Haughton Thornley Medical Centres

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Thornley House Medical Centre on 28 April 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring, responsive and safe services. It was also good for providing services for the populations groups we rate.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand, however there was no evidence of the system being put into practice.
- Patients provided varied feedback on accessing appointment, with a number of patients reporting difficulties getting through to the practice by telephone, however patients reported when they got appointments these were convenient.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management.

We saw several areas of outstanding practice including:

- The practice offered patients direct electronic access to their health records enabling them to routinely read

Summary of findings

their own health records by logging on to an electronic system from home with a user name and password. To date 35% of patient have signed up to allow them access to their records.
- One GP provided dry needling a treatment similar to acupuncture for patients during consultations to provide pain relief and assist injury rehabilitation where required as an alternative or in addition to medication.

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

Importantly the provider should

- Ensure recruitment checks are carried out in line with practice policy.
- Ensure all staff have access to appraisals on an annual basis.
- Ensure data sheets and risk assessments are carried out for Control of Substances Hazardous to Health (COSHH).
- Ensure checks are recorded for the cleaning of clinical equipment.

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 via team meetings to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. 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 the same 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. Staff had received training appropriate to their roles and any further training and updates had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for clinical staff however appraisals were out of date for non clinical staff. Staff worked with multidisciplinary teams.

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?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS England Area Teams and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice with urgent appointments available the same day. 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.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had clear aims to deliver good outcomes for patients. Staff were clear about

Summary of findings

the aims and their responsibilities in relation to the practice. There was a clear leadership and staff felt supported by management. The practice had a number of policies and procedures to govern activity. There were systems in place to monitor and identify risk. The practice sought feedback from staff and patients and this had been acted upon. Staff had received inductions, regular performance reviews and attended staff meetings.

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 population group of older people. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example in dementia, shingles vaccinations and end of life care. The care for patients at the end of life was in line with the Gold Standard Framework.

The practice was responsive to the needs of older people, the GPs and nurses provided home visits and appointments for those in residential or nursing homes, with rapid access appointments for those with enhanced needs.

Working with other practices in the locality and New Charter Housing the practice have access to a full time Healthy Living Project Link worker for patients over 75, patients can be referred to the project where assessment take place to look at medical, social and psychological problems. Initial outcomes for patients have included many patients discovering local groups, and support with amenities such as telephones.

The practice had achieved 76% vaccination rate for the influenza vaccine for those over 65, just above the local average.

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. The practice has an electronic register of patients with long term conditions and has a recall system in place to ensure patients are called for a review annually so their condition could be monitored and reviewed.

The national Quality Outcome Framework (QOF) 2013/14 showed 100% of the outcomes had been achieved for patients with asthma and for patients with Chronic obstructive pulmonary disease (COPD) above the local CCG and national average.

For those people with the most complex needs GPs worked with relevant health and social care professionals to deliver a multidisciplinary package of care.

Summary of findings

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 vulnerable families and who were at risk.

Immunisation rates were high for all standard childhood immunisations.

Appointments were available outside of school hours for children and all of the staff were responsive to parents' concerns and would ensure parents could have same day appointments or telephone consultations for children who were unwell.

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 practice offered online services as well as a full range of health promotion and screening which reflects the needs for this age group. Patients were provided with a range of healthy lifestyle support including smoking cessation. The practice offered NHS health checks to patients including elderly health checks to patients who are 60 plus and not reached the age of 75. Appointments could be booked online in advance and a text message reminder system was in place to remind patients of pre booked appointments.

The practice provided contraception and sexual health service for patients and actively referred patients to specialist service such as genital-urinary medicine (GUM).

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice had carried out annual health checks for people with learning disabilities and offered longer appointments for people where required. For patients where English was their second language, an interpreter could be arranged.

The practice worked with multi-disciplinary teams in the case management of vulnerable people.

Staff knew how to recognise signs of abuse in vulnerable adults and children.

Summary of findings

What people who use the service say

During our inspection we spoke with 14 patients. We reviewed 37 CQC comment cards which patients had completed leading up to the inspection.

The comments were positive about the care and treatment people received. Patients told us they were treated with dignity and respect and involved in making decisions about their treatment options.

Feedback included individual praise of staff for their care and kindness and going the extra mile. We reviewed the results of the GP national survey carried out in 2013/14 and noted 81% described their overall experience of this surgery as good and 90% had confidence and trust in the last GP they saw or spoke to.

Areas for improvement

Action the service SHOULD take to improve

We looked at the recruitment and personnel records of six staff, including those recently recruited. We saw in some records check of the person's skills and experience through their application form, personal references, identification, criminal record and general health had been carried out, however there were gaps in some records including those recently recruited for example two employment references.

We saw that data sheets and risk assessments were not in place for Control of Substances Hazardous to Health (COSHH)

Clinical equipment was routinely cleaned and checked by health care assistants; however there was no schedule in place or records of the cleaning and checks taking place.

The practice had an appraisal system in place for all staff; however appraisals were not up to date for non-clinical staff.

Outstanding practice

One GP provided dry needling a treatment similar to acupuncture for patients during consultations to provide pain relief and assist injury rehabilitation where required as an alternative or in addition to medication.

The practice offered patients direct electronic access to their health records enabling them to routinely read their own health records by logging on to an electronic system from home with a user name and password. To date 35% of patient have signed up to allow them access to their records.

Haughton Thornley Medical Centres

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 specialist advisor, practice manager, practice nurse and an expert by experience. Experts by Experience are members of the public who have direct experience of using services.

Background to Haughton Thornley Medical Centres

Thornley House Medical Centre provides primary medical services in Hyde from Monday to Friday. The practice is open between 8.30am – 6.00pm Monday, Thursday and Friday. The practice have extended hours 8:30am – 8:30pm on Tuesdays and 7:00am – 6:00pm Wednesdays.

Thornley House Medical Centre is situated within the geographical area of NHS Tameside and Glossop Clinical Commissioning Group (CCG).

The practice has a GMS contract. The General Medical Services (GMS) contract is the contract between general practices and NHS England for delivering primary care services to local communities.

Thornley House Medical Centre is responsible for providing care to 6310 patients of whom, 50% were male and 50% were female. Patients are from the third most deprived decile with 9.74% black and minority ethnic (BME) patients.

The practice consists of four GPs, two female and two male, practice nurses and health care assistants. The practice was supported by a practice manager, deputy manager, receptionists and secretaries.

When the practice is closed patients were directed to the out of hours service.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information about the practice. We asked the practice to give us information in advance of the site visit and asked other organisations to share their information about the service.

We carried out an announced visit on the 28 April 2015. We reviewed information provided on the day by the practice and observed how patients were being cared for.

Detailed findings

We spoke with 14 patients and 10 members of staff. We spoke with a range of staff, including the GPs, practice manager, practice nurses, health care assistants and reception staff.

We reviewed 37 Care Quality Commission comment cards where patients and members of the public had shared their views and experiences of the service.

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

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

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

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

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as 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. For example the practice manager had formalised the system for reporting significant events.

We reviewed safety records, incident reports and minutes of meetings and spoke with staff which confirmed incidents were routinely discussed. This showed the practice had managed these consistently over time and demonstrated a safe track record over the long term.

We saw staff had access to multiple sources of information to enable them to maintain patient safety and keep up to date with best practice.

The practice investigated complaints and responded to patient feedback in order to maintain safe patient care.

The practice had systems in place to maintain safe patient care of those patients over 75 years of age, with long term health conditions, learning disabilities and those with poor mental health. The practice maintained a register of patients with additional needs and or were vulnerable and closely monitored the needs of these patients, including regular contact with other health and social care professionals where required. We saw a system was in place to ensure reviews took place in a timely manner for patients who required annual reviews as part of their care;

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording significant events, We saw from the practice significant events records, minutes of meetings and speaking with staff investigations had been carried. All staff told us the practice was open and willing to learn when things went wrong.

Staff told us they received updates relating to safety alerts they needed to be aware of via meetings and emails. The nurses told us they received regular updates as part of their ongoing training, and self-directed learning and attending Clinical Commissioning group (CCG) led monthly learning events.

Reliable safety systems and processes including safeguarding

The staff we spoke with were able to tell us how they would respond if they believed a patient or member of the public were at risk. Staff explained to us where they had concerns they would seek guidance from the safeguarding lead or seek support from a colleague as soon as possible.

We saw the practice had in place a detailed child protection and vulnerable adult's policy and procedure. Where concerns already existed about a family, child or vulnerable adult, alerts were placed on patient records to ensure information was shared between staff to ensure continuity of care.

We spoke with the GP who was the safeguarding lead; they had completed training to level 3 in child protection. We were provided with examples of staff being the first to alert the relevant agencies of concerns about a child or vulnerable adult, notes were placed on patient's records and meetings were held with the local authority safeguarding team, health visitors, district nurses and school nurses where appropriate.

The practice linked with the local authority, health visitors and district nurses to monitor vulnerable patients and attended where possible multi agency case conferences. Speaking with staff at the practice they were knowledgeable about the contribution the practice could make to safeguarding patients. We were provided with examples of where staff had been proactive in safeguarding patients and worked alongside health visitors and social workers. We noted staff were vigilant of patients who may be at risk of domestic violence, and where it was known a patient was a victim of domestic violence alerts were placed within patient's records.

A chaperone policy was in place, Speaking with staff who acted as chaperones, they were clear of the role and responsibilities.

Medicines Management

The practice held medicines on site for use in an emergency or for administration during consultations such as administration of vaccinations.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses had received appropriate training to administer vaccines. Nursing staff

were qualified as independent prescribers and received regular supervision and support in their role as well as updates in the specific clinical areas of expertise for which they prescribed.

We saw emergency medicines were checked to ensure they were in date and safe to use. We checked a sample of medicines and found these were in date, stored safely and where required, were refrigerated. Medicine fridge temperatures were checked and recorded to ensure the medicines were being kept at the correct temperature. We noted records for one fridge showed the fridge had been outside the required temperature range, we raised this with the practice manager who acted on the information on the day of our inspection and confirmed this had been a recording error, following checks on the refrigerator and speaking with the CCG medicines management team.

We saw an up to date policy and procedure was in place for repeat prescribing and medicine review. The practice worked alongside the CCG medicines management team who visited the practice to look at prescribing within the practice and audit medicines such as antibiotics and Benzodiazepines to support the practice in ensuring they are following up to date prescribing guidance.

The practice had shared care protocols in place for patients prescribed Disease-modifying Anti-Rheumatic drugs (DMARDs) normally prescribed for rheumatoid arthritis. For those patients prescribed warfarin the practice had an INR machine on site to allow them to manage in house warfarin dosage. The INR machine monitors how quickly blood clots using a measure known as the international normalised ratio (INR). The INR enables the dose of anticoagulant to be adjusted if required. This in turn can help prevent major bleeding, heart attack or stroke that can result from an over- or under-dose of anticoagulant.

Speaking with reception staff they explained to us the system in place to ensure where changes to prescriptions had been requested by other health professionals such as NHS consultants and/or

following hospital discharge, the changes were reviewed by the GP daily and the changes implemented in a timely manner. We were shown the safety checks carried out prior to repeat prescriptions being issued and where there were any queries or concerns these were flagged with the GP before any repeat prescriptions were authorised.

The practice maintained a register to track prescriptions received and distributed. This was kept separate from the prescription pads which were securely locked away. Prescription pads held by the GP were locked away. A nominated member of staff was responsible for prescription ordering and management of prescriptions.

We saw prescriptions for collection were stored behind the reception desk, out of reach of a patient. Reception staff we spoke with were aware of the necessary checks required when giving out prescriptions to patients who attended the practice to collect them, i.e. date of birth, address of patient.

Cleanliness & Infection Control

The practice was seen to be clean and tidy. A GP took the lead for infection control completing regular update training. The practice carried out annual infection control audits including hand washing. We saw from the audit carried out in April 2015 a compliance of 94% which meant they were complying with best practice. We saw recommendations in place to improve in areas such as wall mounting sharps bins and completing COSHH Data sheets which were not available.

Cleaners were employed by the practice who attended every day. There was a cleaning schedule in place to make sure each area was thoroughly cleaned on a regular basis. We looked in several consulting rooms. All the rooms had hand wash facilities and work surfaces which were free of damage, enabling them to be cleaned thoroughly.

We saw in the majority of rooms dignity curtains were disposable and were clearly labelled as to when they required replacing. The rooms with fabric curtains were in the process of being replaced with disposable curtains.

All the patients we spoke with were happy with the level of cleanliness within the practice.

We saw up to date policies and procedures were in place. The policy included protocols for the safe storage and handling of specimens and for the safe storage of vaccines. These provided staff with clear guidance for sharps, needle stick and splashing incidents which were in line with current best practice.

Good

Are services safe?

All staff we spoke with were clear about their roles and responsibilities for maintaining a clean and safe environment, however only the infection control lead had completed training. We saw rooms were well stocked with gloves, aprons, alcohol gel, and hand washing facilities.

The practice only used single patient use instruments, we saw these were stored correctly and stock rotation was in place.

Clinical equipment was routinely cleaned and checked by health care assistants; however there was no schedule in place or records of the cleaning and checks taking place.

Equipment

The practice manager ensured all equipment was effectively maintained in line with manufacture guidance and calibrated where required. We saw maintenance contracts were in place for all equipment.

All staff we spoke with told us they had access to the necessary equipment and were skilled in its use.

Checks were carried out on portable electrical equipment in line with legal requirements.

The computers in the reception and consulting rooms had a panic alert system for staff to call for assistance.

Staffing & Recruitment

There were formal processes in place for the recruitment of staff to check their suitability and character for

employment. The practice had a recruitment policy in place which was up-to-date. We looked at the recruitment and personnel records of six staff, including those recently recruited. We saw in records checks of the person's skills and experience through their application form, personal references, identification, criminal record and general health had been carried out, however there were gaps in some records including those recently recruited for example two employment references. We raised this with the practice manager who told us the newly appointed deputy manager was appointed with HR experience to enable them to improve and comply with recruitment regulations. We were satisfied that Disclosure and Barring Service (DBS) checks had been carried out appropriately for all clinical staff to ensure patients were protected from the risk of unsuitable staff.

Where relevant, the practice also made checks that members of staff were registered with their professional body and on the GP performer's list. This helped to evidence that staff met the requirements of their professional bodies and had the right to practice.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. The practice had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

The practice manager had responsibility for all maintenance contracts and risk management associated with the building. We saw that data sheets were not in place for Control of Substances Hazardous to Health (COSHH), we raised this with the practice manager who told us they would address this immediately following our inspection.

The practice manager had clear staffing levels identified and procedures in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness; this was recorded within the business continuity plan. Staff told us they worked together to manage staff shortages and plan annual leave so as not to leave the practice short of staff.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. 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. 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.

We saw emergency procedures for staff to follow if a patient informed staff face to face or over the telephone if they

Good

Are services safe?

were experiencing chest pains, this included guidance form the Resuscitation Council and calling 999 for patients where required. Staff were able to clearly describe to us how they would respond in an emergency situation.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of the building management, CCG and associated health and social care professionals.

Records showed that staff were up to date with fire training and regular fire drills were carried out.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that they completed thorough assessments of patients' needs in line with NICE guidelines.

Nurses we spoke with explained how they reviewed patients with chronic diseases such as asthma on an annual basis. The national Quality Outcome Framework (QOF) 2013/14 showed, all clinical and public health outcomes had been achieved above the local CCG and national average. For example 100% of outcomes for patients with asthma or Chronic obstructive pulmonary disease (COPD) had been achieved.

We saw the practice maintained a register of patients with a learning disability to help ensure they received the required health checks and annual reviews; patients had a named GP and reviews were carried out by named GPs to ensure continuity of care and build a relationship with patients and carers. For patients with learning disabilities or poor mental health again the practice had achieved 100% of outcomes significantly higher than the local or national averages.

A named GP carried out annual physical health reviews for patients diagnosed with mental health needs including those with schizophrenia, bi-polar and psychosis as a way of monitoring their physical health and providing health improvement guidance. The QOF 2013/14 provided evidence the practice were responding to the needs of people with poor mental health, above the average of the local CCG, by ensuring for example they had a comprehensive care plan documented in the record and patients had access to health checks as required such as, a record of alcohol consumption and body mass index (BMI) in the preceding 12 months.

We saw from QOF that 100% of child development checks were offered at intervals that were consistent with national guidelines and policy.

We saw from information available to staff and by speaking with staff, that care and treatment was delivered in line with recognised best practice standards and guidelines. Staff told us they received updates relating to best practice or safety alerts they needed to be aware of via emails and the nurses told us they received regular updates as part of their ongoing training and attending monthly practice nurse forums whenever possible.

Clinical staff were able to clearly describe to us how they assessed patient's capacity to consent in line with the Mental Capacity Act 2005.

The practice worked within the Gold Standard Framework for end of life care, where they held a register of patients requiring palliative care. A pathway was in place to enable appropriate referrals and support packages for patients at the end stages of life. Multi-disciplinary palliative care review meetings were held quarterly and minuted with other health and social care providers. Individual cases were discussed regularly between clinical staff to ensure patients and relatives needs were reviewed on a regular

basis to meet patient's physical and emotional needs and ensured that whenever possible patients die in the place of their choosing. The practice used statements of intent to avoid unnecessary involvement of police and coroners at the end of a patient's life. The practice had systems in place to follow in the event of patient death including informing hospitals and pharmacies to avoid unnecessary communication.

We were told for patients where English was their second language an interpreter could be booked in advance. This was in line with good practice to ensure people were able to understand treatment options available.

Management, monitoring and improving outcomes for people

Speaking with clinical staff, we were told assessments of care and treatment were in place and support provided to enable people to self-manage their condition, such as diabetes or Chronic Obstructive Pulmonary Disease (COPD). Assessments were carried out for patients with COPD and where required seasonal adjustments were made which included prescribing rescue medication to help when a patients was experiencing exacerbation.

Good

Are services effective?

(for example, treatment is effective)

In order to prevent multiple surgery attendances, the practice offered patients with multiple medical conditions up to hour long appointments with a nurse. The practice requested relevant blood tests were performed in advance to ensure all clinical information was available to complete reviews. The multi reviews were also provided for housebound patients within their own home.

One GP provided dry needling a treatment similar to acupuncture for patients during consultations to provide pain relief and assist injury rehabilitation where required as an alternative or in addition to medication.

A range of patient information was available for staff to give out to patients which helped them understand their conditions and treatments. The practice nurse provided a range of examples of patient information leaflets they provided to patient to self manage conditions such as COPD and Asthma.

Staff said they could openly raise and share concerns about patients with colleagues to enable them to improve patient's outcomes.

The practice showed us how they monitored patient data which included full clinical audits taking place which demonstrated changes to patient outcomes. Clinical Audit is a process or cycle of events that help ensure patients receive the right care and the right treatment. We were shown two audits including one for contraindications to oral contraception.

The practice used the information they collected for the Quality and Outcomes framework (QOF) and their performance against national screening programmes to monitor outcomes for patients. QOF was used to monitor the quality of services provided. The QOF report from 2013-2014 showed the practice was supporting patients with long term health conditions such as, asthma and for patients with Chronic obstructive pulmonary disease (COPD) above the local CCG and national average.

The practice was also ensuring childhood immunisations were being taken up by parents. NHS England figures showed in 2013, 94% of children at 24 months had received the measles, mumps and rubella (MMR) vaccination.

Information from the QOF 2013-2014 indicated the practice had maintained a high level of achievement with 100% of outcomes achieved above the local CCG and national average.

Patients told us they were happy the doctor and nurses at the practice managed their conditions well and if changes were needed they were fully discussed with them before being made.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw evidence staff had attended mandatory courses such as annual basic life support. We noted a good skill mix among the doctors and nurses with a number having additional training and qualifications. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practice and remain on the performers list with NHS England).

Speaking with staff and reviewing training records we saw all staff were appropriately qualified and competent to carry out their roles safely and effectively.

The practice had an appraisal system in place for all staff; however appraisals were not up to date for non-clinical staff. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. As the practice was a training practice and supported doctors who were training to be GPs they offered extended appointments to patients and had access to a senior GP throughout the day for support.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and treating minor ailments. The nurse practitioner had an extended role to see and treat patients with minor ailments and was able to prescribe a range of medicines including antibiotics. Speaking with the nurse practitioner and looking at training records we saw that they had appropriate training to fulfil the enhanced roles.

All staff we spoke with told us they were happy with the support they received from the practice. Staff told us they were able to access training and received updates. We saw

Good

Are services effective?

(for example, treatment is effective)

the GPs and nurse had access to training as part of their professional development, attending training and monthly CCG education events in which updates on key issues were provided.

Working with colleagues and other services

We found staff at the practice worked closely as a team. The practice worked with other agencies and professionals to support continuity of care for patients and ensure care plans were in place for the most vulnerable patients. Mutli-disciplinary meetings were arranged with other health and social care providers where required and communication took place on a daily basis with community midwives, health visitors and district nurses by telephone and fax. The practice worked closely with the community long term condition teams in managing the care and treatment for patients who were housebound or too ill to visit the surgery. The practice also had a by-pass telephone number which was used by district nurses, care homes, Macmillan nurses to enable them to contact the practice without having to use the main telephone number.

The practice worked with other service providers to meet patient's needs and manage 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 and the 111 service both electronically and by post. The GPs took the lead responsibility for reading and acting on any issues arising from communications with other care providers on the day they were received and disseminating to appropriate staff for action such as reception staff to arrange appointments or home visits. All staff we spoke with understood their roles and felt the system in place worked well.

Working with other practices in the locality and New Charter Housing the practice have access to a full time Healthy Living Project Link worker for patients over 75, patients can be referred to the project where assessment take place to look at medical, social and psychological problems. Initial outcomes for patients have included many patients discovering local groups, and support with amenities such as telephones.

A substance misuse worker from the community Drug and Alcohol team provided weekly clinics at the practice for patients, working closely with GPs to monitor the health and social needs of patients.

One GP worked closely with the local community mental health team in a liaison role between community, secondary care and GP's in developing the services locally.

Information Sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. The practice sent referrals directly to a central referral unit and those referrals such as two week wait referrals were sent electronically.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system 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.

The GPs described how the practice provided the 'out of hours' service with information, to support, for example 'end of life care.' Information received from other agencies, for example accident and emergency or hospital outpatient departments were seen and actioned by the GP on the same day. Information was scanned onto electronic patient records in a timely manner.

The practice worked within the Gold Standard Framework for end of life care (EoLC), where they provided a summary care record and EoLC which was shared with local care services and out of hour providers.

For the most vulnerable of patients at risk of unplanned hospital admissions such as those over 75 years of age, and patients with long term health conditions, information was shared routinely with other health and social care providers to monitor patient welfare and provide the best outcomes for patients and their family.

Consent to care and treatment

A policy and procedure was in place for staff in relation to consent. The policy incorporated implied consent, how to obtain consent, consent from under 16's and consent for immunisations.

We found that staff were aware of the Mental Capacity Act 2005, the Childrens' Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood

Good

Are services effective?

(for example, treatment is effective)

the key parts of the legislation and were able to describe how they implemented it in their practice, this included best interest decisions and do not attempt resuscitation requests (DNACPR). There were policies and procedure in place for staff to refer with regard to the Mental capacity Act 2005 (MCA). Staff told us where they had concerns about a patient's capacity; they would refer patients to the GP. The GPs had received training on the Mental Health Act and Mental Capacity Act, speaking with GPs they told us issues associated with Deprivation of Liberty safeguards (DOLs) were becoming increasingly prevalent and an education session had been planned for May 2015 to address this.

All staff we spoke with made reference to Gillick competency when assessing whether young people under sixteen were mature enough to make decisions without parental consent for their care. Gillick competency allows professionals to demonstrate they have checked the person understands of the proposed treatment and consequences of agreeing or disagreeing with the treatment. The practice had a Gillick competencies checklist for staff to refer to if they were unsure about the process to follow. Speaking with the practice nurses they routinely saw young people unaccompanied and used the Gillick competency to assess their understanding. Where capacity to consent was unclear they would seek guidance prior to providing any care or treatment.

Health Promotion & Prevention

New patients looking to register with the practice were able to find details of how to register on the practice website or by asking at reception. New patients were provided with an appointment for a health check.

The practice had a range of written information for patients in the waiting area and corridors including information they could take away on a range of health related issues, local services health promotion and support for carers.

We were provided with details of how staff promoted healthy lifestyles during consultations. The clinical system had built in prompts for clinicians to alert them when consulting with patients who smoked or had weight management needs. We were told health promotion formed a key part of patients' annual reviews and health checks.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed 65% of patients eligible to health checks took up the offer. The practice followed the guidance from the local CCG to ensure patients followed in a timely manner if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The nurses provided lifestyle advice to patients this included, dietary advice for raised cholesterol, alcohol screening and advice, weight management and smoking cessation. A member of the team from the Local Authority Healthy living project was based at the practice providing health lifestyle programmes for patients and linked with other health care professionals such as falls nurses, dieticians and occupational therapists to improve patient outcomes.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice had achieved 77% vaccination rate for the influenza vaccine for those over 65.

A children's immunisation and vaccination programme was in place. Data from NHS England showed the practice was achieving high levels of child immunisation including the MMR a combined vaccine that protects against measles, mumps and rubella, Hepatitis C and Pertussis (whooping cough). We saw from QOF 100% of child development checks were offered at intervals that are consistent with national guidelines and policy. There was a clear policy for following up non-attenders by the practice nurse.

The practice's performance for cervical smear uptake was 83%, which was higher than the local and national averages. There was a policy to follow up those who did not attend.

The practice was proactive in following up patients when they were discharged from hospital. When the practice received a discharge letter from the hospital, the reception staff would pass onto the GP and where any follow up was required staff would arrange an appointment or home visit.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

During our inspection we observed staff to be kind, caring and compassionate towards patients. We saw reception staff taking time with patients and trying where possible to meet people's needs.

We spoke with 14 patients and reviewed 37 CQC comment cards received the week leading up to our inspection. All were positive about the level of respect they received and dignity offered during consultations.

The practice had information available to patients in the waiting area and on the website that informed patients of confidentiality and how their information and care data was used, who may have access to that information, such as other health and social care professionals. Patients were provided with an opt out process if they did not want their data shared.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and waiting area and the reception desk had windows which staff could close if taking a call which required privacy.

We observed staff speaking to patients, with respect. We spent time with reception staff and observed courteous and respectful face to face communication and telephone conversations. Staff told us when patients arriving at reception wanted to speak in private; they would speak with them in a side. Majority of patients we spoke with gave positive feedback about the helpfulness and support they received from the reception staff. Looking at the results from the GP national survey, 77% of respondents found the receptionists at this surgery helpful.

Staff were able to clearly explain to us how they would reassure patients who were undergoing examinations, and described the use of chaperones and modesty sheets to maintain patient's dignity.

We found all rooms had dignity screens and lockable doors in place to maintain patients' dignity and privacy whilst they were undergoing examination or treatment.

Care planning and involvement in decisions about care and treatment

The patients told us they were happy to see any GP or nurse as they felt all were competent and knowledgeable.

Patients we spoke with told us the GP and the nurses were patient, listened and took time to explain their condition and treatment options. The results from the GP national survey 90% had confidence and trust in the last GP they saw or spoke to and 98% had confidence and trust in the last nurse they saw or spoke to.

We saw from The Quality and Outcomes framework (QOF) data for 2013/14, 95% of patients with poor mental health had a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate; this was above the local and national average.

The practice had formal care plans in place for patients; they included care plans for vulnerable patients over 75 year of age, patients with poor mental health and those patients at risk of unplanned hospital admissions.

We noted where required patients were provided with extended appointments for example reviews with patients with learning disabilities or multiple conditions to ensure they had the time to help patients be involved in decisions.

Patient/carer support to cope emotionally with care and treatment

All staff we spoke to were articulate in expressing the importance of good patient care, and having an understanding of the emotional needs as well as physical needs of patients and relatives.

From the GP national survey 78% of respondents stated the last GP they saw or spoke to was good at listening to them, 80% say the last GP they saw or spoke to was good at giving them enough time and 92% said the last nurse they saw or spoke to was good at giving them enough time.

The practice were able to refer patients to an in house counselling services for those patient who required additional support

The practice had identified within their patient population a number of patients who were carers and had established a carer's register. We saw information for carers was readily available in the waiting area which was updated by the local carers centre and on the practice website.

Good

Are services caring?

Patients who were receiving care at the end of life were identified and joint arrangements were put in place as part of a multi-disciplinary approach with the palliative care team. Bereaved patients were referred to a counselling service where required.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had 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.

The practice worked with patients and families and also worked collaboratively with other providers in providing palliative care and ensuring patient's wishes were recorded and shared with consent with out of hours providers at the end of life.

The practice made reasonable adjustments to meet people's needs. Staff and patients we spoke with provided a range of examples of how this worked, such as, opportunistic screening and reviews, accommodating home visits, booking extended appointments and arranging translators.

The practice had a large population of patients originating from Bangladesh and the practice had established close links with the community in order to meet patients' needs examples include use of translators. The practice worked to respect cultural requests for female staff for female patients and delivered courses to help patients with medical problems cope during Ramadan.

We saw where patients required referrals to another service these took place in a timely manner.

A repeat prescription service was available to patients, via the telephone, website, and a box at reception or requesting repeat prescriptions with staff at the reception desk. We saw patients accessing repeat prescriptions at reception without any difficulties.

The practice offered patients direct electronic access to their health records enabling them to routinely read their own health records by logging on to an electronic system from home with a user name and password. To date 35% of patients have signed up to allow them access to their records. The practice provided a number of examples of where this has benefitted patients for example, if patient have fallen ill away from home and abroad. To date 35% of our Bengali patients, 17% of patients with learning disabilities and 60% of patients with anxiety and depression signing up to the scheme. The practice told us enabling patients to access records has improved transparency and openness between GPs and patients and allows patients to access directly test results prior to speaking with or seeking a consultation with a GP.

The practice had a well established patient participation group (PPG) with 39 members; the group were representative of the patient population and used a variety of methods to engage members such as face to face, email and social media. The PPG had set up three priority areas for the practice during 2014/15 with teams developed to progress the areas for example, supporting a local food bank with a drop of point in the practice waiting area and launching a Health Pledge campaign. The aim of Health Pledge is to encourage patients to make changes to their health choices to improve their physical or mental health.

Tackling inequity and promoting equality

The practice had taken steps to ensure equal access to patients, the website was accessible, and could be translated into different language if required.

The practice was over two floors with all patients accessing services on the ground floor. The practice was accessible for patients with disabilities. A disabled toilet was available as were baby changing facilities. A hearing loop had been installed within the practice to support patients who were hard of hearing. Translation services were available for patients and staff were familiar with how the service worked.

The practice provided longer appointments where necessary and the practice had extended hours 8:30am – 8:30pm on Tuesdays and 7:00am – 6:00pm Wednesdays.

Access to the service

The practice is open between 8.30am – 6.00pm Monday, Thursday and Friday. The practice has extended hours 8:30am – 8:30pm on Tuesdays and 7:00am – 6:00pm Wednesdays.

Appointments with the nurses were available Monday to Friday and could be pre booked. Appointments to see a GP were available via a GP triage system. This involves patients phoning the surgery and providing a brief description as to the nature of the appointment required. A GP then calls the patient back at a time suitable to the patient, to determine whether the problem can be safely dealt with over the phone or whether the patient needs to be seen face to face. Reception staff were trained to take basic information from patients and where they identify when speaking with

Good

Are services responsive to people's needs?

(for example, to feedback?)

patients distress or injury, ill children, or people unable to communicate by phone or where it is clear patients will need to be examined such as a patient with a breast lump appointment were provided without the need for GPs to call back. Children requiring an appointment with a GP were always offered a consultation either face to face or via the telephone on the day. The practice provided 667 consultations a week with 65% of these being telephone consultations.

Patient's views on the appointment system varied with many patients happy with the system. We saw from the GP national survey 84% were able to get an appointment to see or speak to someone the last time they tried and 90% say the last appointment they got was convenient, however patient feedback and data from the GP national survey identified concerns accessing the surgery by telephone, 56% find it easy to get through to this surgery by phone, below the local average of 75%. The practice manager told us they were looking at updating the telephone system to improve the system making it easier for patient to contact the practice.

Comprehensive information was available to patients about appointments on the practice website. This included information about the appointment system and home visits. There was a range of health prevention and support for patient to self manage their conditions via the website and links to local and national support organisations.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed, this information was detailed on the practice website and included information on the urgent care centre which could treat minor injury or illness. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances.

Longer appointments were available for patients who needed them for example those with long-term conditions, patients with learning disabilities or patients who required a translator. This also included appointments with a named GP or nurse.

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 is a designated responsible person who handles all complaints in the practice.

We saw there was a complaints procedure in place. We reviewed complaints made to the practice over the past twelve months and found they were investigated with actions documented. Lessons learnt were shared with staff at team meetings.

We saw a complaints leaflet which was available to patients at reception and a feedback form could be submitted by the practice website.

Patients we spoke with told us they knew how to make a complaint if they felt the need to do so.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's mission statement. The practice mission statement was, "There for you all your life, your good health with our support, empowering you to live well." We saw this demonstrated in the way staff interacted with patients and spoke of the professional relationship developed with patients over a number of years.

We spoke with ten members of staff and they all expressed their understanding of the core values, and we saw evidence of the latest guidance and best practice being used to deliver care and treatment.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff electronically on any computer within the practice. We looked at several of the policies and saw these were up to date and reflected current guidance and legislation, the practice manager told us they were in the process of systematically reviewing all policies and procedure to ensure they were up to date with current guidance.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead GP for infection control and a GP partner was the lead for safeguarding. We spoke with ten members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

We saw the practice made use of data provided from a range of sources including the Clinical Commissioning group (CCG), General Practice Outcome Standards (GPOS) and the national patient survey and the Patient Participation Group to monitor quality and outcomes for patients such as services for avoiding unplanned admissions.

The practice used the range of data available to them, to improve outcomes for patients and work with the local CCG. The practice also used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF 2013/14 data for this practice showed it was performing in line with national standards achieving 100% of outcomes, above the local and national average.

The practice manger and GPs met on a weekly basis to discuss practice issues, practice development and the nurses and health care assistants met weekly to discuss clinical issues. Full staff meetings took place annually and these were minuted. The practice had introduced focus groups for staff where the deputy manager and supervisors discuss issues across the practice to ensure a consistent approach by staff and deal with any issues. All staff told us of an open culture among colleagues in which they talked daily and sought each other's advice.

From the summary of significant events we were provided with and speaking with staff we saw learning had taken place. The GPs within the practice conducted individual clinical audits, in which outcomes were shared during monthly education sessions to monitor quality and share learning.

The practice had arrangements for identifying, recording and managing risks. The practice manager provided us with details of the maintenance and equipment checks which had been carried out in the past twelve months. These helped ensure equipment was safe to use and maintained in line with manufacture guidelines. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented, however we saw that data sheets and risk assessments were not in place for Control of Substances Hazardous to Health (COSHH).

Leadership, openness and transparency

Partner meetings and nurse/HCA took place weekly within the practice and these were minuted. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues with GPs or the practice manager, staff told us there was never a time when there was no one to speak to seek support, advice or guidance.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies and procedures, for example, a recruitment policy and induction programme were in place to support staff.

We were shown evidence that staff as part of induction had access to policies and procedures and all staff were able to

Are services well-led?

Good

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

access policies and procedure via the computer system, this included sections on health and safety, equality, leave entitlements, sickness, whistleblowing and bullying and harassment. Staff we spoke with knew where to find these policies and new members of staff confirmed they formed part of the induction process.

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

The practice had gathered feedback from patients through the national patient survey, The NHS friends and family test, compliments and complaints.

We saw that there was a complaints procedure in place, with details available for patients in the waiting area, practice leaflet and on the website. We reviewed complaints made to the practice over the past twelve months and found they were investigated with actions documented with lessons learnt shared with staff.

We reviewed the results of the GP national survey carried out in 2013/14 and noted 81% described their overall experience of the practice as good. In December 2014 the practice began to ask patients to participate in the friends and family test (The NHS friends and family test (FFT) is an opportunity for patients to provide feedback on the services). We saw for March 2015, 69% selected extremely likely, 17% selected likely, 7% unlikely and 3%selected extremely unlikely that they recommend the GP practice to friends & family if they needed similar care or treatment. Majority of comments were extremely positive about the care and treatment patients had received for example 'Quality medical and admin team'.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had an active patient participation group (PPG) which has steadily increased in size. The PPG included representatives from various population groups; including patients from the Bangladeshi community. The PPG had a number of initiatives such as a food bank and health pledge campaign. The PPG met on a monthly basis and the minutes of meeting were publically available via the practice website.

The practice had a whistle blowing policy which was available to all staff 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. Staff told us that the practice was very supportive of training and development opportunities; however appraisals were not up to date for non-clinical staff.

The practice had reviewed significant events and other incidents and shared with staff informally.