coding and alerts within the clinical record system to ensure that patients with specific needs were highlighted to staff on opening the clinical record. For example, patients on the 'at risk' register and palliative care register. The practice referred patients appropriately to secondary care and other services. Test results and hospital consultation letters were received into the practice either electronically or by paper. These were then scanned onto the system daily and distributed to the relevant GP.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework system (QOF). This is a system for the performance management of GPs intended to improve the quality of general practice and reward good practice. The QOF uses a point system. Records indicated that the QOF points achieved by the practices for 2013-2014 were almost 10% below the national England average and 7.2% below the Clinical Commissioning Group (CCG) average. We discussed this with the practice, who explained that one of their GP partners was absent for a period of time and this resulted in the use of locum GPs, which in turn affected the practice performance. The practice told us that all GP partners were now working at the practice and that the QOF results for the year ending March 2015 were improved.

GPs told us that they did carry out clinical audits around difference aspects of the service they provided. However, there was an informal system where the GPs kept their own clinical audits and did not share these generally with the practice. Some of the audits we saw were also poorly recorded. Having a system in place where all clinical audits are recorded properly and are accessible to the practice

Good

Are services effective?

(for example, treatment is effective)

will ensure learning is shared and may contribute to improving patients' outcomes. We did see completed clinical audit cycles for the monitoring of Lithium medicine (used for mental health conditions) and smoking cessation.

Effective staffing

The practice had an induction programme for newly appointed members of staff that covered such topics as fire safety, health and safety and confidentiality.

Staff also received in house training that included - safeguarding, fire procedures, chaperone training, basic life support, equality and diversity and information governance awareness. The practice nurses attended local practice nurse forums and attended a variety of external training events. They told us the practice fully supported them in their role and encouraged further training. The practice nurses were given protected learning time and supported to attend meetings and events.

Reception and administration staff confirmed they received opportunities to develop their skills and abilities and they had protected learning time each week.

All GPs were up to date with their yearly continuing professional development requirements and all had been revalidated or had their revalidation date scheduled. Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. As the practice was a training practice, doctors who were training to be qualified as GPs had access to a senior GP throughout the day for support. One trainee GP spoke positively of the support they received at the practice.

Staff told us they felt supported and trained to provide a good standard of service to patients.

Working with colleagues and other services

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 both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. All staff we spoke with understood their roles and felt the system in place worked well. Significant event analysis provided evidence that the practice changed their procedures when gaps in performance were identified.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients, patients on the risk register hospital admissions and discharges and attendance at A&E. District nurses and community matron attended these meetings regularly. Hand written notes were made at these meetings. However, we heard that these handwritten notes regarding individual patients care and treatment needs were not recorded on the patient's electronic medical record. This meant that other clinicians potentially did not have access to up to date information about the patient's health and their needs.

Information sharing

The practice used electronic systems to communicate with other providers. They shared information with out of hour's services regarding patients with special needs. They communicated and shared information regularly between themselves, other practices and community health and social care staff at various regular meetings. We saw a variety of documented meetings between the staff teams, which confirmed good working relationships between them and good review and joint decision making in patient care.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. This software enabled scanned paper communications, such as those from hospital, to be saved in the computer system for future reference. All members of staff were trained on the system, and could demonstrate how information was shared.

Consent to care and treatment

We spoke with clinical staff about their understanding of the Mental Capacity Act 2005. The practice nurse and health care assistant told us they had recently attended an external training event about the Mental Capacity Act. They provided examples of their understanding around consent and mental capacity issues. Clinical staff demonstrated a clear understanding of Gillick competencies. These help

Good

Are services effective?

(for example, treatment is effective)

clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment. The practice had policies and procedures to support staff around consent.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures a patient's written consent was obtained and documented in the patient notes. Implied consent was obtained for child immunisations with documentation of explanation and consent obtained in the records.

Health promotion and prevention

The practice supported patients to manage their health and well-being. The practice offered national screening programmes, vaccination programmes, children's immunisations, long term condition reviews and provided health promotion information to patients. They provided information to patients via their website and in leaflets and posters in the waiting area about the services available. This included smoking cessation, obesity management and travel advice.

New patients registering with the practice completed a health questionnaire and were given a new patient medical appointment. This provided the practice with important information about their medical history, current health concerns and lifestyle choices. This ensured the patients' individual needs were assessed and access to support and treatment was available as soon as possible.

The practice also offered NHS Health Checks to all its patients aged over 40. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Performance from 2013 to 2014 for children's immunisations was above average for the CCG.

The practice identified patients who needed on-going support with their health. The practice kept up to date disease registers for patients with long term conditions such as diabetes, asthma and chronic heart disease, which were used to arrange annual health reviews. The practice also kept registers of vulnerable patients such as those with mental health needs and learning disabilities and used these to plan annual health checks.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Staff we spoke with were aware of the importance of providing patients with privacy and of the importance of confidentiality. The computers at reception were shielded from view for confidentiality and staff took patient phone calls away from the main reception area to avoid being overheard.

Consultations took place in rooms with an appropriate couch for examinations and screens to maintain privacy and dignity. We observed staff were discreet and respectful to patients. Patients we spoke with told us they were always treated with dignity and respect.

We received 14 completed CQC comment cards. Two responses referred to their dissatisfaction with the reception staff but commented positively on the quality of care they received from clinicians. The remaining 12 comment cards and the four patients we spoke with on the day were all were complimentary about the reception staff and all the clinicians. They told us staff were helpful, caring, and that they were always treated with dignity and respect.

The results of the National GP Patient Survey published in January 2015 demonstrated the practice performed well, when compared with the average results for the local Clinical Commissioning Group (CCG). For example 98% of respondents stating the last nurse they saw or spoke to was good at giving them enough time; 94% of respondents said the last nurse they saw or spoke to was good at explaining tests and treatments and 75% of respondents stating they usually wait 15 minutes or less after their appointment time to be seen.

The practice had analysed the results of the returned Friends and Family Test questionnaires for January 2015. (The Friends and Family Test is a NHS England initiative that provides patients with the opportunity to provide on their experience). This showed that 89% of the responses indicated they would be either extremely likely or likely to recommend the practice to others.

The practice offered patients a chaperone prior to any examination or procedure. Information about having a chaperone was seen displayed in the reception area and all treatment and consultation rooms.

Care planning and involvement in decisions about care and treatment

Results from the national GP patient survey showed that 80% of respondents said the last GP they saw or spoke to was good at explaining tests and treatments and 92% said they confidence and trust in the last GP they saw or spoke to and 82% the last GP they saw or spoke to was good at listening to them.

Patients we spoke with told us that health issues were discussed with them, treatments were explained, they felt listened to and they felt involved in decision making about the care and treatment they received. Patient feedback on the comment cards we received indicated they felt listened to and supported.

The practice participated in the avoidance of unplanned admissions scheme and worked closely with 12 nursing homes. All their patients living in these care homes had care plans in place, which were regularly reviewed.

Patient/carer support to cope emotionally with care and treatment

There were health promotion and prevention advice leaflets available in the waiting rooms for the practice including information on strokes and immunisations. Detailed information was also available on the practice's website and practice leaflet. Their website also contained a section for 'Common Health Questions' and A-Z information to a wide variety of illnesses to help patients manage their medical conditions.

The practice nurses held a variety of clinics for specific problems and general health checks. The health care assistant, supported by a GP and the practice nurse ran the weekly baby clinic. Comments on feedback cards praised the baby clinic and in particular the health care assistant. Another comment card we received detailed positive and supportive care the practice provided to a vulnerable person at the end of life.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice monitored the service it provided and listened to patients. It was responsive to patients' needs and evidence was available demonstrating it was adapting to improve and maintain the level of service provided. For example, patient feedback regarding access to the service was not good. The practice had introduced a GP telephone triage system from the 1st April 2015 to see if this improved the situation for patients. Initial feedback from patients was that this had improved access.

The practice held information and registers about the prevalence of specific diseases within their patient population and patient demographics. This information was reflected in the services provided, for example screening programmes, vaccination programmes, specific services and reviews for elderly patients, those patients with long term conditions and mental health conditions.

The practice cared for a number of adult patients who lived in a local care or nursing homes. Clinical staff undertook visits to review care plans, any new patients and medications. Patients with dementia, learning disabilities and enduring mental health conditions were reviewed annually. They were encouraged to bring carers with them to these reviews. The practice had implemented the 'named GP' for patients over 75 to support continuity of care. The practice was proactive in contacting patients who failed to attend vaccination and screening programmes.

The practice had recently set up a Patient Participation Group (PPG). The membership numbers were quite low, however posters were displayed in the practice waiting areas advertising the group and asking for new members. We spoke with the two members before our inspection visit. They told us that the service they received from the practice was very good and they were looking forward to working with the practice to develop and improve services.

Tackling inequity and promoting equality

The surgery had access to interpreter services (language line) and staff told us they used an internet service provider online translation service. The reception desk was fitted with a hearing loop and one member of staff could use sign language. The practice also had alerts on patients' records that required extra assistance such as the visually impaired. All staff had received Equality and Diversity training.

The GP Partners had identified that the practice premises were no longer suitable to provide the level and variety of services it offered. At the time of the inspection visit, the GP partners were reviewing the options available to them regarding location and facilities. The building had disabled facilities including access and a ramp. All consulting rooms were on the ground floor. Adapted toileting facilities were available.

The practice provided services to the local transient traveller population. They told us they tried to offer patients who just 'dropped in' an appointment appropriate for their needs with either a GP, practice nurse or the health care assistant.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Access to the service

The practice opens from 8.30 am to 6 pm Monday to Wednesday and Fridays, and opens 8.30 am to 1 pm on Thursdays. The surgery also opens Saturday morning from 8.30 to 11.30 am. Patients requiring a GP outside of normal working hours are advised to contact an external out of hour's service provider Preston Primary Care Centre.

The practice operated a mixture of routine, same day and emergency appointments. Appointments could be booked up to three weeks ahead. The practice was reluctant to extend this time scale due to the high numbers of patients who do not attend these booked appointments.

In response to patient feedback and recognition that patients struggled to get same day emergency appointments, the practice has recently introduced a GP telephone triage service. This meant patients' ringing for same day appointments discussed their health concerns with a GP and the GP then decided the best course of action in response to the patient's need. Three of the four patients we spoke with on the day of our visit had used the GP telephone triage system and had received GP appointments within 2 hours of their telephone call.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patient feedback also indicated that patients struggled to get through to the practice on the telephone. Minutes from team meetings showed that this was discussed frequently and that consultation about the telephone service was being undertaken with the telecommunication provider to change the service to improve accessibility.

On-line services include appointment booking and ordering repeat prescriptions.

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 looked at the records of the ten complaints received by the practice in 2014 and the two complaints received in 2015. We saw the practice responded to complaints proactively investigating the concern, responding appropriately to the complainant, identifying improvements in service quality, sharing learning and adapting practice. Staff spoken with verified that they were consulted and made aware of changes in procedures as a result of complaint investigations.

Information for patients on how to make a complaint was displayed in the waiting room and on their website.

Are services well-led?

Good

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

Our findings

The practice had a clear vision to improve services to patients. Staff we spoke with were eager and enthusiastic to help develop and improve the service. Staff were able to articulate the vision and values of the practice. It was identified that the building the practice operated from did not afford them sufficient space for which to develop initiatives and service improvements. Minutes from a recent team meeting showed that the GP partners were committed to improving and developing the service and wanted all the staff to be involved in this.

Governance arrangements

The practice had policies and procedures to support governance arrangements, which were available to all staff on the practice's computer system. The policies included a 'Health and Safety' policy and 'Infection Control' policy. All the policies were regularly reviewed and in date and staff we spoke with were aware of the contents.

There was a clear organisational and leadership structure with named members of staff in lead roles. We spoke with staff of varying roles and they were all clear about their own roles and responsibilities. They all told us there was a friendly, open culture within the practice and they felt very much part of a team. They all felt valued, well supported and knew who to go to in the practice with any concerns. They felt any concerns raised would be dealt with appropriately.

Staff we spoke with were motivated and wanted to be part of improving the service they provided. Reception staff felt they and the practice would benefit by involving them more in the practice future plans.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed the practice performed below the average for the local clinical commissioning group and the England average in 2013/14. The practice was aware of this and told us that the overall QOF figures for 2014 to 2015 had improved significantly.

Clinical audits were undertaken however, a standardised system of recording and sharing the outcomes from these was not in place.

The practice had arrangements in place for identifying and managing risks. Risk assessments and risk management plans were in place, but general workplace risk assessment could be developed further.

Leadership, openness and transparency

Staff had specific roles within the practice for example safeguarding and infection control. There was a practice manager who oversaw the administration supporting staff.

The practice had a protocol for whistleblowing and staff we spoke with were aware of what to do if they had to raise any concerns. The practice had identified the importance of having an open culture and staff were encouraged to report and share information in order to improve the services provided. Staff we spoke with thought the culture within the practice was open and honest.

The practice held a number of various meetings at regular intervals that were documented. These included clinical, administrative and organisational meetings. Samples of records we viewed demonstrated information was exchanged about improvements to the service, practice developments and the identified learning from complaints and significant events.

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

Results of surveys, significant events and complaints were discussed at staff meetings. A new patient participation group (PPG) had just been established and the two new members told us they were enthusiastic and optimistic that they could influence positively the services delivered to patients. They told us that the practice was patient centred and had involved patients so that they could have their say.

The practice reception staff encouraged all patients attending to complete the new Friends and Family Test as a method of gaining patients feedback. There was also a suggestions box available at reception.

Management lead through learning and improvement

The practice worked well together as a team and held meetings for learning and to share information.

GPs were all involved in revalidation, appraisal schemes and continuing professional development. We saw that staff were up to date with annual appraisals, which

Are services well-led?

Good

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

included looking at their performance and development needs. Staff told us appraisals were useful and provided an opportunity to share their views and opinions about the practice.

The practice had an induction programme for new staff and a rolling programme of mandatory training was in place for all staff. Staff undertook a wide range of training relevant to their role and responsibilities relevant training. Records of staff training and copies of training certificates were available.

Staff told us they had good access to training and support to undertake further development in relation to their role. The practice had training and development half days each month. The practice was a GP training practice and trainee doctors were supported by the GPs and other staff.

The practice recognised future challenges and areas for improvement, had completed reviews of significant events, complaints and other incidents and shared the learning from these with staff at meetings to ensure the practice improved outcomes for patients.