

Dr J Pramanik & Dr J T Pramanik Practice

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?	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

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Overall summary

Letter from the Chief Inspector of General Practice

This is the report of findings from our inspection of Dr J Pramanik & Dr J T Pramanik Practice. Our comprehensive inspection was a planned inspection, which took place on 9 October 2014.

The Dr J Pramanik & Dr J T Pramanik Practice, also known as Hornspit Medical Centre, operates from purpose built premises which opened in 1994. It is located in the heart of a residential community and serves just over 3000 patients.

Patients told us that they were very satisfied with the services they received and spoke very highly about the health care clinicians treating them.

We have rated this service overall as good.

Our key findings were as follows: The service was patient centred in this small family run, well established practice. Patients felt supported and had confidence in the clinicians. The practice demonstrated a track record of seeking to provide safe and improving services in clean facilities to an inner city community with complex needs

and health challenges, including a high incidence of limiting long term illness. It was seeking to improve access to appointments and improve the health and wellbeing of its community.

In addition the provider should:

- Continue to explore improving surgery opening hours and the opportunities for early evening appointments.
- Consider GP training in Deprivation of Liberty Safeguards to support their on-going professional development.
- Consider the introduction of a patient participation group or enhanced local patient surveys.
- Although serious medical emergencies in practice are rare and the practice is situated very close to A&E departments (there are three A&E departments within a three mile radius), it would be best practice to have oxygen available and a revised medical emergencies protocol.

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?

We have rated the practice good for safe. Information from NHS England and the local commissioning group indicated that the practice had a good reputation for maintaining patient safety. Clinical staff ensured that they were up to date with the most recent national and professional guidance for treatment and care. There were good systems in place to monitor safety. Evidence was available which demonstrated that the practice learned from incidents and audits to improve services and prevent incidents recurring.

Emergency equipment and medicines were available and correctly maintained.

All staff had been recruited safely and had received regular updated training in how to respond to medical emergencies.

Staff took action to safeguard adult and child patients and when appropriate made safeguarding referrals using clearly defined protocols.

A range of effective hygiene and infection control measures were in place.

Good



Are services effective?

We have rated the practice good for effective.

All clinicians were trained and up to date. Opportunities had been provided for staff to keep up to date and receive updated training as necessary. Suitable records of this training were kept. The GPs made use of audits and evaluations to help them to maintain and improve clinical outcomes for patients.

All staff had regular, though generally informal, supervision and a documented annual assessment of their performance. This was recorded in order to identify strengths and where any developmental or training needs were identified these were included in a training plan for the upcoming year.

Good



Are services caring?

We rated the practice good for caring.

We spoke with 12 patients during the inspection but received no completed Care Quality Commission (CQC) comment cards.

Good



Summary of findings

Comments we received were positive and patients spoke about the friendliness of the practice and the professionalism of its service. Patients said they were treated with dignity and respect and had confidence in their healthcare professionals.

Patients said they were confident that their confidential and personal information was kept private at all times.

Are services responsive to people's needs?

We have rated the practice as good for responsive to people's needs.

The practice was aware of the identified areas of patients concerns and patient interests. Patients spoke very positively about the practice and said that they held all staff in high regard.

The practice had not set up a patient participation group (PPG). However, the practice had made effort to survey and consult the patients in order to plan and develop the practice and its services. For example the practice had made changes to the availability of appointments in response to the local survey and continued to seek further improvements.

The practice had a complaints policy and the three complaints received in the last year were responded to in a timely manner.

Good



Are services well-led?

We have rated the practice as good for well-led.

The practice had a vision and set of values which were understood by staff. Quality and performance were monitored.

Risks were identified and managed.

Staff told us they felt the practice was well managed with clear leadership from clinical staff and the practice manager. Staff told us they could raise concerns and felt they were listened to. The practice had carried out a local survey and recorded its action plan in response. There was no participation group (PPG).

Good



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 served an established community. Many patients had been with this practice for many years and the GPs had a long established relationship with older patients. These relationships had been established by the GP father of the current partners when he led this practice. The practice was very clear about its ability to meet the health and social needs of older people in this inner city community.

The practice offered a named GP for those patients who were 75 years and older in line with the new GP regulations. The practice also had a system for ensuring elderly patients requiring urgent care were seen on the same day.

Home visits were made when necessary and home bound patients were supported by the practice.

Good



People with long term conditions

The proportion of residents living with a limiting long term illness in the community served by this practice was between 21 and 27%, which is higher than the 20% average in England.

The practice worked hard at supporting individuals with long terms conditions. It had established systems to understand support and review patients with long term illness.

All clinicians demonstrated that they were sensitive to the needs of individuals.

Immunisations such as the flu vaccine were offered to patients both at the practice and at home for those patients who were housebound or living in care homes.

Good



Families, children and young people

Child health surveillance clinics were run on a regular basis. The practice monitored any non-attendance of babies and children at these clinics and worked in collaboration with health visiting service to follow up any concerns. Staff were knowledgeable about child protection and a GP took the lead for safeguarding. Staff maintained alerts in the patient's electronic record when safeguarding concerns were raised in order to keep treating clinicians informed.

Good



Working age people (including those recently retired and students)

The practice had a range of appointments available including pre-bookable, on the day and telephone consultations. Staff told us

Good



Summary of findings

they would try to accommodate patients who were working to have early or late appointments wherever possible. The practice had made changes to the availability of appointments in response to the local survey and continued to seek further improvements in line with patient's feedback.

People whose circumstances may make them vulnerable

The practice had some years of experience in supporting patients living in a variety of vulnerable circumstances. Staff were mindful of patients in vulnerable circumstances. Clinicians sought to provide appropriate and timely access to health care to meet their needs.

Suitable registers were maintained in order to support all staff giving care to vulnerable people including a register of patients with a learning disability and annual health care reviews were provided to these patients. Extended appointment times were offered to patients with a learning disability as necessary.

The practice monitored patients with drug or alcohol addictions and provided appropriate guidance, signposting, support, advice and referrals.

Staff were knowledgeable about safeguarding vulnerable adults. They had access to the practice's policy and procedures and had received training suitable to their role.

Good



People experiencing poor mental health (including people with dementia)

GPs were mindful of the differing needs of patients and the different and diverse mental health issues faced in this community. The practice worked in cooperation with other services to review and share care with specialist teams. The practice maintained a register of patients who experienced mental health problems. The register supported clinical staff to offer patients an annual appointment for a health check and a medication review.

When necessary the out of hour's provider was informed of patients facing crisis who may have need for interventions out of hours.

Referral to support groups and other useful services were made available.

Good



Summary of findings

What people who use the service say

Information from the National GP patient survey 2014 gave feedback saying:-

- 76% of respondents usually wait 15 minutes or less after their appointment time to be seen

CCG (regional) average: **62%**

- 68% of respondents with a preferred GP usually get to see or speak to that GP

CCG (regional) average: **58%**

- 77% of respondents say the last nurse they saw or spoke to was good at involving them in decisions about their care

CCG (regional) average: **70%**

Patients we met with on the day of inspection were very positive about this well established family practice. We spoke with 12 people. Care Quality Commission (CQC) comments cards were available in the surgery, but none had been completed. Everyone we spoke with had confidence in their clinicians.

Some patients wanted improved surgery opening hours, particularly those in the working age population.

Areas for improvement

Action the service **SHOULD** take to improve

- Continue to explore improving surgery opening hours and the opportunities for early evening appointments.
- Consider GP training in Deprivation of Liberty Safeguards to support their on-going professional development.
- Consider the introduction of a patient participation group or enhanced local patient surveys.
- Although serious medical emergencies in practice are rare and the practice is situated very close to A&E departments (there are three A&E departments within a three mile radius), it would be best practice to have oxygen available and a revised medical emergencies protocol.

Dr J Pramanik & Dr J T Pramanik Practice

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, a second CQC inspector and a practice manager.

Background to Dr J Pramanik & Dr J T Pramanik Practice

The practice has two partners, both female GPs, who along with one male locum GP provide medical services under a PMS contract to just over 3,000 patients. In total these three doctors provide the equivalent of two whole time equivalents over five days. They are supported by one senior practice nurse, six reception / administrative staff and one practice manager.

Out of hours services are provided by Urgent Care 24.

The proportion of residents living with a limiting long term illness in this area of the city of Liverpool is between 21% and 27%. The figure for the general population in England with a limiting long term illness is 20%.

The practice provides single storey ground floor facilities accessible to disabled patients. The facilities include toilet, waiting area, private consulting / treatment rooms. Car parking is available on site.

The practice covers the neighbourhood areas of Dovecot and Old Swan in the city of Liverpool. The practice makes every effort to serve its inner city community which faces social and health challenges. The Department for

Communities and Local Government findings, known as the English Indices of Deprivation, is an overall measure of multiple deprivation experienced by people living in an area. This identifies three of local government wards in this neighbourhood area as being amongst the most socially disadvantaged in Liverpool.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This practice had not been inspected before and that was why we included them.

How we carried out this inspection

Before our inspection we requested data from Liverpool Clinical Commissioning group (CCG), information from NHS England and reviewed our own intelligent monitoring data. We were able to consider the services that would be required to meet the needs of all population groups.

Before our inspection, we sent comment cards and posters to the surgery advising patients of our inspection and inviting them to share their views. The practice did not have a patient participant group. We conducted a full day site visit on 9 October 2014. We spoke with all staff including reception and administrative staff, the practice nurse and two doctors, the partners at the practice. We also spoke with patients and their carers.

Detailed findings

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People living in vulnerable circumstances

People experiencing poor mental health (including people with dementia)

Are services safe?

Our findings

Safe Track Record

The practice had records of the safety audits it had carried out.

Also, each day clinicians considered and reviewed individual patient safety, particularly in relation to mental health issues and risks of suicide. The doctors communicated appropriately with the out of hour's service in order to ensure good communication maintained the safety of vulnerable patients. The practice had a system in place to ensure that clinicians received and noted communications daily from the out of hour's service.

Other audits and reviews included discharges from accident and emergency, mortality rates and audits of patient referrals to hospital. Any actions taken as a result of the audits were recorded.

Significant event analysis (SEA) had been carried out and documented. The outcomes of such analysis evidenced lessons learned and changes were implemented accordingly.

This demonstrated that the practice was maintaining its safety over time.

Staff told us how they could raise concerns quickly if they needed to. They told us that as this was a small practice there were no real obstacles to any such reporting, if that was necessary. They told us clearly how they knew they could report incidents in relation to safety to their manager and also through their staff and practice meetings.

Satisfactory records were seen in relation to the safety and maintenance of the premises.

Learning and improvement from safety incidents

The practice had processes in place for reporting, recording, monitoring significant events and learning from them. These outcomes were communicated with relevant staff as appropriate and recorded. Significant events reviews were carried out and recorded.

Significant alerts were noted by the doctors every day.

These processes were used correctly by staff in this close knit family run practice. This practice had a long relationship with the community it served and thereby enabled good communication with patients if things did not go right or well.

Reliable safety systems and processes including safeguarding

Patients attending the practice on the day of our inspection told us they felt safe, having confidence in the care and treatment provided.

Everyone we spoke with who was working at the practice had a good understanding of adult and children's safeguarding issues.

All members of the team at Hornspit Medical Centre knew about the systems, processes and practices which were essential to keep patients safe.

All administrative and clinical staff, including locums had received safeguarding training to a level appropriate to their role and responsibilities.

The practice doctors were correctly trained for adult safeguarding and for working with children, young people and/or their parents/carers to level three. This level of training was appropriate for professionals who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns.

A chaperone policy was in place and the information for patients regarding having a chaperone for their appointment was advertised in the waiting area. A chaperone request typically required 24 hours' notice. Clinicians act as chaperones in the practice.

Medicines Management

There were protocols and procedures in place for the best prescribing of medicines and for reviewing repeat prescriptions which were in line with General Medical Council (GMC) guidance. Repeat prescriptions could be obtained by patients in 48 hours.

Useful patient information about medicines was supported by an extensive range of printed information leaflets, which were available in the waiting area.

Some emergency medicines were available in the practice and all staff knew their location. Emergency medicines were stored and managed correctly.

Vaccinations were also kept correctly and stored within manufacturers' guidelines. There was a clear policy for

Are services safe?

maintenance of the cold chain and action to take in the event of a potential failure. The “cold chain” is a system of transporting and storing vaccines within a recommended temperature range of +2 to +8 degrees Celsius (°C).

Cleanliness & Infection Control

Patients told us that they always found the practice clean and tidy. The practice had named personnel who had lead responsibilities for cleanliness and the management and audit of infection control measures.

We spoke with staff and the practice nurse who was the practice lead for infection control processes.

There were sufficient hand washing facilities in the premises. There were sufficient quantities of gloves and aprons available. The consulting couches had paper rolls protecting them.

There were recorded audits for cleaning, infection prevention and control. An independent annual infection control audit had been carried out and the upcoming infection control review being planned for November 2014.

There had been no reported incidents from sharps injuries or spillage and appropriate policies and protocols were in place.

Clinical and other waste was managed as required by relevant legislation.

We saw staff had received infection control training; all staff we spoke with were clear about their roles and responsibilities for maintaining a clean and safe environment.

Equipment

Records were kept that confirmed all equipment in use was correctly maintained and was safe for use.

Equipment required for resuscitation or other medical emergencies was available and was readily accessible for urgent use. An emergency bag and defibrillator were available. Personnel had been trained and staff had sufficient support and knew what to do in urgent and emergency situations.

Staffing & Recruitment

We looked at the arrangements for recruitment and for obtaining appropriate information about staff working at the practice.

We talked to staff about how they had been recruited and we looked at the recruitment policy. Some staff had worked at the practice for some years others had been recruited in the last few months. They told us that they had applied for their posts through advertisements and that the practice had spoken with previous employers in order to find out if their conduct had been satisfactory. They had then undergone an interview.

We talked to the practice manager about the recruitment and induction processes and checked staff files. There is a legal requirement which sets out for providers all the information which should be obtained and recorded for staff working in the service. This required information was in the staff files.

Disclosure and Barring (DBS) checks were in place for the nursing staff employed by the practice. With regard to doctors; DBS checks were in place as conducted by the Clinical Commissioning Group (CCG). Locum doctors were used regularly and a service level agreement was in place with the agency.

Staffing levels were within safe limits. The practice had two whole time equivalent (WTE) doctors working over 5 days. There was a practice manager, a practice nurse and five administrative staff. Not all staff were full time.

Doctors leave was covered by locum medical staff. Administrative staff provided cover in-house from within the team for their planned absence.

Clinical staff had suitable up to date indemnity insurance and were registered with the appropriate professional body and records of registrations were kept.

Monitoring Safety & Responding to Risk

The service had identified and responded to risks faced by the population groups. For example, it had made good progress with improving the number of patients having breast and cervical screening and was clearly promoting a campaign to prevent or detect bowel cancer. It was also very aware of the raised percentage of patients with mental health problems in the community which it served.

There were procedures in place for monitoring and managing risks to patient and visitor safety with all its health and safety policies. Regular checks, maintenance and assessments of the building were carried out. There was a fire procedures policy and staff had adequate training.

Are services safe?

Arrangements to deal with emergencies and major incidents

An up to date service continuity plan was available. This included staff emergency contact telephone numbers and identified actions to be taken in any emergencies which might impact on the safe delivery of services.

These premises were NHS England premises and in the event of a significant emergency affecting the premises or services in the local area NHS England would have a key role to play in maintaining the safe delivery of NHS primary care services.

All staff were trained to a minimum of basic life support to ensure patients had emergency care if needed.

Fire alarm testing was completed monthly. There was a fire procedures policy all equipment was maintained in good order. There was a process for fire evacuation drills and staff training.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinical staff we spoke with gave good accounts of how they accessed best practice information and guidance. Clinical staff attended regular training events including as provided by the Clinical Commissioning Group (CCG). Clinicians had access to the National Institute for Health and Care Excellence (NICE) guidelines electronically.

All the doctors working at the surgery discussed any new clinical protocols with each other. They also reviewed complex patient needs and kept up to date with best practice guidelines.

The practice nurse was up to date in specialist areas including supporting people with long term conditions such as diabetes, heart disease, chronic obstructive pulmonary disease (COPD) and asthma. The practice nurse met with nurses from other practices by attending network meetings. These helped in forming collaborative working for patients benefit and supported keeping up to date with best practice locally.

All of these actions described above helped clinicians to assess patients' needs and provide care and treatment that were delivered, in line with current legislation, standards and evidence-based guidance.

All staff had received training concerning equality, diversity and human rights. Staff gave good examples of how they applied these principles in the work. Equality and diversity issues were discussed at practice meetings.

The practice had a plan which included looking at ways to reduce unplanned patient attendances at local hospitals. At the time of inspection the practice had not signed up to the Unplanned Admissions Enhanced Service, which looks into avoiding unnecessary unplanned admissions to hospital / accident and emergency department.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included casualty discharge summary and patient referral audits. Clinical staff then used the results in their learning. Another example was the practice carried out a hospital letter audit and as a result it streamlined processes for managing hospital

letters and the information contained. This included monthly searches being undertaken to produce lists of tests due enabling the practice to take the necessary actions.

The practice took part in local neighbourhood meetings. These were a local peer review system with neighbouring GP practices and the Clinical Commissioning Group (CCG). This helped the practice to consider care and treatment outcomes for patients who used this service and how they compared to other similar services and how things had changed over time. This helped the practice to monitor improvements and progress.

Data and statistical information was routinely gathered and considered. This was in relation to various aspects of the clinical outcomes of the service including those for the Quality and Outcomes Framework (QOF). This also helped the practice, as a team, to use the outcome results in their team learning. For example in relation to improving breast cancer screening rates; flu and childhood immunisation uptake and reducing patient attendances at accident and emergency departments.

Effective staffing

The practice had a procedure for the effective recruitment of staff including processes for advertising vacancies, seeking references, proofs of identity and checking qualifications and clinical registrations.

Learning, development and training needs were identified in writing and were determined in association with the appraisal process. Appraisals were recorded for reception and nursing staff. Staff we spoke with said they were supported in their role by their line manager and by the practice partners. Staff said that they had received relevant training in order to equip them to carry out their role competently. The practice joined with others practices for protected staff training time as facilitated monthly by the CCG.

We looked at three staff files and confirmed that an effective recruitment procedure had been followed. We also found that suitable checks were carried out prior to the use of any locum GPs and a service level agreement was in place with the agency supplying the locums.

There was evidence that confirmed all GPs had undertaken annual appraisals and revalidations were in place.

Are services effective?

(for example, treatment is effective)

Working with colleagues and other services

The clinicians at the practice worked closely with other agencies and health professionals to maintain continuity of care for patients and make timely referrals as appropriate and necessary.

The practice made sure that they communicated closely with the 'out of hours' service, Urgent Care 24, with information, to support patients who may need such out of hours care. This included patients who needed terminal care or who faced mental health challenges. Information received from others, such as hospital accident and emergency departments or hospital outpatient departments were read and actioned on the same day.

Information was scanned onto electronic patient records in a timely manner.

The practice kept up to date registers for patients with long term conditions such as diabetes, asthma and chronic obstructive pulmonary disease (COPD), which were used to arrange annual health reviews. They also provided annual reviews to check the health of patients with learning disabilities or patients on long term medication.

Multi-disciplinary team meetings for patients on the palliative care register took place on a regular basis to ensure patients had sufficient levels of support and equipment and drugs were in place in a timely manner.

Information Sharing

The practice made good use of hard copy records and electronic records. Hard copy documents were scanned into the electronic system in a timely manner and staff made sure that patient's information was available to clinicians promptly if patients moved between practices or services.

A process was in place, and used daily, to ensure referral and discharge information between hospital and other services was managed properly and was available to clinicians as necessary.

Clinicians were able to access blood test results electronically.

New patient information was gained promptly by the practice and accessed by the clinicians in a timely manner.

Within the surgery doctors and nurses communicated verbally and in writing about patient's changing needs and confidential information was protected at all times.

Consent to care and treatment

Clinical staff gave clear accounts of how to obtain consent from individual patients. They also gave examples of when and how legislation was relevant. We spoke with clinicians about circumstances as described by the Mental Capacity Act 2005. This Act provides a legal framework for decision-making on behalf of people aged 16 or over who cannot make decisions themselves. It also sets out the law for people who wish to make preparations for a time in the future when they may lack capacity to make decisions. Clinicians had good understanding of this Act, but had not had training in deprivation of liberty safeguards.

Clinical staff were also clear about information sharing, for example with a patient's carer or next of kin.

A log of patient's carers was kept in the electronic system to enable the practice to know who to contact.

The clinicians were aware of Gillick guidelines for children and young people.

Health Promotion & Prevention

New patient assessments were carried out and all new patients were offered a consultation.

A broad range of patients' information posters and leaflets were available in the patient waiting area and patients told us that the doctors and nurses gave them clear and helpful advice about how to improve their health.

Screening programmes, including cervical screening, were well established and used.

Effective vaccination programmes were in place, including childhood vaccination programmes, and practice followed up patients that did not attend. Influenza vaccination was also being promoted in all 'at risk' groups.

The practice offered NHS health checks for patients aged 40–74 years and there were follow up processes in place as required.

The practice was mindful of patients needing end of life or mental health crisis support and made appropriate referrals to other agencies as necessary.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We spoke with 12 patients on the day of the inspection.

Most patients were positive about the reception staff and the majority of patients described them as caring and helpful. One patient who had raised a concern said that the GP made contact with them without delay, the matter was resolved and the patient was very satisfied by the way in which this had been handled.

Music was playing in the waiting area which offered some privacy to patients talking with reception staff. If patients required further privacy they could speak with staff privately in a room away from the waiting area.

All of the patients we spoke with said they were treated with respect and dignity.

The patients we spoke with were aware they could ask for a chaperone if they felt this was needed.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity were maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

The National GP Patient Survey published in 2014 found that the number of patients who described the overall experience of their GP surgery as good 80% compared with the Clinical Commissioning Group (CCG) (regional) average of 89%.

Care planning and involvement in decisions about care and treatment

Patients told us that clinicians clearly communicated with them in terms they could understand in relation to their diagnosis, treatment and treatment options. Clinicians took time to ensure that patients understood the options

available to them. Patients told us they were clear about their treatment choices and felt able to ask questions or seek further information with the support of the all the practice staff, including clinicians and reception staff.

Where English was not a patient's first language arrangements were made for translators or use of a translation service.

Various registers were kept. These computer registers included logs of patient's carers, older people, patients suffering from mental health conditions or learning disabilities, chronic conditions, dementia or cancer. These were kept and used to provide effective communication and support.

The National GP Patient Survey published in 2014 found that 77% of patients said the last nurse they saw or spoke with was good at involving them in decisions about their care compared with the CCG (regional) average of 70%.

Patient/carers support to cope emotionally with care and treatment

Staff explained to us how they recognised the support patients and carers might need to cope emotionally with their care and treatment. Staff were able to support, direct or refer to other health and social care professionals, peer support networks and self-help groups as necessary.

Information was on display in the waiting area about the support available to patients to help them to cope emotionally with care and treatment. This included information about carers support and local support groups. Three patients we spoke with said that they had been referred to or given information about support groups they needed.

Clinicians ensured that people with long term conditions were assessed for any associated anxiety, depression or associated health problems or concerns.

Where bereavement support was needed patients were directed for further support by the practice to appropriate or specialist services locally. GPs and nursing staff were able to refer patients on to counselling services.

The practice ensured that it made the out of hour's service aware of patients who may have out of hour's needs, such as patients receiving end of life care.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The needs of the practice's population were understood and systems were in place to address identified needs. NHS England and Liverpool Clinical Commissioning group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

The practice held information about the prevalence of specific diseases. This information was reflected in the services provided. For example, screening programmes, vaccination programmes and reviews for patients with long term conditions. Immunisations for children were carried out.

The practice was proactive in contacting patients who failed to attend vaccination and screening programmes. The practice nurse went out to visit patients in their own homes annually for those hard to reach and house bound patients. For example to administer flu injections.

The lead GP and practice manager visited the housebound and hard to reach patients every three years.

Referrals for investigations or treatment carried out under the choose and book system were monitored. Records indicated this system worked well with all referrals receiving prompt attention.

The practice maintained a palliative care register and had regular internal meetings as well as regular multidisciplinary meetings to discuss patients and their families care and support needs.

The practice worked collaboratively with other agencies, regularly updated shared information to ensure communication of changes in care and treatment.

There was very little turnover in staff which meant that patients had good continuity of care and accessibility to appointments. The National GP Patient Survey published in 2014 found that 95% had confidence and trust in the last GP they saw or spoke to.

Tackling inequity and promoting equality

The practice was committed to ensuring equal opportunities for access to services and treatments to all patients and avoiding discrimination on the grounds of age, gender, disability, status, orientation, race or religion.

The practice had provided early morning and late evening appointments for working parents. This encouraged good update of child immunisations.

There were long appointment opportunities for patients with learning disabilities.

Carers were given age and care related advice and support.

Emergency appointments and telephone consultations were available.

There was no hearing loop at the surgery, but arrangements could be made in advance for signing services for deaf people. Disabled parking and disabled toilet facilities were available.

Access to the service

The National GP Patient Survey published in 2014 found that 93% of patients said the last appointment they had was convenient for them. Six of the 12 patients we spoke with said that they could get an appointment at a time that suited them. Four patients said that they would like longer opening hours at the surgery up to 8pm if possible in order to improve access to appointments with the doctor.

The practice web site outlined how patients could book appointment and how they could make these appointments online.

Patients were able book appointments on the same day. Appointments were set aside each day for urgent cases or for children under 5 years of age. It was possible for patients to make pre bookable appointments up to six months in advance.

All doctors made home visits as necessary. These visits were managed as separate appointments together with telephone triages.

The National GP Patient Survey published in 2014 found that 76% of patients usually waited 15 minutes or less after their appointment time to be seen.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Their 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.

Are services responsive to people's needs?

(for example, to feedback?)

The complaints policy was last reviewed in September 2014. A log / summary of complaints was maintained to monitor trends and ensure the implementation of any changes made. We looked at the complaints received in 2014. There had been three in total received. Actions had been taken and all complaints had been resolved.

We saw that the complaint policy was displayed in the waiting area and leaflets detailing the procedure were accessible to patients. The patient complaint procedure contained information about the Patient Advisory Liaison Service (PALS) and the Health Service Ombudsman, should patients wish to take their concerns outside of the practice.

Patients that we spoke with told us that they were able to raise concerns with the reception staff or the practice manager.

We looked at patient feedback left on the NHS Choices website. During 2013 and 2014 eight comments were left. Five comments were generally positive and complimentary. The other three comments showed patients were not satisfied with staff attitudes or appointment access. The practice manager had responded to each comment made providing where possible information to help the complainant.

Are services well-led?

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

Our findings

Vision and Strategy

There was a clear vision in the practice.

The practice has described its main aim and objective as:-

“Our main aim here at Hornspit Medical Centre is to provide a good healthcare service which is accessible to all our patients. We wish to continue to provide care for people of all ages, ability and ethnicity. We strive for this to be in a safe, friendly and clean environment. Our main objective is to improve the health of our patients and support them physically, psychologically and socially“.

These were clearly understood by staff working at the practice who knew what their responsibilities were in relation to these.

Governance Arrangements

The practice had policies and procedures in place to govern activities and these were available to staff electronically or in paper format. Staff demonstrated how they accessed policies and procedures. Generally the policies had been recently reviewed and contained the required information.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was overall performing in line with national standards. The GPs told us that QOF data was regularly discussed and action plans were produced to maintain or improve outcomes. For example in relation to improving breast cancer screening rates; flu and childhood immunisation uptake and reducing patient attendances at accident and emergency departments.

The practice participated in a local peer review system they took part in with neighbouring GP practices and the Clinical Commissioning Group (CCG). This enabled the practice to measure their service against others and identify areas for improvement.

The practice had completed clinical audits cycles to evaluate the operation of the service and the care, treatment given and implement lessons learned. Examples of clinical audits included casualty discharge summary audit and patient referral audit. These reviews were completed as part of the practice audit cycle and reviewed to monitor changes made and their consequences.

The practice carried an annual review of complaints at a review meeting. This meeting considered number of complaints, response to complaints, analysis of any trends, and outcomes. The meeting monitored the implementation of any changes made and reviewed their effectiveness.

The practice had systems in place for identifying, recording and managing risks. We looked at examples of significant incident reporting and actions taken as a consequence. Minutes from team meetings showed that significant incidents and how they were to be learned from were discussed.

Leadership, openness and transparency

There was a clear leadership structure in place and clear lines of accountability in this small, friendly family run practice. We spoke with all members of staff on duty on the day of inspection and they were all clear about their own roles and responsibilities. They told us that felt valued, well supported and knew who to go to in the practice with any concerns.

We saw that there was an open culture within the practice. Staff had the opportunities to raise issues at team meetings or as they occurred with the practice manager or registered manager. Staff told us they felt the practice was well managed. Staff told us they could raise concerns and felt they were listened to.

There were structured clinicians meetings and this included the locum GP.

We reviewed staff and recruitment procedures and policies. For example, recruitment policy, induction policy, equal opportunities / anti-discrimination policy, sickness, absence and staff handbook. Staff we spoke with knew where to find these policies if required.

GPs attended prescribing and medicines management and shared information within the practice.

Practice seeks and acts on feedback from users, public and staff

There was no patient participation group (PPG) and patients told us that they had been with the practice for many years and so they felt that they could share any views with the practice and its staff at any time.

Patient feedback was obtained through the comment / suggestion box in the waiting area and by carrying out a local survey. We looked at the last local patient survey

Are services well-led?

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carried out by the practice in 2013. Approximately 100 respondents had participated. There was an action plan prepared by the practice in response and steps had been taken to implement the changes. These related to appointments, surgery times and accessibility.

Management lead through learning & improvement

The partners made sure that all clinical and administrative staff were aware of the benefits of continual learning. They also made sure that learning could be incorporated into maintaining best practice and therefore developing a cycle of continuous improvement.

Clinicians were able to give good examples of how the practice supported clinical professional development through training and mentoring. Annual appraisals included new objectives to promote personal and professional development.

The practice had completed reviews of significant events and other incidents and shared with staff, via meetings, to ensure the practice improved outcomes for patients.