The Headland Medical Centre

Inspection 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 location	Good
Are services safe?	**Good**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Good**

Overall summary

T**his practice is rated as Good overall.** (Previous inspection 24 November 2015 – Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

We carried out an announced comprehensive inspection at The Headland Medical Centre on 25 April 2018 as part of our inspection programme.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- The practice was open and transparent, and had systems in place to adhere to the Duty of Candour.
- The practice displayed a strong commitment to multidisciplinary working and could evidence how this positively impacted on individual patient care.
- Discussion with staff and feedback from patients showed that staff were highly motivated to deliver care that was respectful, kind and caring.
- The practice organised and delivered their services to meet the needs of their patient population. They were proactive in understanding the needs of the different patient groups.

The areas where the provider **should** make improvements are:

- Review and update the fire risk assessment.
- Improve the oversight of the registered nurses in the management of long term conditions.
- Review and amend the system for the ongoing management of high risk drugs.
- Continue to monitor and review the management of sepsis at the practice

Professor Steve Field CBE FRCP FFPH FRCGPChief Inspector of General Practice

Population group ratings

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

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a GP specialist adviser and a second CQC Inspector.

Background to The Headland Medical Centre

The Headland Medical Centre is situated on the headland in Hartlepool, Grove Street. Hartlepool, TS23 0NZ. It is owned and operated by The Headland Medical Centre (www. headlandmedicalcentre.co.uk). It is a purpose built health centre and provides a full range of primary medical services.

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The Headland Medical Centre has a patient list of 5,452 patients.

The practice have a contract to provide General Medical Service (GMS) with Hartlepool and Stockton CCG. They also provided minor surgery to the population of Hartlepool and Stockton CCG and a vasectomy service to Durham, Darlington, Easington and Sedgefield CCG.

Information published by Public Health England shows the practice scores two on the deprivation measurement score; the score goes from one to ten, with one being the most deprived. People living in more deprived areas tend to have greater needs for health services. The practice has a predominately British White population, with a younger patient group. Male and female life expectancy is below the national average.

There are two GPS who are partners of the practice. One of which is male and one of which is female. There are three practice nurses. The practice is supported by a practice manager, accounts manager and range of administration/reception staff.

The practice is open between 8am and 6pm Monday to Friday. Walk-in appointments are from 9am to 11am and 2pm to 4pm daily. Extended hours are offered on a Monday between 6:30pm and 9pm. In addition to pre-bookable appointments that could be booked up to six weeks in advance; urgent appointments are also available for people that need them. Patients requiring a GP outside of normal working hours are advised to contact the GP out of hours' service provided via the NHS 111 service.

Good

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep people safe and safeguarded from abuse.

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Reports and learning from safeguarding incidents were available to staff.
- Staff who acted as chaperones were trained for their role and had received a DBS check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.)
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- There was an effective system to manage infection prevention and control.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics.
- There was an effective induction system for temporary staff.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures. The practice did not have the necessary equipment needed for the management of sepsis in children but this was ordered on the day of the inspection.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. A number of incidents were shared during the inspection and we saw the procedure taking place due to an incident occurring on the inspection day. Clinicians knew how to identify patients with severe infections including sepsis. The practice had the relevant toolkit and flow charts in place which were available to all staff.
- When there were changes to services or staff the practice assessed and monitored the impact on safety. Arrangements were made to provide additional appointments with clinical staff when necessary.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- The care records we saw showed that information needed to deliver safe care and treatment was available to staff. There was a documented approach to managing test results.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance.
- Patients' health was monitored in relation to the use of medicines. Patients were involved in regular reviews of their medicines.
- The management of high risk drugs was looked at during the inspection. We saw there was a system in place for patients to have their blood monitored on a regular basis. We did however see that three patients who had abnormal results were still able to obtain their medication via their repeat prescription. Following the inspection the practice conducted a full audit on all patients who were on high risk drugs and forwarded a

Good

Are services safe?

copy of the audit and actions taken. This showed it was safe for the three patients who were identified with abnormal results to continue to take the required medication.

Track record on safety

The practice had a good track record on safety.

- There were risk assessments in relation to safety issues; however the fire risk assessment needed to be further reviewed and updated by a competent person as it was not comprehensive enough.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture of safety that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned from incidents. There was, however, the need to formally share relevant learning points with the wider team, as appropriate.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.

Please refer to the Evidence Tables for further information.

Good

Are services effective?

We rated the practice and all of the population groups as good for providing effective services overall .

(Please note: Any Quality Outcomes (QOF) data relates to 2016/17. QOF is a system intended to improve the quality of general practice and reward good practice.)

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who were frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- The practice liaised with their allocated Care Coordinator (Hartlepool and Stockton Health Ltd funded post) who helped support older people to meet their social needs. They also supported older people to obtain additional equipment to help them remain at home.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice worked with the Hospital at Home team (NHS Trust provision) for patients with COPD. This service was able to assess patients promptly in order to avoid any unnecessary admissions to hospital.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were in the main in line with the target percentage of 90%.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had arrangements for following up failed attendance of children's appointments in secondary care or for immunisation.
- Health promotion and sexual health advice was provided at the practice. Chlamydia screening kits were available for young patients (aged 16-24).
- The practice had recently been allocated a named health visitor and there were plans in place to have bi-monthly meetings to discuss the need of children on their caseload.
- Families with social and mental health problems were encouraged to self-refer to the Early Help pathway to prevent deterioration of circumstance and the practice would liaise with the family's health visitors if needed.

Working age people (including those recently retired and students):

- The practice's uptake for cervical screening was 74%, which was below the 80% coverage target for the national screening programme. This was however comparable to the local CCG and National average.
- The practices' uptake for breast and bowel cancer screening was in line the national average.

Good

Are services effective?

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- The practice had a Pathway Advisor (from the benefits agency) who attended the practice once every two weeks to support patients with employment related matters, including benefits and to support them on returning to work.
- The practice offered spirometry screening for patients who smoked aged 35 and over without a diagnosis of COPD. A smoking cessation clinic was held each Wednesday.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

People experiencing poor mental health (including people with dementia):

- The practice assessed and monitored the physical health of people with; mental illness, severe mental illness, and personality disorder by providing access to; health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for administration of long term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- 91% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This was above the national average. Carers of patients with dementia were also offered a health check and advice.
- 83% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was below the national average.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example 100% of patients experiencing poor mental health had received discussion and advice about alcohol consumption. This was above the national average.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The practice offered annual health checks to patients with a learning disability.

Monitoring care and treatment

The practice had a programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. Where appropriate, clinicians took part in local and national improvement initiatives.

- The practice used information about care and treatment to make improvements.
- The practice was actively involved in quality improvement activity. Where appropriate, clinicians took part in local and national improvement initiatives.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- The practice nurses were managing patients with long term conditions which included reviewing cholesterol and hypertension results with patients. They decided on the medicine to be prescribed and then took it in to the GPs to get them to sign the prescription. The GPs were taking ultimate responsibility for the medicines being prescribed. However, there was not a system of audit/ oversight of the clinical decision making of the nurses to ensure this was in line with current evidence-based guidelines (i.e. that the algorithms are being followed and are in themselves regularly reviewed). There was also the need for assurance that the practice nurses had the required training to undertake all of these roles such as the diabetes diploma.

Good

Are services effective?

- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- The practice understood the learning needs of staff however limited protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, some appraisals. A more formalise system for delivering clinical supervision was needed as per nursing and midwifery council guidelines.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice shared clear and accurate information with relevant professionals when making decisions about care delivery for people with long term conditions and when coordinating healthcare for care home residents. The shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who had relocated into the local area.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.
- **Helping patients to live healthier lives**

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes. There was an allocated care coordinator who worked with patients, identified by the practice, to support with their health needs and social support.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Please refer to the Evidence Tables for further information.

Good

Are services caring?

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treated people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment. They were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information that they are given.)

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Braille signage was in place throughout the practice.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice proactively identified carers and supported them.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.

Please refer to the Evidence Tables for further information.

Good

Are services responsive to people's needs?

We rated the practice, and all of the population groups, as good for providing responsive services.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population, and tailored services in response to those needs.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services.
- The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.

Working age people (including those recently retired and students):

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.

People experiencing poor mental health (including people with dementia):

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

Timely access to care and treatment

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- The practice operated a walk in system for appointment. Patients were positive about this service even if they had to wait to be seen.
- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment system was easy to use.

Listening and learning from concerns and complaints

Good

Are services responsive to people's needs?

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints. It acted as a result to improve the quality of care.

Please refer to the Evidence Tables for further information.

Good

Are services well-led?

We rated the practice and all of the population groups as good for providing a well-led service.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- There was the need to look at succession planning within the practice. This had been identified by the practice and detailed within their business plan.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.
- The practice had a business plan in place. This was needed to reviewed and updated to demonstrate progress made.

Culture

The practice had a culture of high-quality sustainable care.

- There were mixed views from staff when asked if they felt respected, supported and valued. The practice management team were aware of this and were reviewing ways of supporting staff which included arranging meetings and a full staff team meetings.
- The practice focused on the needs of patients.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. However not all staff had received an appraisal in the last 12 months due to a change in practice management. These were being planned.
- Clinical staff were considered valued members of the practice team. However there was limited protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety of all staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Practice leaders had established proper policies, procedures and activities. However there was the need to ensure that these had been ratified by the most appropriate person to ensure safety and assurance that they were operating as intended.
- There was the need for the practice to assure themselves that the clinical staff reviewing patients with long term conditions had received appropriate support, training professional development or supervision.

Managing risks, issues and performance

There were clear and effective clarity around processes for managing risks, issues and performance.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Practice leaders had oversight of national and local safety alerts, incidents, and complaints.

Good

Are services well-led?

- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care and this was being developed further.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- There was an active patient participation group.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- The practice was working with other local GP practices to look at ways of working together for the benefit of their practices' population.

Please refer to the Evidence Tables for further information.