Maple Access Partnership

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?	Outstanding
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We visited Maple Access Partnership on the 6 October 2014 and carried out a comprehensive inspection. The practice offers a satellite clinic at Oasis House, which is a homeless support centre but we did not inspect that venue.

The overall rating for this practice is good, with areas of outstanding practice for vulnerable groups of people, which includes substances misusers and homeless people, as well as those with mental health needs where the practice has a special interest and has developed tailor made services for their patients.

Our key findings were as follows:

- Patients were satisfied with the service and felt they were treated with dignity, care and respect and involved in their care.
- There were systems in place to provide a safe, effective, caring and well run service.
- There was a good understanding of the needs of the practice population and services were offered to meet these.

We saw areas of outstanding practice including:

- The practice's approach to mental health and services for vulnerable people, including the homeless and substance misusers. They had developed a specialist, non stigmatising service which provided easier access and support for patients who had difficulty in accessing health services or were in crisis. The practice had developed relationships with other agencies to build services and ensure that patients accessed the appropriate support when they needed it and so that all professionals involved in care were aware of the issues facing this vulnerable group of patients.
- The practice offered specialised satellite clinics four times a week at a homeless support centre and worked with the local agencies, such as the local council, police and other agencies of support. This facilitated development of a co-ordinated approach

Summary of findings

and provided patients with access to care when they needed it. They offered a drop in session daily for people who misused drugs to allow them to access help if in crisis.

- They had developed different means of communication to help patients remember to attend appointments, such as text reminders and had also introduced a means of allowing hearing impaired patients to book their appointments by text messaging.

However, there were also areas of practice where the provider should make improvements.

The provider should:

- Ensure their clinical audit process is scheduled, completed and includes minor surgery complications including coils and contraceptive implants.
- Ensure that any staff who may at any time be required to act as a chaperone has received the appropriate training.
- Document that any non-clinical staff who had not received a Disclosure and Barring Service (DBS) check had been risk assessed before commencing employment.
- Ensure that all policies and protocols are updated and reflective of practice that staff should carry out.
- Carry out minor repairs in the treatment room as identified in this report.
- Amend the Controlled Drug policy to include instructions for circumstances when patients may bring in their controlled drugs for administration.
- Review their policy regarding texting patients with results to account for when young people become 17 years of age. Currently there is no system to ensure a change or review of young peoples' contact telephone numbers when they reach the age of 17 as prior to this age they are often registered with their parents contact number. This may result in a breach of confidentiality.

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 safe. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed and risks to patients were assessed and well managed. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff had received training appropriate to their roles and further training needs had been identified and planned. The practice could identify all appraisals and the personal development plans for all staff. Multidisciplinary working was evidenced.

Are services caring?

Good

The practice is rated as good for caring. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for responsive. We found the practice had initiated positive service improvements for their patients that were over and above their contractual obligations. The practice had reviewed the needs of their local patient population, engaged with the NHS England Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure funding to develop and deliver specialised services and improve access to primary care services of vulnerable patients and those with mental health problems.

They had involved secondary care specialists, other health professionals, police, voluntary groups, and charitable organisations to provide a co-ordinated approach to care for all patients but particularly vulnerable groups and patients with mental health

Summary of findings

problems. The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and other agencies. For example, any patient suffering from drug or alcohol problems could drop in to the practice daily at a specific time for help and support.

Patients reported good access to the practice, with continuity of care and urgent appointments available the same day and a named GP for older patients and those with severe mental health problems. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision and strategy to deliver this. Staff were clear about the vision and their responsibilities in relation to this. 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 regular governance meeting had taken place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had not been able to convene a patient participation group (PPG) but had taken alternative steps to gain patient feedback. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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. Despite having a very low number of older people in the practice population, the practice offered proactive, personalised care to meet the needs of the older people. The practice was responsive to the needs of older people, including offering home visits and same day appointments

People with long term conditions

Good

The practice is rated as good for the population group of people with long-term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed longer appointments and home visits were available. All these patients had structured annual reviews to check their health and medication needs were being met.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. For example, children and young people who had a high number of A&E attendances. The practice had systems for call and recall for all standard childhood immunisations. We saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We were provided with good examples of joint working with midwives and health visitors. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the 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 which reflected the needs of this age group.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as outstanding for the population group of people whose circumstances may make them vulnerable. The practice held a register of patients who lived in vulnerable circumstances including homeless people, travellers and those with learning disabilities. They offered longer appointments for people with learning disabilities, drug and substance misusers and those whose first language was not English where a translator was required.

The practice offered specialised satellite clinics four times a week at a homeless support centre and worked with the local agencies, such as the local council, police and other agencies of support. This facilitated development of a co-ordinated approach and provided patients with access to care when they needed it. They offered a drop in session daily for people who misused drugs to allow them to access help if in crisis.

They had developed different means of communication to help patients remember to attend appointments, such as text reminders and had also introduced a means of allowing hearing impaired patients to book their appointments by text messaging.

They worked with multi-disciplinary teams in the case management of vulnerable people on a daily basis. The practice had sign-posted vulnerable patients to various support groups and third sector organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as outstanding for the population group of people experiencing poor mental health (including people with dementia). They had a specialised mental health team at the practice consisting of two GPs, two mental health nurses, and a drug support worker. They offered a drop in session daily for people suffering with mental health problems to allow them to access help if in crisis.

The practice worked closely with the mental health consultant from secondary care and co-ordinated a joint clinic every six weeks. They ensured that there was always a GP on the premises to deal with

Summary of findings

patients in crisis. All mental health patients had a named GP. The GPs were alerted to patients with mental health needs who did not attend for appointment to determine whether contact with them was necessary.

The practice had developed different means of communication to help patients remember to attend appointments such as text reminders and staff were trained to understand and deal appropriately with the issues facing these patients. Staff had received training on how to care for people with mental health needs and dementia.

The practice had developed individualised care plans for all patients with severe mental health problems. They had a system in place to follow up on patients who had attended accident and emergency where there may have been mental health needs.

Summary of findings

What people who use the service say

We spoke with six patients who used the service and received 22 comment cards. Twenty-one comment cards we received expressed satisfaction with the service, referring to a caring service from dedicated helpful staff. Almost all of the comments stated that they were treated with respect and dignity and that staff were kind and understanding.

Some comments gave detail of the significant difference the service had made and how they had made a positive impact on their lives. There were positive comments regarding ease of getting appointments at the right time and the benefit of having appointments texted.

Overall people we spoke with and comment cards we saw indicated that patients were satisfied with the service, although two patients told us they had to wait a long time to see the doctor once they arrived for their appointment.

Areas for improvement

Action the service SHOULD take to improve

There were no clinical audits for complications of minor surgery, contraceptive implants and coils. The practice should ensure that these are audited as part of the service and added to the audit schedule.

The practice should ensure that any staff who may at any time be required to act as a chaperone has received the appropriate training.

The practice should document that any non-clinical staff who had not received a Disclosure and Barring Service (DBS) check had been risk assessed before commencing employment.

There were policies for various procedures undertaken in the practice. However, some policies had not been updated to reflect what staff should do. The practice should ensure that all policies and protocols are updated and reflective of practice that staff should be carrying out.

The wall in one treatment room had a small area where the plaster had been damaged. The practice should repair this to reduce the risk of infection.

The Controlled Drug policy should be amended to include occasions when patients may bring in their controlled drugs for administration.

The practice should review their policy regarding texting patients with results to account for when young people become 17 years of age. Currently there is no system to ensure a change or review of young peoples' contact telephone numbers when they reach the age of 17 as prior to this age they are often registered with their parents contact number. This may result in a breach of confidentiality.

Outstanding practice

The practice had identified that the practice population had a considerable number of patients who were vulnerable, homeless and had mental health and drug and alcohol abuse. They had developed a special interest in improving services and access for vulnerable patients, the homeless and those with mental health and drug and alcohol abuse.

They had worked with commissioners to develop a more specialist, non-stigmatising service that provided easier access and support for patients who had difficulty in accessing health services or were in crisis. The practice had developed relationships with other agencies to build services and ensure that patients accessed the

Summary of findings

appropriate support when they needed it and so that all professionals involved in care were aware of the issues facing this vulnerable group of patients and those with mental health problems.

The practice offered specialised satellite clinics four times a week at a homeless support centre and worked with the local agencies, such as the local council, police and other agencies of support. This facilitated development of a co-ordinated approach and provided patients with access to care when they needed it. They offered a drop in session daily for people who misused drugs to allow them to access help if in crisis.

They had developed different means of communication to help patients remember to attend appointments, such as text reminders and had also introduced a means of allowing hearing impaired patients to book their appointments by text messaging.

Maple Access Partnership

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 another CQC inspector.

Background to Maple Access Partnership

Maple Access Partnership is a purpose built two storey building in the centre of Northampton providing primary medical services to a diverse population of approximately 6,750 patients. The practice population is made up of approximately 3% homeless patients, 38% eastern European, 22% British, 18% Black ethnicities, 11% Asian and dual parentage and 8% included patients from other different groups. The practice has a Personal Medical Services (PMS) plus contract which allows them to tailor more specialised services to a particular patient group and receive additional funding to do this.

The practice provide a specialist service offering access to any patients in the Northampton Borough who are homeless, vulnerable, substance and alcohol misusers and who have mental health problems and have difficulty in accessing primary care. The practice provides primary medical services four times a week at Oasis House, a local centre that supports homeless and vulnerable people. They also register patients living in Northampton and Milton Keynes who have a history of aggressive or abusive behaviour.

They have their own specialist mental health team led by two GPs with an interest in mental health, two registered mental health nurses and a support worker for substance misuse. There are three other GPs including one female, two practice nurses and a health care assistant as well as administrative and reception staff.

The practice service for out of hours care is via the NHS 111 service.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

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

Detailed findings

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We spoke with the local Clinical Commissioning Group (CCG), the Local Medical Committee (LMC) and NHS England. We carried out an announced visit on 6 October 2014. During our inspection we spoke with a range of staff, including GPs, reception staff, nurses, administration staff, reception manager, administration manager and telephone call handlers. We spoke with patients who used the service. We observed how patients and family members were responded to and collected comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe Track Record

The practice had developed a schedule identifying all lead roles within the practice to ensure that staff were aware of who was responsible when issues arose and we saw a copy of this. For example, governance, complaints, and safeguarding. All staff we spoke with were aware of this and were able to identify each lead. There were systems in place to ensure that safety alerts were shared with staff. For example, the governance lead would review these and cascade to all relevant staff via email. We saw that they were also shared with members of the team at practice meetings. Staff we spoke with confirmed this system was in place.

We saw evidence of shared learning with staff from significant event audits, complaints and audits via emails and meetings. For example, we saw that an alert had been received regarding medication and all patients concerned had been reviewed as a result. We saw that there was a template on the system to record significant events and that these were on the agenda for discussion at weekly meetings. We spoke with all staff, who reported that there was good communication in the practice regarding safety issues. They confirmed they were informed of significant events and encouraged to report any concerns identified regarding risk.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We spoke with GPs, nursing and administrative staff who all reported that there was an open and honest approach within the practice regarding learning from incidents. Staff told us that there was a no blame culture and they were encouraged to report incidents and that outcomes of investigation were shared with them. The practice kept a log of significant events and we saw that they were discussed and learning shared at practice meetings.

The practice had identified a lead person to be responsible for significant events and we saw evidence that they were discussed and actions taken where necessary.

Reliable safety systems and processes including safeguarding

We spoke with the practice administrator who informed us that the practice was continuing the process of agreeing and confirming any outstanding policies. These included child protection and safeguarding and safe working practices for prescription management including repeat prescriptions. An identified member of staff was systematically working through all policies to ensure they were complete and up to date.

We spoke with GPs who confirmed that they were aware of the latest best practice guidelines and incorporated this into their day-to-day practice. We saw there were effective systems in place to ensure the staff remained up to date with the latest developments.

The practice had a draft child protection policy and an approved vulnerable adult policy. Staff we spoke with were knowledgeable about identifying, reporting and dealing with suspected abuse. These policies were easily accessible on staff computers. Staff had access to the contact details for both child protection and adult safeguarding teams. Safeguarding matters were routinely discussed at regular practice meetings with the health visitor, the midwife, district nurse and mental health nurse and we saw records which confirmed this.

There was a lead GP responsible for safeguarding in the practice who had attended Level 3 training to support them in carrying out their work. They were knowledgeable about the contribution the practice could make to multi-disciplinary child protection meetings and serious case reviews. They told us that they attended some case conferences but if they were unable to attend would send a report. Nursing and reception staff had also received training in safeguarding and child protection appropriate to their roles within the last 12 months. We saw documentation to confirm this.

Staff ensured that safeguarding alerts were recorded onto the patient's electronic record for any patients who were vulnerable. Staff were proactive in monitoring if children or vulnerable adults attended Accident and Emergency or missed appointments frequently. These were brought to the attention of the GP who worked with other health professionals such as health visitors, midwives, district nurses and mental health nurses.

The practice had a system in place for recalling children who had not attended for immunisation. If they failed to attend after three recalls then the health visitor would be notified. We saw minutes from monthly meeting the practice held focussing on child and maternal health.

Good

Are services safe?

All clinical staff had Disclosure and Barring Service (DBS) checks carried out and reception staff had undergone a risk assessment. However, this had not been documented. The practice should ensure that this is carried out before staff commence employment.

The practice also needs to decide if reception staff are to carry out chaperone duties and if so then a Disclosure and Barring Service check would be necessary. A chaperone policy was available and staff we spoke with confirmed that chaperoning was carried out by the practice nurses. Staff told us that the reception staff would only in extreme circumstances be called upon to chaperone. Discussions with the reception staff confirmed that they had not received chaperone training. The practice was advised during the inspection that any staff who may be required to act as a chaperone must have received the appropriate training.

Medicines Management

The GPs reviewed medication for patients on an annual basis or more frequently if necessary.

Prescription pads and repeat prescriptions were stored securely. Repeat prescriptions were generated electronically and authorised by a GP before being issued to the patient. Reception staff we spoke with were aware of the necessary checks required when giving out prescriptions to patients when they collected them. They were also able to describe the additional checks required when giving out prescriptions for controlled drugs.

Temperature sensitive vaccines were stored at the right temperature in two medicine refrigerators. We checked these refrigerators and found the vaccines were in date, stored at the correct temperature and used in rotation. We checked the temperature records and found that they were stored at the correct temperature.

GPs told us that they did not keep controlled drugs on the premises or accept drugs returned from patients under normal circumstances. However, during our inspection one GP told us of an occasion where a patient brought their own controlled medication to the surgery for storage and administration, for which a recording had not been made in the controlled drug register. This was an unusual occurrence and the practice accepted that although they had a policy to deal with storage and administration of drugs, as the drugs were the property of the patient the policy did not cover this. On reflection, they told us they should have recorded it in the control drugs register and in future would record any such instances.

Cleanliness & Infection Control

During our inspection, we saw that the practice was clean and appeared hygienic. We looked at the cleaning schedules and saw that cleaning staff worked in accordance with this and recorded completion of cleaning appropriately. The business manager at the practice told us that in addition to this they did a daily walk about of the building to ensure the premises were clean.

We spoke with the nurse who had the lead role for infection control; they demonstrated they were knowledgeable in infection control. The practice had a comprehensive system in place for managing and reducing the potential for infection and we saw that an up-to-date infection control policy was available.

We inspected the two treatment rooms where minor surgery took place and saw that they were clean and tidy. However, we found that plaster on a wall in one of the treatment rooms had been damaged in several places exposing a potential infection risk. The practice should have this damage repaired to minimise risk of infection.

There was a needle stick injury policy and spillage kits were available for staff to use if bodily fluids were spilled. The infection control lead told us that an audit of infection control practices had been carried out in 2013 which would be repeated in 2014. We saw the results of this audit which had shown that staff were following infection control practices including hand washing, specimen handling and training. All practice staff had received infection control training and had regularly updated through in-house training provided by the infection control lead. All staff had access to the further information provided by the infection control lead.

Hand washing facilities to promote high standards of hygiene were available. We found protective equipment such as gloves and aprons were available in the treatment and consulting rooms and in reception. Couches were washable and there were privacy blinds in the two treatment rooms.

We were told the practice used instruments which were for single use only. Checks were carried out and recorded to

ensure items such as instruments, gloves and hand gel were available and in date. We checked a sample of the instruments used and found that their sterility was intact and the instruments were in date.

There were a number of stand-alone air conditioning units that serviced the building. We asked about legionella checks and we saw evidence of annual maintenance records for these units which confirmed that there was no risk.

Equipment

The practice administrator had contracts in place for annual checks of fire extinguishers, portable appliance testing and calibration of equipment. The practice kept a record of maintenance of equipment and noted when any items identified as faulty were repaired or replaced. We saw records of portable appliance tests and we randomly checked some equipment which confirmed that checks had been made within an appropriate timescale.

The practice had a contract with an external provider for the routine servicing and calibration of medical equipment where required. The records we saw confirmed that the equipment at the practice was safe to use.

Staffing & Recruitment

The practice had procedures in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness. There was a member of staff responsible for producing the rota and ensuring there was sufficient reception staff on duty each day. They had reviewed and developed the GP appointment system. The practice operated a service at a location called Oasis House on four weekdays providing a specialised service for patients who were homeless, vulnerable or misusers of drugs and alcohol or suffering from mental health problems. The administration manager told us that this presented no problems as there were sufficient numbers of GPs and other staff to manage both Maple Access surgery and Oasis House. On the day of our inspection we saw that there was sufficient staff on duty to deal with expected demand; including home visits and daily telephone triage consultation sessions.

Monitoring Safety & Responding to Risk

The practice had procedures in place to assess, manage and monitor risks to patient and staff safety. These included periodic checks of the building, the environment and equipment. The business manager showed us records of environmental risk assessments as well as records of equipment inspection, maintenance and calibration.

We saw evidence of patient risk assessment to ensure the safety of patients and those around them. We saw that any actual or potential risks were discussed at GP meetings and within the practice team meetings.

We found checks were made to minimise risk, and best practice was followed. Stocks of consumables and vaccines were checked regularly to ensure they were available, in date, stored at the right temperature and ready to use. The clinical staff had received regular cardiopulmonary resuscitation (CPR) training and training associated with the treatment of anaphylaxis. Staff that would use the defibrillator had received training to ensure they remained competent in its use, which ensured they could respond appropriately if patients experienced a cardiac arrest.

For patients with long term conditions there were emergency processes in place. The practice nurse told us that patients with chronic obstructive pulmonary disease (COPD) all had care plans and antibiotics at home to use if there is a change in weather and they start to have an exacerbation of their condition. The practice told us they liaise with the community nurse practitioner and who will visit and discuss their management. Staff gave us examples of referrals made for patients that had a sudden deterioration in health and showed us the template in use for patients with long-term conditions.

There were emergency processes in place for identifying acutely ill children and young people. Reception staff told us that they had been trained and could access a GP immediately via their system to direct the patient to for urgent advice or treatment.

Staff gave examples of how they responded to patients experiencing a mental health crisis. The practice had GPs who had a special interest in mental health and there was always a GP on the premises to deal with a crisis. The practice also had a drop in service between 1pm and 3pm every day to deal with patients who may need help and support urgently.

Arrangements to deal with emergencies and major incidents

The practice had a comprehensive plan to deal with any emergencies that could disrupt the safe and smooth

Good

Are services safe?

running of the practice. We saw that a detailed business continuity plan was in place which accounted for business continuity, staffing, records and electronic systems, clinical and environmental events. All staff we spoke with were knowledgeable about the business continuity plan.

Staff told us that in addition to training in dealing with medical emergencies, including cardiopulmonary resuscitation (CPR) they had also received training in other emergencies such as fire and other disruptive events.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

The clinicians we interviewed demonstrated evidence based practice. All GPs and nurses demonstrated how they accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Staff received emails of updates or changes in guidance and changes were also discussed at the weekly practice meeting. We saw minutes of practice meetings where a variety of clinical issues were discussed together with evidence of presentations to the staff demonstrating the outcome of audits carried out.

Patients had their needs assessed and care planned in accordance to best practice. We saw evidence of care plans. For example, for patients with complex mental health problems. The clinical staff told us that referrals were discussed at weekly meetings and we saw minutes from meetings which confirmed this.

The practice described discussions with the local commissioners where they had identified unmet clinical need for a specific vulnerable patient group which required additional resources. The practice had developed services with additional funding to assist these patients and provide health services. For example, the practice attended Oasis House to provide primary care services. Oasis House is a local homeless shelter which offers help and support to people with problems such as homelessness, mental health, drug and alcohol abuse.

We saw no evidence of discrimination when making care and treatment decisions. Clinical staff talked freely regarding supporting people with choice and informed consent. Discussions with clinicians confirmed knowledge of and commitment to ensure Gillick competence when necessary. Gillick competence refers to a child under 16 who is able to demonstrate they are capable of making decisions and giving consent without parental consent.

Management, monitoring and improving outcomes for people

The practice had carried out audit in a variety of clinical areas. For example, Vitamin D screening, alcohol detoxification and a personality disorder project. However, the audits were mainly one cycle and there was no evidence of re-audit. The practice had already identified this as an area of improvement and had developed a schedule of re-audit which they made available to us.

Doctors in the surgery undertook minor surgical procedures in line with their registration and NICE guidance. The staff were appropriately trained and kept up to date. However, there was no evidence of audit of complications of minor surgery, coil insertion, or insertion of contraceptive implants. The practice should add this to their schedule of audit.

The practice attended meetings with the local Clinical Commissioning Group (CCG) and we saw evidence that they had benchmarked their outcomes of care delivery against other practices within the CCG. This indicated that the practice was generally performing in line with other practices in the CCG, but that they were outlying in some areas. For example, the uptake of flu vaccination administration and prescribing of anti-hypnotic drugs was slightly below the CCG average. This was discussed with the GPs and thought to be due to the transient nature of the practice population.

Effective staffing, equipment and facilities

The practice had a comprehensive induction programme for new staff which included fire awareness, information governance, first aid, and safeguarding. Staff also had access to additional training related to their role. We spoke with staff who demonstrated that they had the knowledge and skills required to carry out their role.

All staff confirmed that they received annual appraisal. We saw records of completed schedules of appraisal and supervision which confirmed that staff were well supported in their role. This included regular conversations about their role with their line manager and clinical supervisor as appropriate.

There was a record of all training undertaken by clinical and administration staff in their personal files to confirm that they had the right skills to carry out their work. We saw that professional registration checks were carried out for GPs, nurses and other clinical staff. The administration manager showed us the process for checking registration with the appropriate professional body. We checked and saw that this all clinical staff were appropriately registered. The GPs told us they received regular appraisals and routinely accessed clinical supervision.

Good

Are services effective?

(for example, treatment is effective)

Working with colleagues and other services

The practice had a system in place for dealing with test results and discharge letters from other health care providers. Staff told us that these were dealt with on a daily basis and allocated to individual patient lists according to specialist interest to provide continuity and ensure the best use of clinical expertise. Out of hours communication was dealt with by a specific GP.

We spoke with GPs and nursing staff who demonstrated that communication and work with other agencies took place on a regular basis. We saw evidence of a variety of meetings involving other services for example, health visitors and midwives. The lead GP met with the mental health consultant regularly to discuss and review patient care. The practice had links with the Crime Reduction Initiative whose staff attended the surgery to support patients with drug and alcohol problems. Monthly multi agency partnership meetings took place with the partners of Oasis House, a centre which provides help and support to homeless, vulnerable people. There was evidence of co-ordinated integrated pathways, for example shared care of patients who misuse substances.

Health Promotion & Prevention

The practice offered new patient health checks with the health care assistant. Any patients who required a medical consultation following this were booked in to see a GP. The practice offered child health medical examinations and immunisations in line with the national programme.

The practice had a register of patient with learning disabilities. Last year due to an organisational issue only just over 50% of patients received health checks. However, the practice have rectified this and identified a staff member to manage the register of patients with learning disabilities. They had reorganised the call and recall schedule and were proactively calling patients for health checks to ensure a higher achievement this year.

We spoke with the practice nurse who demonstrated knowledge of and a commitment to health promotion and we saw range of health promotion literature that they provided for patients. A health visitor attended the practice weekly and midwife three times a week to offer care, advice and support to women during pregnancy and health and development advice to new mothers and their babies. Immunisation was offered and given by the practice nurse.

There was a university residence recently erected nearby and the practice had attended during 'fresher's' week and provided information and forms to help new students register for health care. During our inspection we spoke with students at the practice who confirmed they had received information and application forms to register at a 'Fresher's' week at the university which had assisted them in seeking health advice.

The practice nurse we spoke with had received training in sexual health and provided advice and information regarding contraceptive products to young people who required them. The nurse told us that there was a high teenage pregnancy rate in the area therefore sexual health advice was an important part of their role. The practice also offered chlamydia screening and cervical screening in line with the national screening programme.

The practice kept a register of patients who were identified as being at high risk of admission to hospital and those needing end of life care. They were participating in the enhanced service for unscheduled care and work was on-going to complete care plans for all of those patients.

The practice had systems in place to manage patients' long-term conditions and employed a nurse with a special interest in diabetes who was responsible for those patients. The nurse told us that they liaised with the outreach nurse to ensure a co-ordinated approach to care.

All patients over the age of 75 had a named GP as well as those patients who were vulnerable. We saw evidence of multidisciplinary case management meetings for these patients and communication with other agencies.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

During our inspection we spoke with patients and also observed how they were treated. Patients we spoke with expressed that they were satisfied with the care they received at the practice. Some patients expressed that they waited for long periods of time in the waiting room, but told us they were aware that the GPs would never rush patients during their consultation.

Staff we spoke with were aware of the importance of caring for patients with respect, dignity and compassion. We noted that there was no area in the reception where patients could talk in confidence. The staff told us that if patients wished to discuss something with them away from the reception area then they would offer them a private consulting room. Patients we spoke with confirmed that this had been offered to them. Staff demonstrated a clear understanding of the practice population and the problems they encountered on a daily basis. We observed that they treated people with respect and ensured conversations were conducted in a confidential manner. For example, we observed how a receptionist dealt sensitively and efficiently with an anxious patient arriving without an appointment who needed to see a doctor urgently.

Consultations took place in the privacy of a consultation room. The consultation room doors were routinely locked when patients were being seen. The practice offered patients a chaperone prior to any intimate examination or procedure. Information about having a chaperone was displayed in the waiting area so patients were made aware of this facility. Staff we spoke with were knowledgeable about the role of the chaperone but had not received training to carry out this work. Reception staff explained that it was very rare when they would be asked to be a chaperone as in most instances a qualified nurse would perform this role.

The practice operated a walk in as well as an appointment system to see a GP. Reception staff explained that this system worked well with most patients seeing their preferred GP for routine appointments and seeing other available GPs for urgent appointments. We saw that there were appointments available with a female GP on three days a week for people who had a preference.

We saw that the practice had reported a significant event regarding an issue of confidentiality when information was texted to a person who had previously had parental responsibility. As the patient had reached 17 years of age, the contact details had not been changed and the information was sent to the incorrect person. They identified that when a child reached the age of 17 years then the practice should have a process for alerting staff to review contact details in their records to prevent information being texted to parents who had previously been the point of contact. The practice should ensure that this is written into a procedure to prevent an accidental breach of confidentiality.

Involvement in decisions and consent

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

The practice had a high proportion of patients for whom English was not their first language and staff told us that translation services were available for patients which were used on a daily basis. We saw that the practice had a system in place for arranging translators in a variety of languages and noted that this was in daily use. The reception staff worked with clinicians to coordinate an interpreter for a time which was appropriate to meet the patients' health needs and also ensured a double appointment time was booked to allow for any delay in understanding to be addressed. The practice also had access to a British Sign Language interpreter for patients who were deaf, as well as an induction hearing loop to assist those patients with hearing difficulties.

We spoke with GPs and nurses who were aware of the Mental Capacity Act 2005 and the need to ensure patients understanding of procedures and treatment offered. They had the contact details of the Advocacy Service and gave examples of involving other professionals such as a psychiatrist where necessary to help patients understand their conditions and treatment.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

During our inspection we found the practice, in addition to routine primary medical services, had a specific focus addressing the needs of patients experiencing difficulties in their lives as a result of mental health problems, homelessness and drug and alcohol misuse and associated issues. The practice had identified needs through partnership working and developed plans to support funding to appropriately respond to the needs of vulnerable groups. The service was responsive to people's needs and had sustainable systems in place to maintain the level of service provided.

The needs of the practice population were understood and systems were in place to address identified needs following access to public health data, contact with the population and other partners. The practice told us that they engaged regularly with the NHS England Local Area Team (LAT) and Clinical Commissioning group (CCG) to discuss local needs and service improvements that need to be prioritised. We saw minutes of the practice medical, general clinical and maternal and child health meeting meetings where the practice had discussed and agreed actions to implement service improvements.

We saw that the practice had developed a strategy for personality disorder, setting out an approach and agreed treatment. They had also set up drop-in clinics for patients in crisis. We found from discussions with clinicians and reception staff that longer appointments were made available for patients with mental health problems or issues which required more in depth consultation. The practice had also organised transport on occasions for patients in crisis who were unable to get to the surgery.

There was a system in place whereby vulnerable patients who did not attend for appointment were contacted by telephone, however, this was the decision of the clinician who may have known the patient. Follow up appointments were offered only two days in advance as feedback from patients who had not attended for appointment confirmed that they often forgot if the appointment was booked too far in advance.

We saw that the practice had a palliative care register and saw evidence of weekly clinical meetings. The Macmillan nurses did not attend these meetings and the practice told us that they would contact them if there are any specific issues which needed to be discussed.

The practice worked collaboratively with other agencies, regularly updated and shared information to ensure good, timely communication of changes in care and treatment. We saw evidence of this in minutes of team meetings where health visitors, midwives and district nurses had attended and shared information.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, they attended the local homeless centre and provided consultations there for vulnerable groups such as the homeless, sex workers, people with mental health problems and alcohol and drug misuse. They also provided a substance misuse drop-in service daily at the main surgery. The practice hosted sessions from the Well Being Team from the local NHS Trust which offered psychological counselling and cognitive behavioural therapy two days per week for patients needing additional support or treatment.

The reception staff were knowledgeable regarding the difficulties experienced by some groups of patients who attended the practice. They told us that they had received training in dealing with difficult and aggressive people. They also expressed a commitment to ensure that all patients were treated equally regardless of their health or social circumstances. We saw evidence of this during our inspection. Access to translators was readily available and we saw the record of requests which confirmed that translators were requested on a daily basis to facilitate communication for those patients whose first language was not English. The practice also offered text message appointment booking for patients who were deaf.

Consulting rooms were situated on the ground floor and first floor of the building and lift access was provided to the first floor. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Toilet facilities were available for all patients of the practice.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

The practice had a population which included approximately 38% eastern European, 22% British, 18% Black ethnicities, with 3% homeless and travellers, 11% Asian and dual parentage and the majority of the remainder were from various categories. The practice had a special interest in mental health problems and drug and alcohol misuse and therefore offered a more specialised service tailored to the needs of the practice population. The interpreting service was in use most days and staff told us that double appointment slots were booked for patients requiring an interpreter to allow sufficient time to communicate their needs.

Appointments were available in a variety of formats including pre-bookable appointments, a telephone triage system and a daily 'duty doctor' system. These ensured patients were able to access healthcare when they needed to. In addition to this, the practice held a drop in session daily between 1pm and 3pm for patients who have mental health problems and needed urgent help. This was staffed by a mental health nurse who was also a nurse prescriber and therefore able to deal with prescription issues. The practice staff told us that GP time was staggered throughout the day to ensure there was always a GP available if needed. There was also a practice nurse trained in minor illness to provide access for patients with less serious issues.

Patients we spoke with were happy with the appointment system. All patients expressed that they were able to get appointments without difficulty. Some patients we spoke with told us that they had attended the drop in session when they had an issue with their prescription. The practice offered appointments daily from 8.30am until 12.30pm and 1.30pm until 6.30pm with the exception of Wednesday when appointments were offered until 7.45pm.

The appointment times were available on the practice website and included in the practice leaflet which was made available to us.

The practice website outlined how patients could book appointments and organise repeat prescriptions online. Patients could also make appointments by telephone and in person to ensure they were able to access the practice at times and in ways that were convenient to them.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. This was provided by an out-of hours service. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. We saw that information on how to complain was displayed in the reception and patient waiting areas. A review of the complaints records covering the last year was made available to us. We saw that the practice had contacted the complainants within the time frame specified in their policy and provided a timely response.

A process was in place to analyse each complaint to determine if themes were emerging or identify trends in complaint rates or topics. From the information we looked at no themes were evident but we saw that the staff proactively looked for lessons that could be learnt. The analysis for the last year identified the key learning point from each complaint investigation. Records we saw showed that these were discussed at staff meetings to ensure that all staff were aware of the outcomes.

Are services well-led?

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

Our findings

Vision and Strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients specifically those who were most vulnerable and socially excluded and who may have had difficulty accessing health services. We found the vision and practice values were clearly set out in their statement of purpose and were included in the practice leaflet showing what patients could expect and also what the practice expected from patients. The practice vision and values included examples such as:

- A friendly unbiased approach
- Time to talk and a willingness to listen
- Treatment for all medical and most psychological and substance misuse problems
- Advocacy and advice

We spoke with eight members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. However, the practice was adopting templates which needed personalising to the practice and had not yet all been completed. For example, the child and adult safeguarding policy. Staff were clear about their responsibilities and demonstrated appropriate actions but the policy was not in place to show this. The practice acknowledged that this needed to be completed and were in the process of updating and making all policies more specific. We saw that there were lead roles for each area and that work was ongoing. Policies that had been completed contained front sheet indicating when they had been approved by the clinicians and review dates.

The practice held weekly meetings and governance was included in all meetings. We looked at minutes from the five meetings and found that various aspects of performance, quality and risks had been discussed.

There was a risk management lead who was responsible to ensuring internal training in managing violent or aggressive patients. Staff told us that the risk management lead carried out a formal risk assessment on all patients who had demonstrated violent and aggressive behaviour and completed an action plan regarding how to manage the patient. Reception and clinical staff confirmed that this was shared with staff. We saw a risk management plan on the system showing who was at risk and how patients were to be managed. Staff confirmed that they had received training on how to deal with difficult and aggressive patients.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing below national standards and the CCG standards in some areas, such as hypertension and epilepsy . This was partially explained as being due to the problems encountered by patients often in crisis with a tendency to not attend for appointments when called for routine health checks. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to improve outcomes.

The practice had completed a number of clinical audits, for example Simvastatin medication prescribing and interactions. The practice carried out an audit of patients on this medication and made changes in prescribing as a result. However, audits contained only one cycle and required revisiting to ensure that improvement had been sustained. There was also no evidence of audit for complications of minor surgery, insertion of implants and coils. This is an area that the practice should ensure takes place.

Leadership, openness and transparency

We were shown a leadership structure which had named members of staff in lead roles. For example, there was a lead for health and safety and the senior partner was the lead for safeguarding. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

We saw from minutes that team meetings were held weekly but that not all staff attended weekly. Staff told us that on occasions one member of the team would attend and feedback. 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. We also noted that team away days and protected learning sessions took

Are services well-led?

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

place, which staff confirmed they found useful and a good opportunity to share experiences and develop ideas for the future of the practice. Staff reported that they felt their views were heard and taken account of by senior clinicians.

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

The practice had gathered feedback from patients through NHS Choices and complaints. They had experienced difficulty in establishing a patient participation group due to the nature of the practice population. However, the practice had a system on their website which allowed patients to submit their views and suggestions regarding the service. We saw that feedback from patients on NHS Choices was on the whole positive with patients expressing satisfaction with the service. However, there were also some negative patient comments which we saw had been responded to.

We looked at the results of the annual patient survey and found that 89.1% of patients reported that they were able to get an appointment without difficulty. The practice administrator told us that the practice had changed their telephone system in response to feedback from patients experiencing difficulty in getting through on the telephone. We saw the practice had introduced a telephone system and two call handlers to deal with appointments which allowed the receptionist to deal with patients in person who arrived at the reception desk.

The practice intended to continue to encourage feedback by email via the practice website and also sought the views of patients who attended Oasis House. The practice administrator collated comments and complaints from patients in a year end report and provided feedback to patients who attended Oasis House. We saw evidence that complaints and suggestions were included in minutes of meetings throughout the year.

The practice had gathered feedback from staff through protected learning sessions and generally through staff meetings, appraisals and discussions. Staff told us they were encouraged to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged with the practice to improve outcomes for both staff and patients. They told that they attended whole team training where ideas were shared to achieve the vision of the practice.

The practice had a whistle blowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at two staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.

The practice had completed reviews of significant events and other incidents and shared with staff via meetings to ensure the practice improved outcomes for patients. The practice also had a system in place for managing poor performance. They provided us with an example of where additional support and guidance had been offered and produced a positive outcome and improved performance of a staff member in the past.