Ribbleton Medical Centre

Quality Report

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Date of inspection visit: 08 April 2015
Date of publication: 08/05/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We had previously undertaken an inspection at this practice in July 2014 as part of our pilot inspections testing our new methodology. We found one area for improvement and we issued a compliance action in relation to this at that time.

We carried out an inspection of Ribbleton Medical Centre on 8 April 2015 as part of our new comprehensive inspection programme and to determine the actions taken since the last inspection.

Overall the practice is rated as Good.

Our key findings were as follows:

- Improvements had been implemented for the safe and effective recruitment and employment of staff.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles.
- Patients we spoke with said the GPs and nurses were very good and caring. Out of 106 responses to the Friends and Family test between December 2014 and March 2015, 94 respondents said they were either extremely likely or likely to recommend the practice to friends and family.
- Information about services and how to complain was available and the practice responded appropriately to these.
- Patients said they found it easy to make an appointment with a named GP. The practice was committed to providing continuity of care. Urgent appointments were available each day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

The provider should:

- Ensure that all clinical staff receive training in the principles of the Mental Capacity Act 2005.
- Ensure staff who perform chaperoning duties are trained to undertake this role.
- Ensure that staff training is effectively recorded and monitored and copies of training certificates kept.
- Ensure an accessible record of clinical staff professional registration numbers are kept, so that these can be checked more efficiently.
- Ensure regular checks on infection control are carried out and ensure disposable curtains are changed appropriately.
- Ensure a clear documentary record is maintained of the staff recruitment processes including when references are requested and the actions taken when these are not provided.
- Ensure a Legionella risk assessment is carried out for the premises.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Staff were knowledgeable about what constituted a safeguarding concern and how to respond to this type of concern. Recruitment checks highlighted as not being followed in a previous inspection were conducted for all staff. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Written consent was obtained for minor surgical procedures. Staff had received training appropriate to their roles. Staff had received annual appraisals.The practice regularly met with other health professionals and commissioners in the local area in order to review areas for improvement and share good practice.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients reported good access to the practice and that there was continuity of care, with urgent appointments available the same day. The practice was committed to providing continuity of care. The practice sought to gain patient feedback and had an active virtual

Summary of findings

Patient Reference Group (PRG) who provided ideas and suggestions to help improve the service. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders was evidenced.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision which had quality patient care as its top priority. High standards were promoted and owned by all practice staff with evidence of team working across all roles. Governance and performance management arrangements were proactively reviewed. We found there was a high level of staff engagement with an open door policy for access to all senior staff. Staff told us they were very satisfied with their roles. The practice sought feedback from patients and acted upon it where possible.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. 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 reflected the national average. The practice safeguarded older vulnerable patients from the risk of harm or abuse. There were policies in place, staff had been trained and were knowledgeable regarding vulnerable older people and how to safeguard them. The practice was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. One GP had protected time specifically to focus on the health needs of people living in care homes within the local community.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The practice had a higher than average number of patients with long standing health conditions compared to the local Clinical Commissioning Group (CCG) area. Patients with long term conditions were supported by a healthcare team that cared for them using good practice guidelines and were attentive to their changing needs. Patients had health reviews at regular intervals depending on their health needs and condition. Patients who did not respond to their annual invite to review their healthcare condition were offered a telephone consultation with a GP. The practice maintained and monitored registers of patients with long term conditions including cardiovascular disease and diabetes. These registers enabled the practice to monitor and review patients with long term conditions effectively. The Quality and Outcomes Framework (QOF) information indicated that patients with long term health conditions received care and treatment in line with national averages. One of the homes visited regularly by the GP with protected time catered for patients with brain damage and therefore tended to be a younger age group.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Staff demonstrated a good understanding and were proactive in safeguarding and protecting children from the risk of harm or abuse. The practice had a clear means of identifying in records those children (together with their parents and siblings) who were subject to a child protection plan. The practice had

Summary of findings

appropriate child protection policies in place to support staff and staff were trained to a level relevant to their role. The practice offered a full range of childhood vaccinations and had systems in place to follow up children who did not attend for these.

Working age people (including those recently retired and students)

Good

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

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice was aware of, and identified their vulnerable patients. This was highlighted within patient records. The practice discussed any concerning patients as a team, safeguarding policies and protocols were in place and staff were trained in safeguarding vulnerable adults and children. The safeguarding lead was a GP who had received appropriate training. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. They carried out annual health checks for people with a learning disability and offered longer appointments and offered home visits if required.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice maintained a register of patients who experienced poor mental health. The register supported clinical staff to offer patients an annual appointment for a health check and a medication review. The practice monitored patients with poor mental health according to clinical quality indicators and in line with good practice guidelines. A psychologist worked at the practice one day per week and offered referred patients cognitive behavioural therapy (CBT) which is a talking therapy commonly used to treat anxiety and depression. The practice worked with multi-disciplinary teams and other mental health services in the case management of patients experiencing poor mental health, including those with dementia.

Summary of findings

What people who use the service say

During our visit, we spoke with five patients and one carer. They told us that the GPs and nurses working at the practice were very good. They said they usually could get to see a preferred GP and that on occasion when they had to wait they did not mind. They said the practice was always clean and tidy.

A member of the practice's patient representation group (PRG) told us that the practice consulted with them, listened to them and acted on their suggestions.

Although prominently displayed and readily available to patients, we did not receive any feedback through our CQC comment cards. We therefore reviewed some of the recent feedback the practice had received through their Friends and Family test. The practice had received 106 responses between December 2014 and March 2015. In total 94 respondents said they were either extremely likely or likely to recommend the practice to friends and family.

The results of the National GP Patient Survey published in January 2015 demonstrated the practice performed well with 83% of respondents stating they were satisfied with the surgery's opening hours; 92% of respondents described their overall experience of this surgery as good and 79% of respondents described their experience of making an appointment as good. These percentages were all above the average results for the local Clinical Commissioning Group (CCG).

Areas for improvement

Action the service SHOULD take to improve

Ensure that all clinical staff receive training in the principles of the Mental Capacity Act 2005

Ensure staff who perform chaperoning duties are trained to undertake this role.

Ensure that staff training is effectively recorded and monitored and copies of training certificates kept.

Ensure an accessible record of clinical staff professional registration numbers are kept, so that these can be checked more efficiently.

Ensure regular checks on infection control are carried out and ensure disposable curtains are changed appropriately.

Ensure a clear documentary record is maintained of the staff recruitment processes including when references were requested and the actions taken when these are not provided.

Ensure a Legionella risk assessment is carried out for the premises.

Ribbleton Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP and a specialist advisor (practice manager).

Background to Ribbleton Medical Centre

Ribbleton Medical Centre is in Preston and is part of the NHS Greater Preston Clinical Commissioning Group (CCG.) Services are provided under a general medical service (GMS) contract with NHS England. There are 8,036 registered patients. The practice population includes a higher number (9.2%) of children under the age of 4, and a lower number (10.9%) of people over the age of 65, in comparison with the CCG average of 6% and 15.9% respectively.

There are high levels of deprivation in the practice area. Information published by Public Health England, rates the level of deprivation within the practice population group as one on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest.

The practice opens from 8am to 6pm Monday to Fridays. Patients requiring a GP outside of normal working hours are advised to contact an external out of hour's service provider Preston Primary Care Centre.

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

The practice offers a nurse triage service and urgent appointments are available each day with a GP once the patient has spoken with the triage nurse.

On line services include appointment booking, ordering repeat prescriptions and online access to medical records.

The premises are purpose built and offer access and facilities for disabled patients and visitors.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme and checked whether improvements had been achieved since our last inspection in July 2014. In addition, we checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and looked at the overall quality of the service to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

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

Is it safe?

Is it effective?

Is it caring?

Detailed findings

Is it responsive to people's needs?

Is it well-led?

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

Older people

People with long-term conditions

Families, children and young people

Working age people (including those recently retired and students)

People living in vulnerable circumstances

People experiencing poor mental health (including people with dementia)

Before visiting the practice we reviewed information we held and asked other organisations and key stakeholders to share what they knew about the practice. We also reviewed policies, procedures and other information the practice manager provided before the inspection day. We carried out an announced visit on 8 April 2015.

We spoke with a range of staff including two GPs, a trainee GP, a psychologist, a practice nurse, a health care assistant, reception staff, administration staff, and the practice manager. We sought views from patients and representatives of the patient reference group, looked at comment cards, and reviewed survey information.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. This included investigating reported incidents, checking national patient safety alerts and sharing comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. Reports and data from NHS England indicated that the practice had a good track record for maintaining patient safety.

We reviewed safety records and incident reports. The practice manager, clinicians and any other relevant staff investigated and reported on the incidents and events. Interviews with staff confirmed that incidents were appropriately reported and where improvements and actions were required these were responded to appropriately. Staff told us that they felt confident to report adverse events and incidents.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of significant events that had occurred during the previous 12 months. Significant events were a standing item on the practice's weekly clinical meeting agenda. There was evidence that the practice had learned from these and that the findings were shared with relevant staff.

We saw evidence to confirm that, as individuals and a team, staff were actively reflecting on their practice and critically looked at what they did to see if any improvements could be made. Significant events, incidents and complaints were investigated and reflected on by the GPs and practice manager and learning disseminated to the whole team where relevant. GPs told us they completed incident reports and carried out significant event analysis routinely and as part of their ongoing professional development.

We looked at significant events from April 2014 to January 2015. These had been analysed, reported and discussed with relevant staff. Following a small audit of safeguarding documentation action was taken to improve the quality of interagency communications, improve the quality of recorded information and to ensure Health Visitor attendance at multidisciplinary meetings. Another incident reviewed as a significant event resulted in procedures being reviewed and amended to make sure accurate records were maintained following a minor family planning procedure.

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

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records, which showed that staff had received relevant role specific training on safeguarding. We asked members of the medical, nursing and administrative staff about their understanding of abuse and their responsibilities when they suspected a patient was at risk of abuse. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. All staff had access to the practice policy and procedure for safeguarding children and adults. They knew how to share information, properly record safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours.

The practice had one GP partner as the lead for safeguarding and another GP partner as the deputy lead. They had been trained to level 3 as required to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

Good

Are services safe?

There was a system to highlight or flag vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

There was a chaperone policy, which was visible in both waiting rooms on the ground and first floor. (A chaperone is a person who acts as support and a safeguard and witness for a patient and health care professional during a medical examination or procedure). Nursing staff and the health care assistant usually carried out chaperone duties. We were told on rare occasions reception staff were used to provide chaperoning duties. However, it was unclear what training reception staff had to undertake this role.

Medicines management

We checked medicines stored in the treatment rooms and fridges. We found that they were stored appropriately. All medicines that we checked were found to be in date.

There was a current policy and procedures in place for medicines management including cold storage of vaccinations and other drugs requiring this. We saw the checklist that was completed daily to ensure the fridges remained at a safe temperature and staff told us of an incident where one of the pharmaceutical fridges failed over a weekend. The result was a failure of the cold chain. The cold chain refers to the process used to maintain optimal conditions during the transport, storage, and handling of vaccines so that they remain viable and safe to use. Following the breakdown of the fridge the manufacturers of each affected vaccine was contacted and their advice followed regarding the disposal of these vaccines. A policy and procedure for the maintenance of the cold chain was available to staff.

GPs reviewed their prescribing practices as and when medication alerts or new guidance was received. Clinical audits had also been undertaken on the use of some medicines in response to alerts and we saw examples of these. Examples included the use of Metoclopramide. This is used to relieve nausea and vomiting. The outcome of the audit resulted in a change of prescribing practice and identified areas for further improvement when prescribing this medication.

Patient medicines were reviewed on a regular basis in line with current guidance and legislation depending on the nature and stability of their condition. We saw from data produced at Clinical Commission Group (CCG) level that audits were carried out by the CCG medicines management pharmacist to optimise the prescribing of certain medicines such as antibiotics or medicines for patients with long term conditions. Data indicated that the practice had a higher than average antibiotic prescribing level. We were told that this was due to specific medical reasons, a higher than average number of children on the practice register and the level of deprivation in the local community.

All prescriptions were reviewed and signed by a GP before they were given to the patient. The practice had recently installed electronic prescribing which meant that patient prescriptions could be sent automatically to the patient's preferred pharmacist or chemist. This reduced the need to use paper prescriptions. Blank prescription forms were stored securely.

Medicines for use in medical emergencies were securely stored in the treatment rooms. One practice nurse had lead responsibility for checking stocks of medicines and their expiry dates. We saw these regular checks were recorded. All staff knew where the emergency medicines were stored. There was oxygen kept by the practice for use in case of an emergency. This was checked regularly. The practice also had emergency medicine kits for anaphylaxis (a severe, potentially life-threatening allergic reaction that can develop rapidly).

GPs did not routinely carry medicines in their doctors' bags. Medicines were taken from the emergency stock for home visits if the GP believed they might need this. There was sufficient stocks of medicines for the GPs to do this without compromising the remaining medicines available at the practice. We were told this protocol enabled the nurse to monitor stocks and expiry dates more easily.

Cleanliness and infection control

We saw the premises were clean and tidy. There were cleaning schedules in place and cleaning records were kept. We saw audits to confirm that monthly monitoring checks to ensure the practice cleanliness were carried out. Patients we spoke with told us the practice was always clean and tidy. They told us that clinical staff washed their hands and used gloves and aprons appropriately.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy. Staff received training about infection control specific to their

role. We looked at an audit undertaken in 2014, which identified areas for improvement in the clinical rooms where minor surgical procedures were undertaken. At our visit we could see the improvements to the environment that had had been made to ensure the risk of transmitting infection was reduced. The lead for the infection control was not available at our visit but we were told that they checked the practice regularly to ensure procedures were followed. However, the records of these checks were not available. We observed that some of the disposable privacy curtains had passed the planned date for renewal.

Staff understood their role in respect of preventing and controlling infection. For example reception staff could describe the process for handling submitted specimens.

We inspected treatment and clinical rooms. We noted that all consultation and treatment rooms had adequate hand washing facilities. Instructions about hand hygiene were available throughout the practice with hand gels in clinical rooms. We found protective equipment such as gloves and aprons were available in the treatment/consulting rooms. Couches were washable in the treatment rooms and cleaned following each use.

We were told the practice only used instruments that were single use. Procedures for the safe storage and disposal of instrumentation, sharps and waste products were evident. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice had recently been assessed for asbestos; however, a policy for the management, testing and investigation of Legionella (a bacterium that can grow in contaminated water and can be potentially fatal) was not available. The practice manager confirmed they would take immediate action to address this.

Equipment

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

All equipment was tested and maintained regularly and we saw equipment maintenance logs, contracts and other records that confirmed this. Contracts were in place for annual checks of fire extinguishers and portable appliance testing (PAT). We saw that annual calibration and servicing of medical equipment was slightly out of date. We were told that the servicing of the medical equipment had been arranged; however, the appointment was cancelled and had been rearranged.

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

Staffing and recruitment

At the last inspection, a requirement was made for the practice to improve its recruitment procedures to ensure staff were safely and effectively recruited.

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. This included application forms with full work histories, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). One older recruitment file, for a non clinical staff member did not have any references. Discussion with the practice manager identified that they had requested references on a number of occasions but none were supplied. The practice manager stated that they contacted one of the referees and they had advised it was not their company policy to provide references. The practice manager confirmed that in future they would record all attempts to obtain pre-employment references and develop a protocol of how to proceed if these were not forthcoming.

There was an informal system in place to record and check professional registration of the GPs with the General Medical Council (GMC) and the practices nurse with the Nursing Midwifery Council (NMC). We saw evidence that demonstrated professional registration for clinical staff was up to date and valid. However, an easily accessible record of clinical staff professional registration numbers would enable monitoring checks to be carried out more efficiently.

Staff told us there was 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 and chaperoning.

The practice had developed clear lines of accountability for all aspects of care and treatment. Clinical staff had lead roles for which they were appropriately trained. The diversity and skill mix of the staff was good; each person knew exactly what their role was and undertook this to a high standard. Staff were skilled and knowledgeable in their field of expertise and were able to demonstrate how they could support each other when the need arose.

As a teaching practice, the GPs had mentorship roles with the doctors training in their practice. The second year training GP doctor felt that they received good training and was not being used as an extra pair of hands.

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. All new employees working in the building were given induction information for the building, which covered health and safety and fire safety.

There was a staff handbook available for all staff and this was supported by a health and safety, general workplace and clinical policies and procedures for staff follow.

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

Arrangements to deal with emergencies and major incidents

Staff could describe how they would alert others to emergency situations by use of the panic button on the computer system.

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

Staff had received training in dealing with medical emergencies including cardiopulmonary resuscitation (CPR). This was updated annually. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia and suspected meningitis. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

There was a fire procedure policy in place, which identified key personnel, such as fire marshals and their duties in the event of a fire. Weekly fire alarm tests were carried out and equipment maintained by a contracted company.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients told us clinicians listened to them and they were confident in the treatment they received. All the clinicians we spoke with were familiar with, and using current best practice guidance. The staff we spoke with and evidence we reviewed, confirmed that care and treatment delivered was aimed at ensuring each patient was given support to achieve the best health outcomes for them. Each clinician confirmed that they had online access to NICE guidance.

The local community where Ribbleton Medical Centre was located has been classified as having high levels of multiple deprivation. (Multiple deprivation is when different types of deprivation e.g. lack of education, poor health, high crime levels, high unemployment are combined into one overall measure of deprivation, and are indicators of the quality of life that the local population experience). We found clinicians and staff were familiar with the needs of their local population and the impact of the socio-economic environment on their health and wellbeing. National data showed that the practice had 71.9% per 1000 patients claiming disability allowance compared with England average of 50.3%. The practice also had a lower percentage of patients in paid work and a higher percentage of unemployed patients compared with the England average.

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 practice referred patients appropriately to secondary care and other services. Test results and hospital consultation letters were received into the practice either electronically or by paper. These were then scanned onto the system daily.

New patient health checks were carried out by the health care assistant and cardiovascular and other regular health checks and screenings were ongoing in line with national expectations.

People with long term conditions were helped and encouraged to self-manage, and checks for blood counts, blood pressure and general wellbeing had been combined into single appointments where possible to create a holistic approach. One GP had responsibility to work with vulnerable patients who were at high risk of hospital admission and for carrying out planned weekly visits to patients living in care homes.

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

One practice nurse provided a daily triage service to patients to assess their health care needs and direct them to the most appropriate level of medical support. The other practice nurses, in the main, managed long-term conditions such as diabetes, heart disease and asthma. Nurses told us they were able to focus on specific conditions and provide patients with regular support based on up to date information about each long-term conditions. The practice offered mixed clinics, which provided patients with flexibility to attend appointments when it suited them. Systems were in place to identify and recall patients who did not attend for follow up appointments.

Clinical staff told us the practice focused on learning and developing to improve outcomes for patients. They said they were open about asking for and providing colleagues with advice and support. GPs told us they supported all staff to continually review and discuss new best practice guidelines for the management of long-term health conditions. In addition, the practice nurses received a monthly group tutorial on different clinical conditions with one of the GPs. A practice nurse told us that they were supported by the GPs and they felt able to discuss any concerns they had about a patient or the management of a patient's condition

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

Management, monitoring and improving outcomes for people

The practice routinely collected information about patients' care and treatment. It used the Quality and Outcomes Framework (QOF) to assess its performance and

undertook regular clinical audits. QOF data showed the practice performed above the national average for the local clinical commissioning group and the England average for the last four years. The practice actively monitored its performance alongside the Clinical Commissioning Group (CCG) and bench marking against quality frameworks.

The practice had a system in place for completing clinical audit cycles. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. For example, following an alert from the Medicines and Healthcare Products Regulatory Agency (MHRA) regarding a medicine used to reduce nausea and vomiting .The aim of the audit was to review dosage and duration of administration alongside the new guidance and to ensure that all patients prescribed this medicine long term did not experience neurological side effects. The outcome of the audit was shared with the GPs so appropriate action was taken.

Examples of other clinical audits included looking at a sample of 19 patients who were triaged by the nurse to assess the quality of the assessment provided to the patient and the written notes recorded following the consultation. The audit identified a positive outcome with evidence of appropriate consultation and recording. A recent audit of cytology smears showed that the practice had a lower score on inadequate smears when compared to the other locations, which used the Manchester Cytology centre to analyse these. Therefore, patients did not need to return for a repeat procedure.

Minor surgical procedures and Intra Uterine Device Implants (IUD or coil) were undertaken at the practice in line with their registration and NICE guidance. We saw that patients consented to these procedures and the signed paper consent forms were scanned into the patients' medical notes.

The practice also provided enhanced services such as the violent patient scheme and ankle brachial pressure index (ABPI) monitoring. This is a diagnostic assessment of blood pressure in a patient's ankle where there is suspected peripheral arterial disease. In addition, a cognitive behavioural therapist worked at the practice for a day each week and saw between five and six patients each time. They told us that the service they provided was benefiting some of the severely depressed patients they were seeing.

Regular meetings took place with multi-disciplinary team attendance to share information and provide reflection and learning to the benefit of the patients. We saw evidence of collaborative working with other healthcare professionals, which resulted in positive outcomes for the patients concerned.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff personnel files and these contained evidence of the training they had received. However, the sample of staff files we saw did not have copies of training certificates. In addition a staff training matrix detailing what mandatory and other training staff had received was not available. A staff training matrix or similar record would allow for gaps in a staff member's training to be easily identified and assist in the forward planning of staff training.

All staff had access to a staff handbook which included a range of employment policies and procedures and included information on safeguarding and whistleblowing. Staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors with a number having additional training certificates in children's health, family planning, and minor surgery. Practice nurses had defined duties and were able to demonstrate that they were trained to fulfil these duties.

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

All staff undertook annual appraisals that identified learning needs from which action plans were documented. As the practice was a training practice, doctors who were training to be qualified as GPs had access to a senior GP throughout the day for support. One trainee GP spoke positively of the support they received at the practice. They felt they were provided with opportunities to learn and develop and compared this favourably to another practice they had been training at.

Good

Are services effective?

(for example, treatment is effective)

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

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X-ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients, patients on the risk register hospital admissions and discharges and attendance at A&E.

Minutes from meetings showed that a variety of professionals attended the meetings including district nurses, community matron, cancer nurse specialist and social services support. The practice had taken action to try to get a health visitor to attend the meetings also.

Information sharing

The practice used electronic systems to communicate with other providers. They shared information with out of hour's services regarding patients with special needs. They communicated and shared information regularly between themselves, other practices and community health and social care staff at various regular meetings.

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, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

All clinical staff (GPs and nurses) we spoke with demonstrated an awareness of the Mental Capacity Act 2005 (MCA) and their duties in respect of this. However, staff we spoke with said they had not had training specifically in relation to the MCA. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

The practice on occasion carried out some minor surgical procedures. For these minor surgical procedures, written consent was obtained and scanned into the patient's electronic records.

Staff had access to an updated consent policy, which reflected current guidance. Information about consent was also available on the practice's website.

Patients we spoke with confirmed that consent was always sought before examinations or procedures were undertaken.

Health promotion and prevention

There were health promotion and prevention advice leaflets available in the waiting rooms at the practice including information on strokes, meningitis, cancer and immunisations. The practice web site had a range of information and useful links for further supporting information for family health, long term conditions and minor illnesses. There was also information available about travel vaccinations with links to regions in the world to assist people in identifying what vaccinations they required.

The practice nurses held a variety of mixed clinics including a weekly baby clinic and for specific problems and general health checks. There was a weekly diabetic clinic on Tuesdays although appointments were flexible to assist patients to attend when they were available. The health care assistant provided a lifestyle management support to patients. This included discussions about the patient's environment, family life, carer status, mental health and physical wellbeing as well as checks on blood pressure, smoking, diet and alcohol and drug dependency if appropriate.

The practice also operated NHS health checks for patients between 40-74 years of age.

The practice used the coding of health conditions in patients' electronic records and disease registers to plan and manage services. For example, patients on disease

Good

Are services effective?

(for example, treatment is effective)

registers were offered reviews with the nurse. The practice had ways of identifying patients who needed additional support, and it was pro-active in offering additional help. The practice kept a register of all patients with a learning disability and they were all offered an annual health check. There were local health and support groups that they accessed and referred patients with mental health and learning disabilities needs.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The results of the National GP Patient Survey published in January 2015 demonstrated the practice performed well with 83% of respondents stating they were satisfied with the surgery's opening hours; 92% of respondents described their overall experience of this surgery as good and 79% of respondents described their experience of making an appointment as good. These percentages were all above the average results for the local Clinical Commissioning Group (CCG). A further 98% of respondents stated they had confidence and trust in the last GP they saw or spoke to.

Although prominently displayed and readily available to patients, we did not receive any feedback through our CQC comment cards. We therefore reviewed some of the recent feedback the practice had received through their Friends and Family test. The practice had received 106 responses from between December 2014 and March 2015. In total 94 respondents said they were either extremely likely or likely to recommend the practice to friends and family.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. There were privacy curtains for use during physical and intimate examinations and a chaperone service was available. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Staff and patients informed us they were aware there was a room available if patients or family members requested a private discussion.

The patient electronic recording system included flags on patient records to alert staff to patient needs that might require particular sensitivity. For example, where a patient had a learning disability.

A member of the patient reference group (PRG) told us that the practice contacted them to seek their ideas and feedback about different aspects of the service being delivered. Recently the PRG member said they had been asked for ideas and suggestions to reduce the high number of patients who did not attend for their booked appointments. The PRG member said their suggestions and ideas were listened to and gave an example of where they had identified information on the practice website which required updating. This was responded to within a week.

Care planning and involvement in decisions about care and treatment

Patients we spoke with confirmed they felt involved in decisions about their care and treatment. Patients told us diagnosis and treatment options were clearly explained and they did not feel rushed in their appointment. Comments from patients included that they felt listened to and treated with respect, and options were always discussed.

The National GP Patient Survey published in January 2015 identified 88% of respondents said the last GP they saw or spoke to was good at listening to them; 85% of respondents said the last GP they saw or spoke to was good at explaining tests and treatments and 81% of respondents said the last GP they saw or spoke to was good at involving them in decisions about their care

GPs confirmed that all patients over 75 years had a named GP. An electronic coding system maintained registers of patients with particular conditions or vulnerabilities, for example, diabetes, mental health issues and learning disabilities.

Staff told us that they used an internet search engine translation service to help communicate with people who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

Notices in the waiting room, and on the practice website told patients how to access a number of support groups and organisations. The practice's patient information leaflet included details of support groups such as child bereavement services and Cruse bereavement care.

Reception staff knew that when patients wanted to discuss sensitive issues or appeared distressed and they could offer them a private room to discuss their needs.

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, patients felt listened to and felt both the GP, practice nurses and most reception staff were caring and compassionate.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The needs of the practice 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. This information was reflected in the services provided, for example screening programmes, vaccination programmes and reviews for patients with long term conditions and mental health conditions.

A psychologist worked at the practice one day per week and offered referred patients cognitive behavioural therapy (CBT) which is a talking therapy commonly used to treat anxiety and depression. A physiotherapist worked at the practice three days per week and saw patients referred by the GPs. In addition, Help Direct (a service to help people with their socio-economic needs) was also based at the practice. The patients could self refer to this service.

Patients with dementia, learning disabilities and enduring mental health conditions were reviewed annually. They were encouraged to bring carers with them to these reviews. One GP had protected time to focus on the needs of patients living in nursing homes and care homes. The objective of this was to meet these patients' needs proactively and prevent unnecessary hospital admissions. The practice was proactive in contacting patients who failed to attend vaccination and screening programmes. Home visits could be arranged for children who missed their childhood immunisations.

The practice had an active Patient Reference Group (PRG). We spoke with a member of the group. They told us that the practice contacted them to seek their ideas and feedback about different aspects of the service being delivered. The PRG member told us that they had been recently consulted on ideas to reduce the rate of patients who did not attend for appointments. The member told us that they were aware that the practice tried to actively recruit members to the PRG right from the point of registration with the practice.

Tackling inequity and promoting equality

The practice had consultation, treatment rooms and waiting rooms both on the ground and first floor. Disabled access into the building was available and a passenger lift was available to the first floor for people with mobility problems and parents with prams. Corridors and doorways were wide enough for people who used mobility aides and prams. Disabled toilet facilities were accessible and an induction hearing loop was available for people with hearing impairment. Consultation and treatment rooms doors all had colour coded discs on them as well as the practicing clinician's name. This helped patients with visual impairment and those who may have poor literacy skills.

The practice analysed its activity and monitored patient population groups. They had tailored services and support around the practice populations needs and provided a good service to all patient population groups. The GP partner explained that one of the challenges they faced was finding solutions to reduce the number of patients who did not attend for their planned appointments.

Between October 2014 and March 2015 the practice had provided three additional GP surgeries each week to help cope with the winter pressures demand. These additional surgeries were provided through the working day. The practice had assessed that the patient demand and the safety of staff influenced the decision to provide additional surgeries through the daytime. At our visit, we heard that the practice had received the go ahead to continue to provide the additional GP surgeries each week. However, the practice manager stated that this service would only be provided if they could secure the long term commitment of a locum GP to ensure patients received continuity of care.

The practice population included a small group of patients whose first language was not English. We were told that the practice used a well known internet search engine translation service. Staff told us that this was effective.

The staff we spoke with demonstrated a good understanding of how to meet the specific needs of patients with different religious or cultural backgrounds, however specific training in equality and diversity had not yet been undertaken.

Access to the service

The practice was open Monday to Friday 8 am until 6 pm. The practice did not offer late night or early morning appointments. The practice had assessed that the patient demand and the safety of staff influenced the decision to provide additional surgeries through the daytime as opposed to the evening or early morning. Information was

Good

Are services responsive to people's needs?

(for example, to feedback?)

available to patients about appointments on the practice website and in the practice information leaflet. This included information on who to contact for advice and appointments out of normal working hours and the contact details for the out of hours medical provider. The practice offered pre bookable and urgent (on the day) appointments and home visits. Appointments could be made in person, by phone or online. Priority was given to children; babies and vulnerable patients. These patients were always offered a same day or urgent appointment.

Appointments were tailored to meet the needs of patients, for example those with long term conditions and those with learning disabilities were given longer appointments. Home visits were made to care homes, older patients and those vulnerable housebound patients. The practice offered mixed clinics for patients with long term conditions as this provided flexibility to attend appointments at times convenient to them.

Patients we spoke with, and patient survey results told us patients were satisfied with the service they received from the practice. The results of the National GP Patient Survey published in January 2015 recorded that 97% of respondents said the last appointment they got was convenient. 79% of respondents described their experience of making an appointment as good; 82% of respondents were able to get an appointment to see or speak to someone the last time they tried and 72% said they found it easy to get through to this surgery by phone.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice.

We looked at the audit of complaints received by the practice between March 2014 and February 2015. The practice had received six complaints. Complaints were broken down into different categories, none contained any clinical care elements. We saw the practice responded to complaints proactively investigating the concern, responding appropriately to the complainant, identifying improvements in service quality, sharing learning and adapting practice.

Information for patients on how to make a complaint was displayed in the waiting room and in their information leaflet available at the ground floor reception.

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

Ribbleton Medical Centre did not have a formal written vision and strategy. Staff reported an open culture where they felt safe to report incidents and mistakes knowing they would be treated as a learning opportunity. Staff told us the practice put the patient at the centre of everything they did.

All staff we spoke with demonstrated a commitment and enthusiasm and were engaged in providing a high quality service. Each member of staff had a clear role within the structure of the practice and it was evident that there was a strong culture of teamwork and supporting each other.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the computer shared drive. Policies and procedures we viewed were dated and reviewed appropriately and were up to date. Staff confirmed they had read them and were aware of how to access them. Staff could describe in detail some of the policies that governed how they worked for example the safeguarding children's policy and procedures.

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

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed the practice performed above the national average for the local clinical commissioning group and the England average for the last four years.

The practice had a programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. Audits undertaken by the clinical staff were decided on either by the local Clinical Commission Group (CCG) or national priorities but also in response to complaints and significant events. Minutes of meeting provided clear evidence that the outcome of the audits were discussed at meetings and training and development days.

The practice had arrangements in place for identifying and managing risks.

Leadership, openness and transparency

There was a well-established clearly identified management 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 good clear leadership which articulated vision and motivated staff to provide a good service.

Staff felt well supported in their role. They felt confident in the senior team's ability to deal with any issues, including serious incidents and concerns regarding clinical practice. All the staff we spoke with told us they felt they were valued and their views about how to develop the service were acted upon.

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

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

We reviewed complaints and found they were well managed. The practice investigated and responded to them in a timely manner. They were discussed at staff meetings and were used to ensure staff learned from the issues raised.

There was an active Patient Reference Group (PRG). The practice manager told us it was challenging trying to get the local patient population to participate in sharing their views about the practice. One member of the PRG confirmed that they were consulted on issues and that the practice responded to their comments and suggestions.

The practice manager was actively promoting the Friends and Family Test. The practice had received 106 responses from between December 2014 and March 2015. In total 94 respondents said they were either extremely likely or likely to recommend the practice to friends and family

There was a whistleblowing policy in place. Staff told us they had no concerns about reporting any issues internally.

Are services well-led?

Good

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

Management lead through learning and improvement

GPs were all involved in revalidation, appraisal schemes and continuing professional development. We saw that staff were up to date with annual appraisals which included looking at their performance and development needs. Staff told us appraisals were useful and provided an opportunity to share their views and opinions about the practice.

The practice had an induction programme for new staff. Staff undertook training relevant to their role and responsibilities. Records of some training staff had received was available. However, a matrix to easily identify what training each staff member (including all clinicians) had had and when refresher training was due was not available nor were copies of all training certificates available.

The staff had protected education training (PET) each month. The practice nurses had a monthly tutorial with one of the GPs and a trainee GP commented positively on the support they received and compared this to other locations they had received training.

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