Dr Manuel Enrique Martin Hierro

Quality Report

Woodchurch Medical Centre
33 Poolwood Road
Woodchurch
Wirral
CH49 9BP
Tel: 0151 606 1908
Website: www.woodchurchmedicalcentre.nhs.uk

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This is the report of findings from our inspection of Dr. Manuel Enrique Martin Hierro. The practice is registered with the Care Quality Commission to provide primary care services.

We undertook a planned, comprehensive inspection on 13 January 2015 at the practice location Woodchurch Medical Centre. We also followed up concerns that we found at the last inspection of this location in July 2014. We spoke with patients, relatives, staff and the registered provider.

The practice was rated overall as Requires Improvement. They provided care and treatment that addressed the needs of the diverse population it served however aspects of the service needed improvement.

Our key findings were as follows:

- There were aspects of safety which needed improvement to ensure systems were fully embedded to keep patients safe from risks and harm. Incidents and significant events analysis and sharing of information needed improvement. Staff were safely recruited. Infection risks and medicines were generally managed safely.
- Patients spoke highly of the practice. They told us staff were helpful and caring and treated them with dignity and respect.
- The practice provided good care to its population taking into account their health and socio economic needs. Access to suitable, convenient appointments was good and patients had confidence in the practice staff. Complaints were managed appropriately.
- Patients' needs generally were assessed and care was planned and delivered in line with current legislation and guidance. However the practice needed to improve their recording of care and treatment in relation to patients who experienced poor mental health to ensure patients received appropriate care and treatment.

Summary of findings

- There was good team working evident. Staff enjoyed working for the practice and felt well supported and valued. Clinical Governance systems were in place however these were not fully embedded into practice to ensure continuous quality monitoring.

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

Importantly, the provider must:

Have an effective system in place to regularly assess and monitor the quality of services provided. Have an effective system in place for identifying, assessing and managing risks related to the health and safety of service users and others. Have an effective system in place for reporting, analysing, learning from and disseminating significant events.

In addition the provider should:

- Ensure all clinical staff, including practice nurses are trained to a higher level of safeguarding than non-clinical staff and that level should be relevant to their role.
- Ensure the vaccine fridge is situated in a suitable safe location and that the fridge plug is labelled warning people not to inadvertently unplug it.
- Improve recording of care and treatment for patients with poor mental health to ensure they are reviewed and monitored regularly and that information regarding their health is gathered. Ensure any informal patient drop in sessions are fully documented.
- Ensure medical equipment and portable electrical appliances are regularly calibrated, tested and maintained.
- Hold regular documented multi-disciplinary meetings occur to discuss care and support for palliative care patients.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

There were aspects of the service that required improvements in safety. The practice safeguarded vulnerable adults and children and demonstrated knowledge in respect of this. However staff had not all received appropriate training in safeguarding. There was access to policies, procedures and guidance to support staff. There were systems in place to safely recruit staff and we saw these processes had been followed. Infection control and medicines generally were managed to ensure risks were mitigated.

Significant events were reported and investigated appropriately on most occasions, however the practice should ensure the analysis and action planning of significant events is fully documented and all staff are involved in dissemination of lessons learnt.

Are services effective?

Good

This practice had achieved slightly lower than average scores for the Quality and Outcomes Framework (QOF) over the last year (91.4%, national average = 96.4%) However the scores demonstrated they mostly delivered effective care to patients. The National Institute for Health and Care Excellence (NICE) guidance was accessible, discussed, referenced and used routinely. The practice had identified specific needs of their patients and assessed and planned care effectively for older patients, families with children and babies, working age patients and those with long term conditions. Clinical staff had undertaken further training in relation to their roles for caring for patients with long term conditions and children. Patients' needs were mostly delivered in line with current legislation and guidance. This included assessment of capacity.

Data demonstrated that patients with poor mental health including those with dementia were not reviewed regularly and did not have information recorded about their lifestyles such as smoking status and alcohol consumption.

Are services caring?

Good

Results from the national GP patient survey, patients we spoke with and those who completed the CQC comment cards were complimentary about the service. They said the staff were kind, considerate and helpful. They told us they were treated with dignity and respect. Patients were involved in their care and treatment. We observed a patient-centred culture and staff were aware of the importance of providing patients with privacy and of confidentiality.

Summary of findings

Are services responsive to people's needs?

Good 

The practice had identified and reviewed the needs of their local population and provided tailored services accordingly. Access to appointments was good with the practice performing well in patient surveys in respect of this. They responded well to the specific needs of patients by offering length of appointment times that were suitable to their needs.

Complaints were responded to appropriately and there was an accessible complaints policy and procedure.

Are services well-led?

Requires improvement 

Staff were proud of the practice, its teamwork and the service it provided for its patients. There was a leadership structure in place that staff understood, with staff understanding their own roles and responsibilities. Staff were supported by a clinical and management team. The practice had policies and procedures in place to govern activity.

Clinical governance systems had been implemented and we found improvement since the last inspection, however the framework was not fully embedded across the practice with all staff participating and contributing to the assessing and monitoring of the quality of services. There were systems in place to identify risks.

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

Requires improvement

The practice did not have a high population of elderly patients. Care and treatment was delivered in line with current published guidelines and good practice. For example the Quality and Outcomes Framework (QOF) information indicated the percentage of patients aged 65 and older who had received a seasonal flu vaccination was similar to the national average. It offered a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older patients in that it offered home visits and extended appointments for those with enhanced needs. The GPs supported some older patients living in nursing and care homes locally. They visited on a regular basis and undertook reviews of patients' needs and medicines.

The practice generally safeguarded older vulnerable patients from the risk of harm or abuse. There were policies in place to support staff. However staff had not been appropriately trained in safeguarding vulnerable older people.

People with long term conditions

Requires improvement

The practice had a higher than average number of patients with long standing health conditions (63% of its population). Patients with long term conditions were supported by staff that cared for them using good practice guidelines. Patients had health reviews at regular intervals depending on their health needs and condition. Patients spoken with confirmed medication reviews took place regularly. The practice maintained and monitored registers of patients with long term conditions for example asthma, diabetes and chronic obstructive pulmonary disease. The Quality and Outcomes Framework (QOF) information indicated that patients with long term health conditions received care and treatment similar to the national average. This included for example, patients with diabetes having regular screening and monitoring and clinical risk groups (at risk due to long term conditions) having average uptake rates for seasonal flu vaccinations. However it was noted that the practice did not hold regular multi-disciplinary meetings to review palliative care patients and aspects of the service required improvement to ensure patients with long term conditions were safe from risks and harm.

We spoke to patients with long term conditions at the inspection, they all said they received good care and treatment; staff treated them with care, compassion and respect. The practice was accessible to disabled patients.

Summary of findings

Families, children and young people

Requires improvement

The practice served a higher than average younger population. We received positive feedback from mothers with children that we spoke with at the time of the inspection regarding their care and treatment at the practice. They told us they were confident with the care and treatment provided to them. The practice had a policy of always offering a same day urgent appointment to children who were ill.

Staff demonstrated a good understanding and awareness in safeguarding and protecting children from the risk of harm or abuse. The practice had a clear means of identifying in records those children who were subject to a child protection plan. The practice had appropriate child protection policies in place to support staff. However staff had not all received appropriate training for their role. Aspects of the service required improvement to ensure families, children and young patients were safe from risks and harm.

The practice ran weekly baby clinics with the practice nurse leading on this. They offered a full range of childhood vaccinations.

Working age people (including those recently retired and students)

Requires improvement

Aspects of the service required improvement to ensure working age patients (including those recently retired and students) were safe from risks and harm including ensuring that staff were appropriately trained in safeguarding and chaperoning.

The practice had a higher than average working age population. The practice was responsive to this group's needs. The practice offered evening appointments for patients who worked and had extended hours once a week. Telephone consultations were available and appreciated by working patients. The practice provided a full range of health promotion, such as smoking cessation, and screening that reflected the needs for this age group. The practice scored highly in the latest national GP patient survey in accessibility of appointments.

Repeat prescriptions could be ordered online and the practice website also contained various information regarding long term conditions and health and wellness.

People whose circumstances may make them vulnerable

Requires improvement

The practice was aware of, and identified their vulnerable patients. This was highlighted within patient records. There was evidence of the practice having discussed any concerning patients with community staff, safeguarding policies and protocols were in place. Aspects of the service required improvement to ensure patients

Summary of findings

whose circumstances may make them vulnerable were safe from risks and harm. Not all staff were appropriately trained in safeguarding and some staff who acted as chaperones had not received relevant training.

The practice held a register of patients living in vulnerable circumstances including those with a learning disability. They carried out health checks for people with a learning disability although this was found not to have always been recorded accurately in their records. They offered longer appointments for people whose circumstances may make them vulnerable when needed.

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice maintained a register of patients who experienced poor mental health. QOF data showed that performance of recording certain information for patients with poor mental health was below average. For example the percentage of patients with psychotic disorders who did not have a comprehensive care plan, record of alcohol consumption or smoking status recorded in the preceding 12 months was well below national average. The percentage of patients diagnosed with dementia who did not have a face to face care review in the preceding 12 months was also well below the national average. The practice acknowledged the need to improve their recording of care and treatment in relation to patients who experienced poor mental health and were addressing this.

The practice supported patients with depression, however this was through informal drop in sessions and consultations were not always recorded.

Summary of findings

What people who use the service say

We spoke with five patients on the day of our inspection and we received eight completed CQC comment cards. Patients whom we spoke with varied in age and population group. They included older people, those with long term conditions, younger people and those with children.

Patients were mostly positive about the practice, the staff and the service they received.

They told us staff were kind and treated them with respect. Staff knew patients individually and took time to listen to them. Doctors were generally good and patients felt safe in their care. Ninety six percent of respondents to the latest national GP patient survey (published in July 2014) found the receptionists at this surgery helpful. Patients told us the environment was clean and hygienic.

Mostly there were no concerns with access to appointments and the latest patient survey demonstrated positive feedback in relation to appointments. Ninety seven percent of patients responding to the survey said it was easy to get through to the surgery by phone. Eighty one percent described their experience of making an appointment as good and 91% were satisfied with the surgery's opening hours. We received one concern regarding the appointment system; the patient said they had to wait for over half an hour after the appointment time. The latest national GP survey showed that 98% of respondents usually waited 15 minutes or less after their appointment time to be seen.

Patients were generally very satisfied with the care and treatment received from the practice. They told us they were treated with dignity and respect and had confidence in the staff and the GPs who cared for and treated them. The results of the national GP patient survey told us that 85% of respondents said the last GP they saw or spoke to was good at treating them with care and concern, 82% of respondents said the last GP they saw or spoke to was good at involving them in decisions about their care and 85% of respondents said the last nurse they saw or spoke to was good at treating them with care and concern. Eighty eight percent said the last GP they spoke to or saw was good at listening to them, whilst 89% said the GP was good at explaining treatment and tests and 95% had confidence and trust in the GP. The data demonstrated the practice was performing average and above for the majority of questions asked regarding patient experience of the practice.

Areas for improvement

Action the service MUST take to improve

Have an effective system in place to regularly assess and monitor the quality of services provided. Have an effective system in place for identifying, assessing and managing risks related to the health and safety of service users and others. Have an effective system in place for reporting, analysing, learning from and disseminating significant events.

Action the service SHOULD take to improve

- Ensure all clinical staff, including practice nurses are trained to a higher level of safeguarding than non-clinical staff and that level should be relevant to their role.
- Ensure the vaccine fridge is situated in a suitable safe location and that the fridge plug is labelled warning people not to inadvertently unplug it.
- Improve recording of care and treatment for patients with poor mental health to ensure they are reviewed and monitored regularly and that information regarding their health is gathered. Ensure any informal patient drop in sessions are fully documented.
- Ensure medical equipment and portable electrical appliances are regularly calibrated, tested and maintained.
- Hold regular documented multi-disciplinary meetings occur to discuss care and support for palliative care patients.

Dr Manuel Enrique Martin Hierro

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Lead Inspector and included a GP, a specialist advisor who was a Practice Manager and a second CQC inspector.

Background to Dr Manuel Enrique Martin Hierro

Dr Manuel Enrique Martin Hierro is registered with the Care Quality Commission to provide primary care services. It provides GP services for approximately 2100 patients living in and around the Woodchurch area of the Wirral. The practice has one GP who is supported by locum GPs, a practice manager, practice nurse, phlebotomist and administration and reception staff. At the time of the inspection Dr. Martin-Hierro was suspended from the clinical performers list by NHS England. He was managing the practice which had locum GPs and the practice nurse and phlebotomist undertaking clinical duties.

The practice is open Monday to Friday from 8.00am to 6.30pm. Patients can book appointments in person or via the telephone. The practice provides telephone consultations, pre bookable consultations, urgent consultations and home visits. The practice treats patients of all ages and provides a range of primary medical services.

The practice is part of Wirral Clinical Commissioning Group (CCG). The practice is situated in a deprived area of the country. The practice population is made up of a higher than national average younger population and a lower than national average of patients aged over 65 years. Sixty three percent of the patient population have a long standing health condition and there is a higher than national average number of unemployed and patients claiming disability allowance.

The practice does not deliver out-of-hours services. These are delivered by Wirral Community NHS Trust who provides a service in the local hospital.

As part of this inspection we followed up areas of concerns identified at a previous inspection carried out in July 2014. The provider had submitted an action plan telling us how they would meet the regulations breached. We followed up these actions and improvements were evident.

The CQC intelligent monitoring placed the practice in band 1. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. We carried out a comprehensive inspection of this service under Section 60

Detailed findings

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

How we carried out this inspection

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)

Before our inspection we carried out an analysis of the data from our Intelligent Monitoring system. We also reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We reviewed the practice's policies, procedures and other information the practice provided for us on the day of the inspection. The information reviewed highlighted some areas of risk across the five key question areas. We looked at these during our inspection.

We reviewed all areas of the practice including the administrative areas. We sought views from patients face-to-face, looked at survey results and reviewed comment cards left for us on the day of our inspection.

We spoke with the registered manager who was the GP, a locum GP, the practice nurse, phlebotomist, administrative and reception staff on duty. We spoke with patients who were using the service on the day of the inspection.

We observed how staff handled patient information, spoke to patients face to face and talked to those patients telephoning the practice. We discussed how GPs made clinical decisions. We reviewed a variety of documents used by the practice to run the service.

Requires improvement

Are services safe?

Our findings

Safe track record

Reports from NHS England indicated that the practice did not have a good track record for maintaining patient safety. The provider GP had been suspended from the performers list by NHS England. Following an investigation carried out by NHS England assurance had been given that patient care and treatment was now delivered safely.

GPs told us they completed incident reports and carried out significant event analysis routinely and as part of their on-going professional development. Locum GPs reviewed their significant events with their locum Chambers. (GP Chambers provides a support structure for freelance GPs/ Locums working in general practice. They provide administrative and continuing professional development support).

Significant event reporting had improved since our last visit. Documented evidence confirmed that incidents were appropriately reported. We saw five events reported and reviewed since August last year. These were completed on a template and in three of the events, demonstrated recording of key risk issues, actions to be taken and learning points of the event. The remainder of these were not completed fully. There was evidence of discussion of one significant event at a team meeting to disseminate learning from this. Staff were knowledgeable regarding the reporting of incidents and told us how they actively reported any incidents that might have the potential to adversely impact on patient care.

Learning and improvement from safety incidents

The practice had a system in place, supported by policy and procedures, for reporting, recording and monitoring significant events and accidents/incidents. A standardised template was used for the reporting of all incidents. This included category of description of events, location, people involved, what action had been agreed and what learning ensued.

There was no overarching summary log and no evidence to demonstrate overall review to identify themes and trends. This would improve patient experience and reduce the risk of re occurrence of significant incidents.

We looked at the records of five significant events that had occurred in the last six months. There was evidence in one significant event that appropriate learning had taken place and that findings had been disseminated to relevant staff at a meeting. Others included actions taken to reduce further risks. However two of the others were not fully completed without any learning points identified.

We were told that national patient safety alerts were disseminated by the practice manager to relevant staff. The GP told us they took responsibility for such alerts and notices in the absence of the practice manager.

Reliable safety systems and processes including safeguarding

The practice had up to date policies for safeguarding children and young adults and for vulnerable adults. These provided staff with information about identifying, reporting and dealing with suspected abuse and at risk patients. The policies were available to staff on their computers and in hard copy. Staff had access to guidance flow charts and contact details for both child protection and adult safeguarding teams. We saw evidence of such information for child protection displayed in all clinical, reception and administrative areas.

All staff had received training on safeguarding children, however not all staff had received training in safeguarding of vulnerable adults. The practice nurse had only received a basic level of training; clinical staff should undertake a higher level of safeguarding training than non-clinical staff to support their role. All staff we spoke with were knowledgeable about the types of abuse to look out for and how to raise concerns. Staff were able to discuss examples of at risk children and families and how they were cared for.

The principal GP took the lead for safeguarding. They had attended appropriate training to support them. In the absence of the GP the practice manager and practice nurse led on safeguarding supported by a local practice GP safeguarding lead. All staff we spoke to were aware of who to speak to in the practice if they had a safeguarding concern. Codes and alerts were applied on the electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The clinical staff were fully aware of the vulnerable children and adult patients at the practice.

The practice had a current chaperone policy. Mostly clinical staff who were appropriately trained and had a Disclosure

and Barring Service (DBS) check acted as a chaperone. However, we found that one person had acted as a chaperone and had not received specific training for this. They did have a suitable DBS check in place. A chaperone policy notice was displayed in the reception area and in all treatment and consultation rooms.

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. 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. All medicines that we checked were found to be in date. We found that the vaccine fridge was not hard wired into the electric circuit but plugged into a wall socket. It was located in a communal staff area. The plug was not labelled with a cautionary notice on it warning that it was a medicines fridge and should not be unplugged. There was a potential risk of the fridge temperatures not being consistent if the fridge was unplugged by mistake.

Medicines for use in medical emergencies were kept securely in one of the treatment rooms. Staff knew where these were held and how to access them. There was oxygen kept by the practice for use in case of an emergency. This was checked regularly and checks were recorded.

The practice was supported by the medicines management team of the Clinical Commissioning Group (CCG) in keeping up to date with medication and prescribing trends. The CCG medicines management team were available for assistance and advice when needed.

Spare prescription pads were stored securely. Repeat prescriptions were held securely in the administration office. We saw these were not pre signed.

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.

Cleanliness and infection control

Patients commented that the practice was clean and appeared hygienic. The practice had undertaken an infection control audit in July 2014. We saw the outcome report with actions implemented. Improvements had been made to the environment as a result, for example replacement of dressing trolleys and waste bins. Cleaning was carried out under contract and the cleaning schedule was monitored. The practice nurse was lead for infection control. They had received training in infection control and this was updated annually.

There was an up-to-date infection control policy and associated procedures in place. A needle stick injury policy was in place, which outlined what to do and who to contact in the event of accidental injury. We saw current protocols for the safe storage and handling of specimens and for the safe storage of vaccines. These provided staff with guidance and were in line with current best practice.

Formal infection control training had not been undertaken by all staff. The practice nurse was the lead for infection control and had the appropriate skills and knowledge for this role. Non-clinical staff had not received any formal training in infection control. However staff we spoke with demonstrated general knowledge around infection control in relation to their role.

We inspected the treatment and clinical rooms. We saw that all areas of the practice were clean and tidy. Consultation and treatment rooms had adequate hand washing facilities. Instructions about hand hygiene were available throughout the practice. We found protective equipment such as gloves and aprons were available in the treatment/consulting rooms. Couches were washable. Privacy curtains in the treatment rooms were washable and a record of when they were last changed/washed was held.

We were told the practice did not use any instruments which required decontamination between patients and that all instruments were for single use only. Procedures for the safe storage and disposal of needles and clinical waste products were evident in order to protect the staff and patients from harm.

Regular testing and investigation of legionella (bacteria found in the environment which can contaminate water systems in buildings) had not taken place. This should be done to protect staff, patients and visitors from the risk of infection.

Equipment

Requires improvement

Are services safe?

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

There was no evidence of some of the medical equipment having been tested and maintained regularly. The phlebotomist told us the equipment she used was regularly calibrated and maintained however we did not find any evidence of records of this. There were contracts in place for annual checks of fire fighting equipment. There was no evidence of portable appliance testing (PAT) having been undertaken, however the GP had made plans for this to be undertaken within the week.

Emergency drugs were stored in a separate cupboard. There was an oxygen cylinder, nebulisers and an automated external defibrillator. These were checked regularly. There was a contract in place to maintain the oxygen.

Staffing and recruitment

An up to date recruitment policy was in place. This was in line with current guidance and regulations. We looked at a sample of four staff recruitment files. The practice employed locum GPs. The suitability and required checks for the locum doctors was verified by the agency that employed and supported them.

We found that generally all the required information relating to workers was available in the staff files that we looked at. There were appropriate Criminal Records Bureau (CRB) or Disclosure and Barring Service (DBS) checks for clinical and non-clinical staff. We saw evidence that demonstrated professional registration for clinical staff was up to date and valid.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. 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.

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 had health and safety policies in place. The GP was the lead for health and safety at the practice. Improvements had been made since the last inspection. There was a fire risk assessment template with generic risk assessments in place. The template detailed the hazard, who was at risk, likelihood and severity with control measures and actions to be taken. The practice was yet to undertake a localised environmental risk assessment to complete the template. There was a local fire safety policy in place and we saw evidence that staff had been trained recently in fire safety.

The practice used electronic record systems that were protected by passwords on the computer system. Paper records were seen to be stored securely in a suitable building in suitable locked cabinets.

Arrangements to deal with emergencies and major incidents

A current business continuity plan was in place. This 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 and by the practice manager and GP.

Staff could describe how they would alert others to emergency situations by use of the panic button on the computer system. Staff had received training in dealing with medical emergencies including cardiopulmonary resuscitation (CPR). This was updated annually. There was suitable emergency equipment and medicines available that were checked and maintained.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The clinicians (locum GPs) 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. We found from our discussions that mostly staff completed, in line with The National Institute for Health and Clinical Excellence (NICE) and local commissioners' guidelines, assessments and care of patients' needs and these were reviewed. NICE guidance was available so that staff had access to them. The practice had 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 Quality and Outcomes Framework (QOF) is a system for the performance management and payment of GPs in the NHS. It was intended to improve the quality of general practice and the QOF rewards GPs for implementing "good practice" in their surgeries. This practice had achieved slightly lower than average scores for QOF over the last year (91.4%, national average = 96.4%) However the scores demonstrated they mostly delivered effective care to patients. QOF information indicated patients with long term conditions and older patients received care and treatment as expected and in line with the national average. This included for example patients with diabetes had regular screening and monitoring and clinical risk groups (at risk due to long term conditions or aged over 65) had good uptake rates for seasonal flu vaccinations.

QOF data told us that there was improvement needed to the care of patients with poor mental health including those with dementia. The practice performed worse than the national and Clinical Commissioning Group (CCG) average in these areas and performance had decreased in the last QOF scores than in previous years. Patients with dementia were at risk as there was no evidence to demonstrate they had received a face to face review in the preceding 12 months and patients with mental health problems had records that showed poor performance in relation to them having an agreed care plan, record of alcohol consumption and smoking status. We were told on discussion with the GP that patients with poor mental health were reviewed and cared for appropriately, however there was a lack of accurate recording of this information which would demonstrate review and monitoring had taken place. The GP told us how he invited patients with poor mental health to attend informal support appointments, usually later in the day in order to encourage patients to attend. They felt the informal, quiet atmosphere encouraged patients to visit the GP for support. However these appointments were not always formally documented.

The practice nurse managed long term conditions such as diabetes, heart disease and asthma. This meant they were able to focus on specific conditions and provide patients with regular support based on up to date information. We saw examples of some recently introduced clinical meetings and the minutes demonstrated that staff discussed patient treatments and care. We saw an example of one multi-disciplinary clinical meeting to discuss patients on the Gold Standard Framework. (The National Gold Standards Framework (GSF) Centre in End of Life Care provides training to enable generalist frontline staff to provide a gold standard of care for people nearing the end of life).

The practice provided services for people in the local community including a younger than average population with a higher than average number of unemployed, patients living in a deprived area and those experiencing long term health conditions. Patients of the practice area experienced a lower than average life expectancy . We found GPs and other staff were familiar with the needs of their patients and the impact of the socio-economic environment.

The practice nurse had completed accredited training around checking patients' physical health and around the management of the various specific diseases and long term conditions. Older patients were well cared for by the practice. The over 75 health checks were undertaken and patients with long term conditions told us they all received regular reviews of their health and medication. Children and younger people were well cared for, childhood immunisations were undertaken with the practice nurse holding weekly baby clinics and regular baby progress checks. We found evidence of staff identifying when a child had missed an appointment for their condition check and

Good

Are services effective?

(for example, treatment is effective)

this was followed up. Patients and staff reported that the practice was very flexible with appointment times. They had a policy of ensuring ill children and babies were seen the same day and very urgently if required.

The practice referred patients appropriately to secondary care and other services. The locum GPs we spoke with used national standards for referral, for example in suspected cancers. 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. We did not find any outstanding results or letters waiting to be addressed.

We found that the GPs and nurse ensured consent was obtained and recorded. Patients told us that GPs and the nurse always gained their consent either formally or implied when undertaking any investigations, examinations or procedures.

Management, monitoring and improving outcomes for people

The practice collected information about patients' care and treatment using the Quality and Outcomes Framework (QOF).The locum GPs and practice nurse undertook clinical audits. QOF data showed the practice performed fairly well, slightly below national average. However there was no evidence that the practice regularly monitored its performance against QOF standards or benchmarked their performance to other locality practices.

We looked at two audits that the practice GP locums had undertaken. These included management of Atrial Fibrillation and antibiotic prescribing. These were completed audits where the practice was able to demonstrate improvements since the initial audit. The practice nurse showed us the infection control audit that had been undertaken last year with actions taken for improvement.

The practice implemented the gold standards framework for end of life care. They had a palliative care register. However they had performed poorly in respect of not having regular (at least three monthly) multidisciplinary meetings. Information was shared with the out of hour's services to inform them of any particular needs of patients who were nearing the end of their lives.

Effective staffing

There was a staff induction programme in place. One newly recruited staff member told us they had undergone this induction and felt it covered what was needed. The induction covered awareness of the practice policies and procedures, IT system and some mandatory training such as safeguarding and cardio-pulmonary resuscitation (CPR). There was a record of the induction in the staff file.

We saw a basic training record for staff which identified mandatory subjects and the dates they were completed. This record demonstrated that staff were mostly up to date with mandatory training such as safeguarding of children, CPR and Fire safety.

Staff also had access to additional training related to their role. For example reception staff had received training in complaints handling and dealing with difficult patients. Staff we spoke with told us they felt they were trained sufficiently to undertake their role.

We found that staff had received appraisals. Staff told us they felt supported by the GP, practice nurse and the rest of the team. Locum GPs received formal supervision with their GP chambers; the practice nurse was able to seek support for the GPs and with the practice nurse forum of which she was a member.

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

The practice nurses performed defined duties and extended roles. They were able to demonstrate that they were appropriately trained to fulfil these duties. For example, administration of vaccines and cervical cytology. The practice employed a phlebotomist who undertook health promotion (smoking cessation) as well as taking blood samples. They had also completed training relevant their role.

Working with colleagues and other services

The practice provided the out of hour's service with information, to support, for example, end of life care. Information received from other agencies, for example the

Good

Are services effective?

(for example, treatment is effective)

accident and emergency department or hospital outpatient departments were read and actioned by the GPs in a timely manner. Information was also scanned onto electronic patient records in a timely manner.

We saw an example of the practice meeting with other agencies to discuss safeguarding and at risk patients; however data showed that they needed to improve performance with multi-disciplinary team working for patients on the Gold Standard Framework (GSF).

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Information sharing

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system.

The practice used electronic systems to communicate with other providers. They shared information with out of hour's services regarding patients with special needs.

We found that the practice could improve communication within the practice. Staff reported that meetings were irregular for dissemination of information and improvements from lessons learnt. There were infrequent clinical meetings held to discuss patient care and treatment decisions with clinical staff seeking support from GPs as needed informally

Consent to care and treatment

Clinical staff we spoke with understood and were aware of the Mental Capacity Act 2005 and their duties in respect of this. They gave examples of when best interest decisions were made and mental capacity was assessed. Clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the capacity to consent to medical examination and treatment). The consent policy and procedures included Gillick competency.

Patients we spoke with told us that clinicians sought consent from them at all times, whether it be formal consent or implied consent.

Health promotion and prevention

The practice supported patients to manage their health and well-being. The practice offered national screening programmes, vaccination programmes, long term condition reviews and provided health promotion/lifestyle advice clinics. They provided information to patients via their website. There were some information leaflets, noticeboards and posters in the reception and waiting area regarding services available such as carer's information, flu immunisation programme, various cancers, alcohol and diabetes. The practice employed a phlebotomist who also ran a weekly smoking cessation clinic at the practice.

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The practice offered a health check to all new patients registering with the practice and 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.

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. They were very proud of the practice and the caring nature of its staff.

Patients we spoke with and results of the latest national GP survey told us that they felt well cared for and were treated with care and compassion. Eighty five percent of respondents said the last GP and the last nurse they saw or spoke with was good at treating them with care and concern

Consultations took place in purposely designed rooms with an appropriate couch for examinations and screens to maintain privacy and dignity. We observed staff were discreet, respectful and friendly to patients. Patients we spoke with told us they were always treated with dignity and respect. The computers at reception were shielded from view for confidentiality and staff took patient phone calls away from the main reception area so as to avoid being overheard.

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

Patients told us they felt involved in decisions about their own treatment, they received full explanations about diagnosis and treatments and staff listened to them and gave them time to think about decisions. This was reflected in the patient survey results with 82% of respondents saying the last GP they saw or spoke to was good at involving them in decisions about their care. Ninety five percent said they had confidence and trust in the last GP they saw or spoke to.

We found that healthcare professionals demonstrated knowledgeable about the Mental Capacity Act 2005. We found that clinical staff understood how to make 'best interest' decisions for people who lacked capacity and sought approval for treatments such as vaccinations from children's legal guardians.

Patient/carer support to cope emotionally with care and treatment

Patients were positive about the care they received from the practice. Patients we spoke with told us they had enough time to discuss things fully with the GP and most patients felt listened to and felt clinicians were empathetic. Results from the national GP patient survey told us that 91% of patients said the last GP they saw or spoke to was good at giving them enough time, 88% said the GP was good at listening to them and 89% said they were good at explaining tests and treatment.

The practice participated in the Gold Standards Framework for patients coming towards the end of their lives and terminally ill. They had a palliative care register which informed the clinicians of those patients to help them identify specific needs. However they did not hold regular formal multidisciplinary team meetings to discuss these patients and their care.

The practice publicised a carers group by a large poster and information displayed in the reception. They also had a carers weekly drop in session for support and a counsellor held a clinic at the practice once a week to whom GPs could refer patients. This included for bereavement support.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice responded to patients' needs and had systems in place to improve and maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. 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 and those patients with long term conditions.

The practice was responsive to the needs of older patients, and offered home visits and extended appointments for those with enhanced needs. They provided double time appointments for patients with long term conditions and those with poor mental health. Patients with long term conditions were reviewed annually by the practice nurse who took the lead for this group of patients. Patients we spoke with confirmed they were recalled regularly to have reviews of their condition and medicines.

The practice cared for a number of elderly adult patients who lived in local care homes. GPs would undertake visits to these homes when needed to review patients' health and medicines.

Improvements had been made since the last inspection as the practice had recently supported the development of a Patient Participation Group (PPG). We saw the group had developed a constitution and terms of reference and had held an initial meeting recently with the aim to contribute views and participate in developments with the practice management team. .

Tackling inequity and promoting equality

The practice was aware of the challenges they faced with their population. They were situated in a deprived area of the country with a higher than average younger population, unemployed and with long standing health and disability conditions.

The practice analysed its activity and monitored patient population groups. This enabled them to direct appropriate support and information to the different groups of patients.

The practice had a majority population of English speaking patients though it could cater for other languages as it had access to translation services. There were a variety of information leaflets available in different languages on their website.

The premises and services met the needs of people with disabilities. The medical centre was located in an adapted house. There were disabled toilet facilities and disabled accessible front entrance. Consultations and treatments were offered in ground floor rooms.

Access to the service

The practice was open Monday to Friday 8.00am until 6.30pm. Information was available to patients about appointments on the practice website and in the practice reception. This included who to contact for advice and appointments out of normal working hours when the practice was closed such as contact details for the out of hours medical provider. The practice offered pre bookable and urgent (on the day) appointments, telephone consultations and home visits.

Priority appointments were given to children and babies.

Appointments were tailored to meet the needs of patients, for example those with long term conditions needing full reviews or assessments were given longer appointments. Home visits were made to care homes, older patients and those vulnerable housebound patients.

Patients whom we spoke with, comment cards and patient survey results told us patients were generally satisfied with the appointment system. They told us there was usually no difficulty getting through to the practice on the telephone and getting a convenient appointment. The practice performed well in patient surveys for access to the appointments system with 97% saying they found it easy to through to the practice by phone and 83% described their experience of making an appointment as good. Ninety nine percent of respondents said the last appointment they got was convenient. These results were above average for the Clinical Commissioning Group (CCG) area. We received one concern regarding the appointment system; the patient

Good

Are services responsive to people's needs?

(for example, to feedback?)

said they had to wait for over half an hour after the appointment time. The latest national GP survey showed that 98% of respondents usually waited 15 minutes or less after their appointment time to be seen.

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. This was the practice manager who liaised with all relevant staff in dealing with the complaints on an individual basis. Staff we spoke with were able to tell us how they would handle initial complaints made at reception or by telephone and some had received complaints handling training.

We looked at complaints for the last 6 months and found that complaints had been dealt with and responded to appropriately. The practice took action in response to complaints to help improve the service. Complaints were investigated and we saw examples of a complaint being discussed at a practice meeting in order to learn from it and improve. A summary and overview log was not evident and there was no regular annual or more frequent overarching review of complaints. This would have enabled analysis of the complaints to identify trends and themes in order to improve learning and practice.

Patients we spoke with were aware of how to make a complaint. However we did not see any written information for patients regarding the complaints process at the practice.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

Staff were able to articulate their values of providing high quality care and treatment and were passionate about the practice and the work they did. They fully supported the GP. The GP had identified limitations for delivering good quality services single handed and had recognised the need to develop a new method of delivering services through integration with a larger corporate practice partnership. This had been shared with the staff who mostly were very positive about the new development.

The practice did not have a current formal strategy but through discussion with all staff and the GPs they articulated a passion for delivering services to their patient group. Staff articulated they felt very proud of the practice and the care they gave to their patients and to each other as a team.

Governance arrangements

The practice had taken steps to improve governance arrangements since the last inspection. However the clinical governance framework was not embedded into the practice culture to ensure continuous monitoring and evaluation of the service provided. This framework should include all staff to enable them to learn and make improvements and for them to be able to contribute and feedback on the quality of services.

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the computer and in hard copy. The majority of the policies and procedures were dated and had recently been reviewed. Staff confirmed they were aware of how to access them. Staff could describe some of the policies that governed how they worked for example the safeguarding children's policy and procedures.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was currently performing below the CCG and national average. There was a low rate of completion and QOF data was not monitored on a regular ongoing basis by the practice with no evidence of discussion at team or clinical meetings.

We saw two examples of clinical audits that were undertaken by the medical staff. They were completed well; with review of actions and improvements evident. External audits such as infection control audits were also undertaken and we also saw evidence of actions taken for improvement. However not all staff were involved in audits and there was no evidence of a culture encouraging audits to be undertaken on a regular basis. There was no audit plan or programme that identified how many and which audits were to be undertaken or how audits were decided upon.

The practice had a risk assessment and risk management protocol and policies in place; however formal updated environmental risk assessments were not fully documented. We were told by the GP that the templates were in place and risk assessments would be carried out imminently.

We found that legionella testing and equipment checks and calibration had not been undertaken. There were no risk assessments for these to ensure related risks were minimised.

Leadership, openness and transparency

There was a clear structure with staff viewing the GP as the leader even though he had not been present in the practice and working clinically for some time.

There was a well-established clearly identified leadership structure with clear lines of responsibility. We spoke to staff with differing roles within the service and they were clear about the lines of accountability and leadership. They all spoke of the GP as their leader and showed loyalty and respect for them. Staff demonstrated proudness towards the care and support they gave their patients and to the practice.

Staff told us they felt they could report any issues or incidents to the management team and that these would be dealt with appropriately. They felt they were valued and felt the practice leader cared for their staff as well as patients. Staff told us they felt they worked well as a team and they all supported each other.

Improvements were noted from the last inspection in that we now saw evidence of staff and clinical meetings being held over the last six months. Examples of meeting minutes demonstrated information exchange and learning from complaints and significant events took place. However not

Are services well-led?

Requires improvement

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

all staff felt these meetings were embedded into the culture of the practice fully and some staff were not involved in the meetings and therefore did not receive information about changes in practice to improve services.

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

We looked at complaints and found there were improvements in their management since the last inspection. The practice investigated and responded to them in a timely manner, and complainants were generally satisfied with the outcomes. We saw evidence of discussion of complaints documented with staff at one of the team meetings.

There was a recently formed Patient Participation Group (PPG) which had developed a constitution, terms of reference and had held an inaugural meeting. We did not see any minutes from the meeting as this had only recently taken place.

We noted there was a suggestion/comments box situated in the reception area to encourage patient feedback and there was information in reception for patients encouraging them to access and participate in the NHS friends and family test. The NHS friends and family test (FFT) is an opportunity for patients to provide feedback on the services that provide their care and treatment. It was available in GP practices from 1 December 2014.

The practice reviewed the results of the national GP patient survey; however we did not see any evidence of action plans for areas where they could improve such as respondents recommending the practice to someone new and the overall experience of the surgery. The practice performed well in relation to patients accessing appointments that were convenient and good performance of the GPs and practice nurse in caring for patients. We saw a format for an internal practice patient survey however we did not see any collated results for this and this had not been undertaken recently.

There was a whistleblowing policy in place. Staff told us they had no concerns about reporting any issues internally. Staff told us they felt able to give feedback and discuss any concerns or issues with colleagues and management. The practice had recently improved its performance in reporting and learning from significant events and incidents. We saw evidence of some feedback in meeting minutes, again these had recently been improved and regular team and clinical meetings were being embedded into practice.

Management lead through learning and improvement

We saw that most staff were up to date with annual appraisals which included looking at their performance and development needs. The practice had a basic induction programme which was evident in the records of newer staff. We saw evidence of training records for staff for mandatory training. Staff had completed training such as cardio pulmonary resuscitation (CPR), safeguarding of children, complaints handling and fire safety.

Staff told us they had access to and were supported in mandatory training. However due to staffing constraints they were not always able to access other training they had identified as important to their role.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **How the regulation was not being met:** People who use services and others may be at risk of inappropriate care and treatment due to: a) The provider not having an effective system in place to regularly assess and monitor the quality of services provided, and b) The provider not having an effective system in place for identifying, assessing and managing risks related to the health and safety of service users and others. C) The provider not having an effective system to reflect information and make changes to treatment and care relating to the analysis of significant events and incidents. Regulation 10 (1) (a) (b). Regulation 10 (2) (c) (i)