

Heath Lane Medical Centre

Quality Report

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

Ratings

Overall rating for this service

Good



Are services safe?

Good



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

Contents

Summary of this inspection

| | Page |
|---|------|
| Overall summary | 2 |
| The five questions we ask and what we found | 4 |
| The six population groups and what we found | 6 |
| What people who use the service say | 9 |
| Areas for improvement | 10 |

Detailed findings from this inspection

| | |
|---|----|
| Our inspection team | 11 |
| Background to Heath Lane Medical Centre | 11 |
| Why we carried out this inspection | 11 |
| How we carried out this inspection | 11 |
| Detailed findings | 13 |

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Heath lane Medical Centre on 13th April 2016.

Overall the practice is rated as good.

Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Staff were aware of procedures for safeguarding patients from the risk of abuse.
- There were systems in place to reduce risks to patient safety, for example, infection control procedures and the management of staffing levels. Improvements should be made to the management of blood test results and to the records of staff recruitment and significant events.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.

- Staff felt well supported. They had access to training and development opportunities and had received training appropriate to their roles.
- Patients generally said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. We saw staff treated patients with kindness and respect.
- Services were planned and delivered to take into account the needs of different patient groups.
 - Access to the service was monitored to ensure it met the needs of patients.
- Information about how to complain was available. There was a system in place to manage complaints.
- There were systems in place to monitor and improve quality and identify risk.

The areas where the provider should make improvements are:

Summary of findings

- All blood test results should be reviewed by a clinician with access to the medical record and the training to understand the significance of the result.
- Document reviews of significant events to demonstrate that actions identified have been implemented.
- Ensure that there is a record of the required recruitment information to confirm the suitability of staff employed.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as good for providing safe services. Safety events were reported, investigated and action taken to reduce a re-occurrence. Reviews of significant event investigations to demonstrate that all action identified had been taken should be documented. There were appropriate systems in place to ensure that the premises were safe. There were systems to protect patients from the risks associated with staffing levels, medicines management and infection control. Staff were aware of procedures for safeguarding patients from risk of abuse. We found that evidence of Disclosure and Barring Service (DBS) checks was not in place for all staff where this was required. These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. Following our visit the practice confirmed these checks had been applied for. We found that following a risk assessment the practice had introduced a system to manage the large volumes of blood test results received that included GPs not reviewing all normal blood test results. As some normal blood results may require a particular action by a clinician we were concerned that this system may result in these results being overlooked. All results should be reviewed by a clinician with access to the medical record and the training to understand the significance of the result.

Good



Are services effective?

The practice is rated good for providing effective services. Patients' needs were assessed and care was planned and delivered in line with current legislation. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Staff worked with other health care teams and there were systems in place to ensure appropriate information was shared. Staff had access to training and development opportunities and had received training appropriate to their roles.

Good



Are services caring?

The practice is rated as good for caring. Data from the National GP Patient Survey showed patients rated the practice about average when compared to other practices. Patients generally said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. One patient indicated they lacked confidence in a clinician at the practice and

Good



Summary of findings

another said they sometimes felt rushed during their consultation. Information for patients about the services available was easy to understand and accessible. We saw staff treated patients with kindness and respect, and maintained patient confidentiality.

Are services responsive to people's needs?

The practice is rated good for providing responsive services. Services were planned and delivered to take into account the needs of different patient groups. Access to the service was monitored to ensure it met the needs of patients. The practice had a complaints policy which provided staff with clear guidance about how to handle a complaint.

Good



Are services well-led?

The practice is rated good for providing well-led services. The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance and staff meetings. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active. There was a strong focus on continuous learning and improvement at all levels.

Good



Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as good for the care of older people. The practice was knowledgeable about the number and health needs of older patients using the service. They kept up to date registers of patients' health conditions and used this information to plan reviews of health care and to offer services such as vaccinations for flu and shingles. The practice had identified patients with high accident and emergency attendance and a care plan had been developed to support them. This included having a named clinician to promote continuity of care. These patients also had access to a telephone number to enable quicker access to clinical staff. The practice worked with other agencies and health providers to provide support and access specialist help when needed. Multi-disciplinary meetings were held to discuss and plan for the care of frail and elderly patients. The practice was working with neighbourhood practices and the CCG to provide services to meet the needs of older people. They had implemented a pilot project whereby a practice nurse visited frail older housebound patients to provide reviews of care and assessments following discharge from hospital after an unplanned admission.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions. The practice held information about the prevalence of specific long term conditions within its patient population such as diabetes, chronic obstructive pulmonary disease (COPD), cardiovascular disease and hypertension. This information was reflected in the services provided, for example, reviews of conditions and treatment, screening programmes and vaccination programmes. The practice had a system in place to make sure no patient missed their regular reviews for long term conditions. The clinical staff took the lead for different long term conditions and kept up to date in their specialist areas. The practice had multi-disciplinary meetings to discuss the needs of palliative care patients and patients with complex needs. The practice worked with other agencies and health providers to provide support and access specialist help when needed. The practice referred patients who were over 18 and with long term health conditions to a well-being co-ordinator for support with social issues that were having a detrimental impact upon their lives. Mail shots were sent to patients advising them about education and self-help services that were available to support them to manage their long term conditions. A patient hub was in the process of being set-up next to the waiting area. This would contain

Good



Summary of findings

equipment for the self-monitoring of health conditions, useful information for patients about community health and social care services and would be a base for community services to provide face to face information to patients visiting the practice.

Families, children and young people

The practice is rated as good for the care of families, children and young people. Child health surveillance and immunisation clinics were provided. The staff we spoke with had appropriate knowledge about child protection and all staff had safeguarding training relevant to their role. The safeguarding lead staff liaised with school health, midwives and health visiting colleagues to discuss any concerns about children and how they could be best supported. Electronic software that could be downloaded to mobile devices had been developed to encourage younger patients to review and access the services offered by the practice. Two sixth form students had recently become members of the Patient Participation Group (PPG) which would enable the views of younger patients to be considered.

Good



Working age people (including those recently retired and students)

The practice is rated as good for the care of working-age people (including those recently retired and students). The practice offered pre-bookable appointments, book on the day appointments and telephone consultations. Patients could book appointments on-line or via the telephone and repeat prescriptions could be ordered on-line which provided flexibility to working patients and those in full time education. Electronic software that could be downloaded to mobile devices had been introduced to provide further access. The practice was open from 08:00 to 18:30 Monday to Friday allowing early morning and late evening appointments to be offered to this group of patients. An extended hour's service for routine appointments was commissioned by West Cheshire CCG. The practice website provided information around self-care and local services available for patients. The practice offered health checks to patients aged 40 – 74 which included cholesterol and blood glucose checks to help identify potential health risks.

Good



People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable. Patients' electronic records contained alerts for staff regarding patients requiring additional assistance. For example, if a patient had a learning disability to enable appropriate support to be provided. There was a recall system to ensure patients with a learning disability received an annual health check. The staff we spoke with had appropriate

Good



Summary of findings

knowledge about safeguarding vulnerable adults and all staff had safeguarding training relevant to their role. Services for carers were publicised and a record was kept of carers to ensure they had access to appropriate services. A member of staff was the carer's link. A representative from the Carers Trust visited the practice and provided information for patients about the services provided. The practice referred patients to local health and social care services for support, such as drug and alcohol services and to the wellbeing coordinator.

People experiencing poor mental health (including people with dementia)

The practice is rated good for the care of people experiencing poor mental health (including people with dementia). GPs worked with specialist services to review care and to ensure patients received the support they needed. The practice had a policy in place for following up any patient who did not attend their mental health appointments. The practice maintained a register of patients who experienced poor mental health. The register supported clinical staff to offer patients experiencing poor mental health, including dementia, an annual health check and a medication review. The practice referred patients to appropriate services such as psychiatry and counselling services. Counsellors were based at the practice which enabled patients to be seen in their own surgery and facilitated good communication and liaison between the community and practice team. The practice had information in the waiting areas about services available for patients with poor mental health. For example, services for patients who may experience depression. Clinical and non-clinical staff had undertaken training in dementia to ensure all were able to appropriately support patients.

Good



Summary of findings

What people who use the service say

Data from the National GP Patient Survey January 2016 (data collected from January-March 2015 and July-September 2015) showed that patients' responses about whether they were treated with respect, compassion and involved in decisions about their care and treatment were similar to local and national averages. Two hundred and fifty two survey forms were distributed, 106 (42%) were returned which represents 1.5% of the total practice population.

- 85% said the GP was good at listening to them compared to the CCG average of 92% and national average of 89%.
- 95% said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and national average of 95%.
- 81% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 89% and national average of 85%.
- 94% said the nurse was good at listening to them compared to the CCG average of 92% and national average of 91%.
- 97% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and national average of 90%.
- 98% said they had confidence and trust in the last nurse they saw compared to the CCG average of 98% and national average of 97%.
- 78% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 85% and national average of 81%.
- 92% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 86% and national average of 85%.

The National GP Patient Survey results showed that patient's satisfaction with access to care and treatment was generally in line with or above local and national averages. For example:

- 87% of patients said they could get through easily to the surgery by phone compared to the CCG average of 71% and national average of 73%.
- 90% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 87% and national average of 85%.
- 78% of patients were satisfied with the practice's opening hours compared to the CCG average of 75% and national average of 75%.
- 71% patients described their experience of making an appointment as good compared to the CCG average of 74% and national average of 73%.

Patient responses concerning waiting times was below local and national averages:

- 51% of patients said they usually waited 15 minutes or less after their appointment time to be seen compared to the CCG average of 67% and national average of 65%.

The practice was aware of the patient feedback from the National GP Patient Survey and the partners, practice manager and patient participation Group (PPG) had met to look at the performance of the practice and how any issues raised could be addressed.

We received 14 comment cards and spoke to seven patients. The majority of comments showed that patients felt a very good service was provided and that clinical and reception staff were dedicated, professional and listened to their concerns. Patients considered their privacy and dignity was promoted and they were treated with care and compassion. One patient indicated they sometimes felt rushed during an appointment and one indicated a lack of trust in a clinician at the practice. Patients said that they were able to get an urgent appointment when one was needed, they were able to get through to the practice by phone easily and were happy with the opening hours. Three patients and 1 comment card indicated that there could be a wait of up to two weeks for routine appointments.

Summary of findings

Areas for improvement

Action the service **SHOULD** take to improve

The areas where the provider should make improvements are:

- All blood test results should be reviewed by a clinician with access to the medical record and the training to understand the significance of the result.
- Document reviews of significant events to demonstrate that actions identified have been implemented.
- Ensure that there is a record of the required recruitment information to confirm the suitability of staff employed.

Heath Lane Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector and included a GP specialist advisor and a practice manager specialist advisor.

Background to Heath Lane Medical Centre

Heath Lane Medical Centre is responsible for providing primary care services to approximately 7,300 patients. The practice is based in an area with lower than average levels of economic deprivation when compared to other practices nationally. The number of patients with a long standing health condition is about average when compared to other practices nationally.

The staff team includes two partner GPs, three salaried GPs, two advanced nurse practitioners, two practice nurses, two health care assistants, a phlebotomist, practice manager and administration and reception staff.

The practice is open 08:00 to 18.30 Monday to Friday. An extended hour's service for routine appointments and an out of hour's service are commissioned by West Cheshire CCG and provided by Cheshire and Wirral Partnership NHS Foundation Trust.

The practice has a General Medical Service (GMS) contract. The practice offers a range of enhanced services such as flu and shingles vaccinations, minor surgery and timely diagnosis of dementia.

Why we carried out this inspection

We carried out a comprehensive inspection of the services under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We carried out a planned inspection to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to provide a rating for the services 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 whose circumstances may make them vulnerable

Detailed findings

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

Before our inspection we 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 before the inspection. We carried out an announced inspection on 13th April 2016. We reviewed all areas of the practice including the administrative areas. We sought views from patients face-to-face and reviewed CQC

comment cards completed by patients. We spoke to clinical and non-clinical staff. We observed how staff handled patient information and spoke to patients. We explored how the GPs made clinical decisions. We reviewed a variety of documents used by the practice to run the service.

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

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting, recording and investigating significant events. The practice had a significant event monitoring policy and a significant event recording form which was accessible to all staff via computer. All staff spoken with knew how to identify and report a significant event. The practice carried out an analysis of significant events and this also formed part of the GPs' individual revalidation process. We looked at a sample of significant events and found that action had been taken to improve safety in the practice where necessary.

The practice held staff meetings at which significant events were discussed in order to cascade any learning points. We identified that one clinician was unable to attend these meetings and that the minutes of the meetings did not sufficiently detail significant events and the learning points. Although a log of all significant events was in place for reference, more detailed minutes would ensure the accessibility of this information. Following our visit we were provided with a revised protocol for the recording of significant events to address this. A log of significant events was maintained which enabled patterns and trends to be identified. A review of the action taken following significant events was not being documented to demonstrate that actions identified had been implemented.

Overview of safety systems and processes

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and procedures were accessible to all staff. The procedures clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. A printed flowchart with telephone numbers was on display outlining the process of making children's safeguarding referrals however the process for making adult safeguarding referrals was not. The flowchart with contact telephone numbers was found during our visit and the practice manager told us it would be clearly displayed for staff to refer to. There was a lead member of staff for safeguarding. The practice had systems in place to monitor and respond to requests for attendance/reports at safeguarding meetings. Staff demonstrated they understood their responsibilities and all had received safeguarding children training relevant to their role. The safeguarding lead GP liaised with the school health team, midwives and health visiting service to discuss any concerns about children and their families and how they could be best supported. Alerts were placed on patient records to identify if there were any safety concerns.
- A notice was displayed in the waiting room and in all treatment rooms, advising patients that a chaperone was available if required. All staff who acted as chaperones had received training for this role. A disclosure and Barring Service (DBS) check had not been undertaken for all clinical staff who acted as chaperones. A DBS check had not been undertaken for a nurse and health care assistant employed at the practice for several years. These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. Following our visit the practice manager confirmed these checks had been applied for. Non-clinical staff who acted as chaperones had been DBS checked. Further non-clinical staff had been trained to act as chaperones and we were told would undertake these responsibilities when a DBS check had been undertaken. The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training.
- An infection control audit was undertaken by the Infection Prevention and Control Team in July 2015 and the practice scored 85%. Areas were identified for improvement, an action plan had been put in place and the lead for infection control told us that action had been taken to address the issues identified. A further audit was carried out by the infection control lead in January 2016.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe. Regular medication audits were carried out with the support of the local CCG pharmacy teams to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and

Are services safe?

there were systems in place to monitor their use. Vaccines were securely stored, were in date and we saw the fridges were checked daily to ensure the temperature was within the required range for the safe storage of vaccines.

- We reviewed four personnel files of staff employed within the last two years and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS. A system was in place to carry out periodic checks of the Performers List, General Medical Council (GMC) and Nursing and Midwifery Council (NMC) to ensure the continued suitability of staff. A DBS check had not been undertaken for a nurse and health care assistant employed at the practice for several years. Evidence that all GPs had a DBS check was not held at the practice, although the GPs spoken with confirmed these had been carried out as part of their inclusion on the Performers List. Following our visit the practice manager confirmed that these checks had been applied for.

Monitoring risks to patients

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster displayed for staff to refer to. The practice had an up to date fire risk assessment and regular checks were made of fire safety equipment. A fire drill took place every 12 months. We noted that a list of all staff who participated was not recorded which would assist in ensuring all staff were aware of the fire safety procedure. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to

ensure it was working properly. The practice also had a variety of other risk assessments in place to monitor the safety of the premises such as control of substances hazardous to health and legionella.

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty.
- A system had been introduced following an assessment of risk that some normal blood test results would be added to patient records without GP oversight. We were told that this system was introduced in response to large numbers of blood test results being received and enabled the clinicians to focus on abnormal results. Safety measures had been introduced to mitigate the risks in this process. However, as some normal blood results may require a particular action by the clinician we were concerned that this system may result in these results being overlooked. All results should be reviewed by a clinician with access to the medical record and the training to understand the significance of the result.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. All staff had up to date basic life support training. The practice had a defibrillator and oxygen available on the premises which was checked to ensure it was safe for use. There were emergency medicines available which were all in date, regularly checked and held securely.

The practice had a business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met peoples' needs.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. QOF is a system intended to improve the quality of general practice and reward good practice. Patients who had long term conditions were continuously followed up throughout the year to ensure they attended health reviews. Current results were 94% of the total number of points available with 13.8% exception reporting. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014-2015 showed that outcomes were comparable to other practices nationally:

- The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months was 76% compared to the national average of 75%.
- The percentage of women aged 25-64 whose notes record that a cervical screening test has been performed in the preceding 5 years (01/04/2014 to 31/03/2015) was 81% compared to the national average of 82%.
- The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2014 to 31/03/2015) was 75% compared to the national average of 80%.

- The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2014 to 31/03/2015) was 87% compared to the national average of 84%.

We saw that audits of clinical practice were undertaken. Examples of audits included audits of medication, cytology and hormone replacement therapy. The audits indicated that practices had been evaluated and changes made as a consequence. The practice had also recently funded a pharmacist to carry out an evaluation of older patients taking four or more medications. This had resulted in improvements to prescribing for patients.

The GPs and nurses had key roles in monitoring and improving outcomes for patients. These roles included the management of long term conditions, palliative care, safeguarding and promoting the health care needs of patients with a learning disability and those with poor mental health. The clinical staff we spoke with told us they kept their training up to date in their specialist areas. This meant that they were able to focus on specific conditions and provide patients with regular support based on up to date information.

Clinical staff worked with the Clinical Commissioning Group (CCG) to promote patient care. For example, one GP specialised in mental health and chaired the CCG mental health local enhanced services group. This included developing services for and referral pathways for patients with poor mental health.

Staff worked with other health and social care services to meet patients' needs. The practice had three monthly multi-disciplinary meetings to discuss the needs of patients with complex needs and the needs of patients receiving palliative care needs. Clinical staff spoken with told us that frequent liaison occurred outside these meetings with health and social care professionals in accordance with the needs of patients.

Effective staffing

Staff told us that they had the skills, knowledge and experience to deliver effective care and treatment. Evidence reviewed showed that:

Are services effective?

(for example, treatment is effective)

- The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as fire safety, health and safety and confidentiality.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff told us they felt well supported and had access to appropriate training to meet their learning needs and to cover the scope of their work. This included appraisals, mentoring and facilitation and support for the revalidation of doctors. A system was in place to ensure all staff had an annual appraisal. We noted that the learning requirements for a newly employed clinical member of staff had not been documented.
- All staff received training that included: safeguarding children, fire procedures, basic life support, infection control, health and safety and information governance awareness. Role specific training was also provided to clinical and non-clinical staff dependent on their roles. Staff had access to and made use of e-learning training modules, in-house training and training provided by external agencies. There was a training plan in place to ensure staff kept up to date. We noted that a record was not kept of the mandatory training completed by GPs that would assist with identifying their training needs.

Coordinating patient care

The information needed to plan and deliver care and treatment was available to relevant staff through the practice's patient record system and their intranet system. This included assessments, care plans, medical records and test results. Information such as NHS patient information leaflets were also available. There were systems in place to ensure relevant information was shared with other services in a timely way, for example when people were referred to other services and the out of hours services.

Consent to care and treatment

We spoke with clinical staff about patients' consent to care and treatment and found this was sought in line with legislation and guidance. Clinical staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Consent forms for surgical procedures were used and scanned in to medical records. Written guidance was available about consent to care and treatment. Some clinical staff had not received formal training on the Mental Capacity Act 2005 and the practice manager was in the process of identifying training to address this.

Supporting patients to live healthier lives

The practice offered national screening programmes, vaccination programmes, children's immunisations and long term condition reviews. Health promotion information was available in the reception area and on the website. The practice had links with health promotion services and recommended these to patients, for example, smoking cessation, alcohol services, weight loss programmes and exercise services.

New patients registering with the practice completed a health questionnaire and were offered a health assessment with the nurse or health care assistant. A GP or nurse appointment was provided to new patients with complex health needs, those taking multiple medications or with long term conditions.

The practice monitored how it performed in relation to health promotion. It used the information from the QOF and other sources to identify where improvements were needed and to take action. QOF information for the period of April 2014 to March 2015 showed outcomes relating to health promotion and ill health prevention initiatives for the practice were comparable to other practices nationally. Childhood immunisation rates for vaccinations given for the period of April 2014 to March 2015 were generally comparable to the CCG averages (where this comparative data was available).

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and helpful to patients both attending at the reception desk and on the telephone. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations to promote privacy. Patients who were distressed or who wanted to talk to reception staff in private were offered a private room to discuss their needs.

We received 14 comment cards and spoke to seven patients. Patients indicated that their privacy and dignity were promoted and they were generally treated with care and compassion. One patient indicated they sometimes felt rushed during an appointment and one indicated a lack of trust in a clinician at the practice. A number of comments made showed that patients felt a very good service was provided and that clinical and reception staff were dedicated, professional and listened to their concerns.

Data from the National GP Patient Survey January 2016 (data collected from January-March 2015 and July-September 2015) showed that patients responses about whether they were treated with respect and in a compassionate manner by clinical and reception staff were about average when compared to local and national averages for example:

- 85% said the GP was good at listening to them compared to the CCG average of 92% and national average of 89%.
- 88% said the GP gave them enough time compared to the CCG average of 90% and national average of 87%.
- 95% said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and national average of 95%.
- 81% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 89% and national average of 85%.

- 94% said the nurse was good at listening to them compared to the CCG average of 92% and national average of 91%.
- 95% said the nurse gave them enough time compared to the CCG average of 93% and national average of 92%.
- 97% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and national average of 90%.
- 98% said they had confidence and trust in the last nurse they saw compared to the CCG average of 98% and national average of 97%.
- 81% patients said they found the receptionists at the practice helpful compared to the CCG average of 87% and national average of 87%.

The practice manager and partners reviewed the outcome of any surveys undertaken to ensure that standards were being maintained and action could be taken to address any shortfalls.

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection told us that they felt health issues were discussed with them, they felt listened to and involved in decision making about the care and treatment they received.

Data from the National GP Patient Survey January 2016 showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and results were generally in line with local and national averages. For example:

- 85% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 89% and national average of 86%.
- 78% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 85% and national average of 81%.
- 92% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 91% and national average of 90%.
- 92% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 86% and national average of 85%.

Are services caring?

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. Written information was available to direct carers to the various avenues of support available to them. Clinical staff referred patients on to counselling services for emotional support, for example, following bereavement.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local CCG to improve outcomes for patients in the area. For example, the practice offered a range of enhanced services such as flu and shingles vaccinations, minor surgery and timely diagnosis of dementia. The practice was working with neighbourhood practices and the CCG to provide services to meet the needs of older people. For example, they had implemented a pilot project whereby a practice nurse visited frail older housebound patients to provide reviews of care and assessments following discharge from hospital after an unplanned admission.

The practice had multi-disciplinary meetings to discuss the needs of young children, palliative care patients and patients with complex needs.

Services were planned and delivered to take into account the needs of different patient groups. For example;

- The practice was open from 08:00 to 18:30 Monday to Friday allowing early morning and evening appointments to be offered to working patients.
- Urgent access appointments were available for children and those with serious medical conditions.
- There were longer appointments available for patients with a learning disability.
- Home visits were made to patients who were housebound or too ill to attend the practice.
- Translation services and an audio hearing loop were available if needed.
- Reception staff had been trained to assist patients to use the blood pressure monitoring machine. A patient hub was in the process of being set-up next to the waiting area. This would contain equipment for the self-monitoring of health conditions, useful information for patients about community health and social care services and would be a base for community services to provide face to face information to patients visiting the practice.
- The staff had received training in dementia awareness to assist them in identifying patients who may need extra support.

- The practice referred patients who were over 18 and with long term health conditions to a well-being co-ordinator for support with social issues that were having a detrimental impact upon their lives. It was reported that this service was beneficial in reducing access to the out of hours and accident and emergency services.
- The practice was piloting the Physio First service which provided physiotherapy appointments for patients without the need to see a GP for a referral.
- Reception staff were able to sign post patients to local resources such as Pharmacy First (local pharmacies providing advice and possibly reducing the need to see a GP). Further training was planned to enable them to be "community navigators" assisting patients to identify useful health and social care services.
- Clinical staff referred patients on to counselling services for emotional support, for example, following bereavement.
- The practice had a website that provided up to date information for patients on the services available and any changes to the practice. Electronic software that could be downloaded to a mobile device had been recently developed to improve patient access. A quarterly patient newsletter was also available.

Access to the service

Appointments could be booked in advance and booked on the day. Telephone consultations were also offered. Patients could book appointments in person, on-line or via the telephone. Repeat prescriptions could be ordered on-line or by attending the practice.

Results from the National GP Patient Survey from January 2016 (data collected from January-March 2015 and July-September 2015) showed that patient's satisfaction with access to care and treatment was generally in line with or above local and national averages. For example:

- 87% of patients said they could get through easily to the surgery by phone compared to the CCG average of 71% and national average of 73%.
- 90% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 87% and national average of 85%.

Are services responsive to people's needs?

(for example, to feedback?)

- 78% of patients were satisfied with the practice's opening hours compared to the CCG average of 75% and national average of 75%.
- 71% patients described their experience of making an appointment as good compared to the CCG average of 74% and national average of 73%.
- 81% of patients found the receptionists at this surgery helpful compared to the CCG average of 87% and national average of 87%.

Patient responses concerning waiting times was below local and national averages:

- 51% of patients said they usually waited 15 minutes or less after their appointment time to be seen compared to the CCG average of 67% and national average of 65%.

The practice was aware of the patient feedback from the National GP Patient Survey and the partners, practice manager and patient participation Group (PPG) had met to look at the performance of the practice and how any issues raised could be addressed. Records and a discussion with staff and the PPG showed the actions taken as a result. For example, the reception area and team had been re-organised and reception staff had been provided with training to update their customer service strategies. The practice had also employed a further advanced nurse practitioner to improve urgent access.

We received 14 comment cards and spoke to seven patients. Patients said that they were able to get an urgent

appointment when one was needed, they were able to get through to the practice by phone easily and were happy with the opening hours. Three patients and 1 comment card indicated that there could be a wait of up to two weeks for routine appointments.

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. Information about how to make a complaint was available for patients to refer to in the waiting room, in the patient information booklet and on the practice website. This included the timescale for when the complaint would be acknowledged and responded to and details of who the patient should contact if they were unhappy with the outcome of their complaint.

The practice kept a record of written complaints. We reviewed a sample received within the last 12 months. Records showed they had been investigated, patients informed of the outcome and action had been taken to improve practice where appropriate. A log of complaints was maintained which allowed for patterns and trends to be easily identified. The records showed openness and transparency with dealing with the complaints.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice had a statement of purpose which outlined its aims and objectives. These included providing a high standard of medical care, offering a range of clinical appointments to meet the needs of patients and referring patients to other services when necessary. The practice also had a mission statement which was publicised on patient literature and in the waiting area:-

“Our aim is to help you live a healthy life. We will do this with respect, a smile and a positive attitude.”

The staff we spoke with knew and understood the aims and objectives of the practice and their responsibilities in relation to these.

Governance arrangements

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

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities
- Practice specific policies were implemented and were available to all staff
- A comprehensive understanding of the performance of the practice was maintained
- Audits were used to monitor quality and to make improvements
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. We identified that improvements were needed to how learning from significant event investigations were shared with staff unable to attend team meetings. Following our visit we were provided with a revised protocol for the recording of significant events to address this. A review of the action taken following significant events was not being documented to demonstrate that actions identified had been implemented.

Leadership and culture

The partners were visible in the practice and staff told us they were approachable and always took the time to listen to all members of staff.

The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents.

There were clear lines of accountability at the practice. We spoke with clinical and non-clinical members of staff and they were all clear about their own roles and responsibilities. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings or as they occurred with the practice manager, registered manager or a GP partner. Staff said they felt respected, valued and supported. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Meetings took place to share information, look at what was working well and where any improvements needed to be made. The practice closed one afternoon per month which allowed for learning events and practice meetings. Clinical staff met to discuss new protocols, to review complex patient needs, keep up to date with best practice guidelines and review significant events. Clinical staff attended away days twice a year to review service provision. The reception and administrative staff met monthly to discuss their roles and responsibilities and share information. There was also a brief informal meeting twice a week which all staff could attend which allowed any issues concerning the operation of the service to be discussed. Partners and the practice manager met to look at the overall operation of the service and future development.

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

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

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met

Are services well-led?

Good 

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

regularly and submitted proposals for improvements to the practice management team. For example, the PPG had recommended that changes be made to the reception layout, parking, signage and the website. The practice had worked with the PPG to make the changes identified. The PPG members spoken with felt they were listened to and kept informed and consulted about changes and developments at the practice.

- The practice sought patient feedback by utilising the 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 had gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example, the practice was working with neighbourhood practices and the CCG to provide services to meet the needs of older people. For example, they had implemented a pilot project whereby a practice nurse visited frail older housebound patients to provide reviews of care and assessments following discharge from hospital after an unplanned admission. The practice had developed electronic software to promote information sharing with the patient population and was working on developing a patient hub to promote patient health and well-being.