Oulton Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out this comprehensive inspection on 7 October 2014. Oulton Medical Centre provides primary medical services (PMS) to approximately 13,500 patients in the catchment area of Oulton, Woodlesford and surrounding areas. The practice also has a branch surgery at Marsh St, Rothwell, which we did not inspect as part of the process, although we did interview staff working at both sites.

Overall, we rated this practice as good.

Our key findings were as follows:

- The practice provided a good standard of care, led by current best practice guidelines.
- People told us they were treated with dignity and respect.
- The practice worked well with other providers, especially around end of life care and complex conditions.
- The practice had systems and processes in place to ensure the practice provided a safe service.
- The building was clean, and the risk of infection was kept to a minimum by systems such as the use of disposable sterile instruments.
- The practice offered a variety of pre-booked appointments, walk-in clinics and extended opening hours.
- Incidents and complaints were appropriately investigated and responded to, and learning shared across the practice.

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

The provider should:

- The provider should take measures to ensure that patient records are transferred safely and securely between the two surgeries.
- The provider should monitor the times taken and methods for medicines to be transferred between the two surgeries so they can demonstrate that the cold chain was not interrupted.

Summary of findings

- The provider should improve communication with patients accessing the walk in services so patients know how long they may have to wait and can plan accordingly.
- The provider should assess how to improve privacy in the waiting area.

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 safe. Staff understood their roles and responsibilities in raising concerns, and reporting incidents. Lessons were learned from incidents and these were communicated throughout the practice. The practice had assessed risks to those using or working at the practice and kept these under review. There were sufficient emergency procedures in place to keep people safe. There were processes around use of equipment, infection control and medicines management which kept people safe. There were sufficient numbers of staff with an appropriate skill mix to keep people safe.

Are services effective?

Good

The practice is effective. Quality data showed patient outcomes were at or above average for the locality. NICE guidance was referred to routinely, and people's needs were assessed and care planned in line with current legislation. This included promotion of good health and assessment of capacity where appropriate. Staff had received training appropriate to their roles, and had protected learning time to facilitate ongoing training. Clinical staff undertook audits of care and reflected on patient outcomes. The practice worked with other services to improve patient outcomes and shared information appropriately.

Are services caring?

Good

The practice is caring. The majority of patients gave us positive feedback where they stated that they were treated with compassion, dignity and respect, and involved in their treatment and care. The practice was accessible. In patient surveys, the practice scored highly for satisfaction with their care and treatment. There was however, considerable dissatisfaction around the lack of privacy in the reception area.

Are services responsive to people's needs?

Good

The practice is responsive. The practice had initiated extended opening hours and walk in clinics in response to patient demand, although this was still an area of patient dissatisfaction. The practice had a good overview of the needs of their local population, and had engaged with the Clinical Commissioning Group (CCG) and secured service improvements where these were required. The practice had good facilities and was well equipped to meet patient need. Information was provided to help people make a complaint, and there was evidence of shared learning with staff.

Summary of findings

Are services well-led?

Good

The practice is well-led. There was a long standing visible management team, with a clear leadership structure. Staff felt supported by management. There were some objectives and action planning for the future, and a clear mission statement. There were systems in place to monitor quality and identify risk. The practice had an active Patient Participation Group (PPG) and was able to evidence where changes had been made as a result of PPG and staff feedback.

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.

The practice held regular multi-disciplinary meetings to discuss those with chronic conditions or approaching end of life care, and care plans had been produced for these. Information was shared with other services, such as out of hours services and district nurses. Nationally reported data showed the practice had good outcomes for conditions commonly found in older people, for instance 96.5% of people with dementia had been reviewed in the last 15 months.

People with long term conditions

Good

The practice is rated as good for people with long term conditions.

People with long term conditions were monitored and discussed at multi-disciplinary clinical meetings so the practice was able to respond to their changing needs. Information was made available to out of hours providers for those on end of life care to ensure appropriate care and support was offered. People with conditions such as diabetes and asthma attended regular nurse clinics to ensure their conditions were appropriately monitored, and were involved in making decisions about their care. Attempts were made to contact non-attenders to ensure they had required routine health checks.

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 to identify children who may be at risk. For instance, the practice monitored levels of children's' vaccinations and attendances at A&E. Immunisation rates were high for all standard childhood immunisations. There were designated mother and baby clinics, and people could also access midwife services two days a week at the practice. Full post natal and six week baby checks were carried out by GP's, and regular 'well baby' clinics could be accessed.

Working age people (including those recently retired and students)

Good

The practice is rated as good for this population group.

The practice had recognised that some working people with long term conditions (for instance diabetes) could have difficulty attending at normal clinic times, so patients were able to pre-book a

Summary of findings

double appointment to see the GP lead for their condition in advance. Well women clinics were run, giving advice on issues such as breast care, blood pressure and cervical screening tests. The needs of the working population had been identified, and services adjusted and reviewed accordingly. Routine appointments could be booked up to four weeks in advance, although these could not be made online. Repeat prescriptions could be ordered online.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for this population group.

The practice had a register of those who may be vulnerable, including those with learning disabilities, who were offered annual health checks. People or their carers were able to request longer appointment in needed. The practice had a register for looked after or otherwise vulnerable children and also discussed any cases at weekly practice meetings where there was potential risk or where people may become vulnerable. The computerised patient plans were used to flag up issues where a patient may be vulnerable or require extra support, for instance if they were a carer. Staff were aware of their responsibilities in reporting and documenting safeguarding concerns.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for this population group.

Nationally returned data showed the practice performed well in carrying out additional health checks and monitoring for those experiencing a mental health problem. A high percentage of patients had a comprehensive care plan. The practice had a mental health lead. The practice made referrals to other local mental health services, but recognised there may be a waiting list, therefore would ask to see the patient again as an interim measure to ensure they were not left on their own while awaiting their first appointment with an external service.

The practice had a register of those with a learning disability and these patients were invited for an annual health check-up.

Summary of findings

What people who use the service say

In the most recent NHS England GP patient survey, 83% of people described their overall experience as good or very good. From the practice annual survey of 332 responses in January 2014, 83% of patients would recommend the practice to friends or family, 80% were satisfied with their visit to the practice and overall the feedback of good or excellent was 80%.

There were however, some areas of dissatisfaction, including: See a general practitioner within 48hrs (38%)

See practitioner of choice (37%) and Waiting time (47%). The practice had anticipated some of these responses and had initiated some changes as a result of these, for instance to the way walk-in clinics were run.

We spoke to a member of the Patient Participation Group (PPG) prior to the inspection, and spoke to 13 patients during the inspection. We also collected 50 CQC comment cards which were sent to the practice before the inspection for patients to fill in. These contained comments pertaining to care given at both sites, which we included as most staff work across both sites. Of these, 36 were positive comments, with people praising all the staff as caring, professional and helpful, and praising the care they had received. People also commented that the building was clean.

Of the 14 negative comments, common issues reflected the findings of the practice's own patient survey, with people either saying it was difficult to get a booked appointment, or not liking that they had to either wait in the surgery for a walk-in appointment or may get told to return later that morning. Some people also commented that their consultations felt rushed, and that they felt reception staff could be rude on occasion. People we spoke to in the surgery gave broadly similar feedback; praising the care they were given. The most frequent complaint was access to appointments with pre-booked appointments up to a month in advance, or a wait of up to two hours in a walk-in clinic.

NHS choices website had six reviews posted in the last 12 months. While four were positive about the care received and empathy of staff, two people again complained about access to appointments or having to wait at the walk-in clinic. The practice had also received directly and logged nine positive comments from patients over the period October 2013- March 2014, with people commenting on the quality of care delivered and how they felt looked after with compassion by all staff.

Areas for improvement

Action the service SHOULD take to improve

The provider should take measures to ensure that patient records are transferred safely and securely between the two surgeries.

The provider should monitor the times taken and methods for medicines to be transferred between the two surgeries so they can demonstrate that the cold chain was not interrupted.

The provider should improve communication with patients accessing the walk in services so patients know how long they may have to wait and can plan accordingly.

Assess how to improve privacy in the waiting area.

Oulton Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP, a second CQC inspector, a Practice Manager and an Expert by Experience.

Background to Oulton Medical Centre

Oulton Medical Centre, Quarry Hill, Rothwell provides primary medical services (a PMS contract) to approximately 13,500 patients from its catchment area of Oulton, Woodlesford and surrounding areas. The practice also has a branch surgery at Marsh St, Rothwell. Clinical staff work across both sites and patients can choose to attend at either.

There are nine GP's, of whom eight are partners and one is salaried. Seven GP's are female, two male. There is one senior nurse practitioner, four practice nurses, and four other clinical staff. They are supported by a team of management, reception and administrative staff. The practice is a training practice and was supporting a medical student at the time of inspection.

The practice is registered with the Care Quality Commission (CQC) to provide the regulated activities of diagnostic and screening procedures; family planning; maternity and midwifery services; surgical procedures, and treatment of disease, disorder and injury. The practice population aged under 18 years is slightly higher than the England average, and slightly below average for those aged 65 and over. The practice is in a comparatively less deprived area than the average for the Leeds and South East Clinical Commissioning Group.

Out of Hours services are provided primarily by West Yorkshire Urgent Care and from 6-6.30pm each evening by Local Care Direct.

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.

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.

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

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?

Detailed findings

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

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

Before our inspection we carried out an analysis of data from our Intelligent Monitoring system. We also reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We reviewed the practice's policies, procedures and other information the practice provided before the inspection. We also spoke with a member of the Patient Participation Group. The information reviewed did not highlight any significant areas of risk across the five key question areas.

We carried out an announced inspection on 07 October 2014 and spent eight hours at the practice.

We reviewed all areas of Oulton Medical Centre including the administrative areas. We sought views from patients both face-to-face and via comment cards. We spoke with the assistant practice manager, registered manager, GP's, nurses and a nurse practitioner, healthcare assistants, and administrative and reception staff. The practice manager was on leave at the time of inspection.

We observed how staff handled patient information received from the out-of-hour's team and patients ringing the practice. We reviewed how GPs made clinical decisions. We reviewed a variety of documents used by the practice to run the service. We also talked with carers and family members of patients visiting the practice at the time of our inspection.

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. This included reported incidents, national patient safety alerts, and complaints, some of which were then investigated as significant events. Prior to inspection the practice gave us a summary of 15 significant events from the period October 2013 - March 2014, six of which involved other healthcare providers, but the practice has reported on them due to impact on their patients and to identify any learning needs. From April 2014 - present there had been a further four incidents, which had been reviewed and disseminated.

The records showed that staff reported incidents, including their own errors. Staff we spoke to were aware of the incident policy and how to access this, and felt encouraged to report incidents. The incidents were discussed and learning/action points raised as a result. GPs told us they completed incident reports and carried out significant event analysis as part of their ongoing professional development.

The practice had systems in place to record and circulate safety and medication alerts received into the practice. From our discussions we found that GPs and nurses were aware of the latest best practice guidelines and incorporated this into their day-to-day practice.

Information from the quality and outcomes framework (QOF), which is a national performance measurement tool, showed that in 2012-2013 the provider was appropriately identifying and reporting significant events. We found that the practice used information from different sources, including patient safety incidents, complaints and clinical audit to identify incidents that were occurring.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. The practice worked with the Clinical Commissioning Group (CCG) in reporting any incidents of poor performance and missed follow up. Feedback information received was reported back to patients via the Patient Participation Group (PPG).

We saw where incidents had been discussed and reviewed, and the information then shared across the practice as learning points at weekly practice meetings, or as direct emails to staff. The practice carried out a six monthly review of events and summarised learning points. While the practice carried out significant analyses and identified learning points from these, at times these did not included a full root cause analysis, for instance the cause could be defined as 'human error', but further investigation did not always then take place to look at factors such as whether the staff member had sufficient time or training, which may have contributed to the error. Staff members did say they were encouraged to report incidents and felt confident doing so.

We could see from a summary of significant events and complaints that in each case the practice had communicated with people to offer a full explanation and apology, and told what actions would be taken as a result.

National patient safety alerts were disseminated by email or via the practice's online system to staff, and staff were able to give recent examples of alerts relevant to them and how they had actioned them.

Reliable safety systems and processes including safeguarding

The practice had up to date 'child protection' and 'vulnerable adult' policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. Staff knew how to access these. Staff had access to contact details on display boards for both Local Authority safeguarding teams, and were able to described types of abuse and how to report these. Staff were able to describe scenarios in which they had acted appropriately. The practice had a named GP safeguarding lead, who staff were able to identify. Clinical staff had been trained to either Level 2 or 3, and other staff to Level 1 or 2 according to need.

The practice had a register for looked after or otherwise vulnerable children and also discussed any cases at weekly practice meetings where there was potential risk or where people may become vulnerable. The computerised patient plans were used to enter codes to flag up issues where a patient may be vulnerable or require extra support, for instance if they were a carer. The practice had systems to monitor children who failed to attend for childhood immunisations, or who had high levels of attendances at A&E.

Good

Are services safe?

The practice had chaperone guidelines, and there was information on this service for patients in reception. A mixture of clinical and non-clinical staff had been given chaperone training.

The recruitment policy of the practice stated that candidates would only be offered a position following receipt of reference, satisfactory Disclosure and Barring Services (DBS) checks and proof of qualification and identity. The policy also contained guidelines for risk assessment of staff starting without a DBS check in certain limited circumstances.

Ongoing patient records were kept on an electronic system which collated all communications about the patient including scanned and email communications. However older paper records were not always stored and shared appropriately in a way which kept people safe, in that paper records could be transferred between the two surgeries in a shopping bag in the back of staff cars. The senior GP partner explained that staff were instructed to lock the car if unattended and go straight to the surgery, but accepted that this was not best practice.

Medicines Management

The practice was not a dispensing practice. Medicines stored in the practice were kept securely and could only be accessed by the clinical staff and pharmacy support person. We saw evidence that the doctors bags were regularly checked to ensure that the contents were intact and in date, although we did find a minority of emergency medicines which were out of date. There was an element of personal preference as to which emergency medicines each doctor carried, and there was no clear decision or risk assessment documented for this.

We checked medicines stored in the fridges and found these were stored appropriately. Appropriate checks took place to make sure refrigerated medicines were kept at the correct temperature, and we could see where corrective actions had been taken and logged in response to a recent fridge failure. All medicines were delivered to the main Oulton site and then some were transferred to the branch site at Rothwell. There were procedures to ensure this was done efficiently, although times were not logged of when the medicines left and were delivered to allow auditing of the cold chain. There was informal temperature monitoring in treatment rooms where some medicines were kept at ambient temperature, but this was not formally recorded, to ensure the medicines were kept below the manufacturer's guidelines of 25 degrees centigrade.

Clear records were kept of any medicines stored in the practice and records of when they were used. Stock totals of medicines we checked correctly tallied with the practice records, and medicines we checked were within their expiry dates. Prescriptions were stored securely, and there was a system in place for GP's to double check repeat prescriptions before they were generated. Any errors were logged as incidents and investigated.

There was a process to regularly review patients' repeat prescriptions to ensure they were still appropriate and necessary. Any changes in medication guidance were communicated to clinical staff, and staff were able to describe an example of a recent alert and what action had been taken. This ensured staff were aware of any changes and patients received the best treatment for their condition. GPs reviewed their prescribing practices at least annually, or as and when medication alerts were received. The practice had a prescribing and medication policy which was regularly reviewed and had been agreed with the CCG pharmacist.

Cleanliness & Infection Control

We observed all areas of the practice to be clean, tidy and well maintained. Patients we spoke with told us they found the practice to be clean and had no concerns about cleanliness. The practice had infection prevention and control (IPC), waste disposal and legionella testing policies, and these were reviewed and updated regularly. There was an identified IPC lead. We saw evidence that staff had training in IPC to ensure they were up to date in all relevant areas. Aprons, gloves and other personal protective equipment (PPE) were available in all treatment areas as was hand sanitizer and safe hand washing guidance.

Sharps bins were appropriately located, labelled, closed and stored after use. We saw that cleaning schedules for all areas of the practice were in place. Public toilets were observed to be clean and have supplies of hot water, soap, paper towels and hand sanitizer, as did treatment rooms.

Staff said they were given sufficient PPE to allow then to do their jobs safely, and were able to discuss their responsibilities for cleaning and reporting any issues. Staff we spoke with told us that all equipment used for invasive

procedures and for minor surgery were disposable. Staff therefore were not required to clean or sterilise any instruments, which reduced the risk of infection for patients. We saw that other equipment such as blood pressure monitors used in the practice was clean.

e saw evidence that staff had their immunisation status for Hepatitis B checked which meant the risk of staff transmitting infection to patients was reduced. They told us how they would respond to needle stick injuries and blood or body fluid spillages and this met with current guidance.

Regular IPC audits were carried out, although staff told us they did not really have involvement in these, and corrective actions logged. The practice had declared itself non-compliant with IPC at registration with CQC in 2013, due to some treatment rooms having carpet. We saw that this had since been changed to an impervious surface which could be more easily cleansed.

Equipment

There were procedures in place to ensure that equipment was checked, calibrated and functioning correctly. Staff were trained and knowledgeable in the use of equipment for their daily jobs. Most equipment was duplicated across the two surgeries so emergency back-ups were available.

Items of medical equipment were on service maintenance contracts where necessary to ensure their speedy repair or replacement. Contracts were in place for annual checks of equipment such as fire extinguishers, fire alarms, panic alarms, and portable appliance testing was carried out. Review dates for these were overseen by the practice manager. Staff told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments.

Staffing & Recruitment

The practice annual report for 2013/14 reported that the practice undertook a nursing team skill mix assessment and trained health care assistants and phlebotomists to complement the practice team to offer more locally based services. This showed the practice monitored staff numbers and skill mix to meet patients' needs.

There were arrangements in place for members of staff, including GP's, nursing and administrative staff to cover each other's leave. The senior partner reported there was generally a sufficient pool of staff across both sites to cover eventualities, and they rarely had to use locums. One GP had been brought in on a short term contract to cover a long term leave.

Staff said their agreed hours were flexible where required, and staff turnover was generally low. Staff explained they could backfill positions and transfer patients or services to the branch surgery to ensure safe continuity of care. The practice had recently had a meeting involving all team members in response to changing demand, from this an action plan had been produced which was being kept under review. Staff confirmed some of their duties were changing in response to patient need. The reception supervisor confirmed there were allocated minimum numbers of staff which could then be supplemented if necessary from the branch surgery, or overall pool of staff.

The provider recruitment policy was in place and up-to-date. We looked at a sample of recruitment files for doctors, administrative staff and nurses. Appropriate pre-employment checks were completed for a successful applicant before they could start work in the service, for instance proof of identification references, qualifications, and criminal records checks by the Disclosure and Barring Service (DBS).

Monitoring Safety & Responding to Risk

We found that staff recognised changing risks within the service, either for patients using the service or for staff, and were able to respond appropriately. There were procedures in place to assess, manage and monitor risks to patient and staff safety. These included annual, monthly and weekly checks and risk assessments of the building, the environment and equipment, and medicines management, so patients using the service were not exposed to undue risk.

There were health and safety policies in place covering subjects such as fire safety, manual handling and equipment, and risk assessments for the running of the practice. These were all kept under review to monitor changing risk.

Patients with a change in their condition or new diagnoses were discussed each week at practice clinical meetings, which allowed clinicians to monitor treatment and adjust according to risk. Therefore the practice was positively managing risk for patients. Patients with an emergency or

sudden deterioration in their condition could be referred immediately via telephone. Information on such patients was made available to out of hours providers so they would be aware of changing risk.

Arrangements to deal with emergencies and major incidents

Staff we spoke with were able to describe what action they would take in the event of a medical emergency situation. We saw records confirming staff had received Cardio Pulmonary Resuscitation training. Staff who would use the defibrillator were regularly trained to ensure they remained competent in its use, which ensured they could respond appropriately if patients experience a cardiac arrest. Staff could readily describe the roles of accountability in the practice and what actions they needed to take if an incident or concern arose.

The practice had a suite of documents including fire risk assessments, first aid, and procedures in the event of a bomb threat. These were reviewed regularly. Weekly fire alarm checks took place and fire drills every six months. A business continuity plan was in place which had been recently updated, which included details of emergency contacts and scenarios they may be needed in.

The practice was sufficiently large that it operated a buddy system for doctors and nurses to cover for each other, so that the practice rarely had to use locums in the event of staff disruption. Reception staff told us they were changing duties in response to patient need to ensure reception was covered at all times, and some roles were being 'up-skilled' to provide better continuity of service. Staff and services were able to swap between sites, as were patients, if one site had an issue or was short-staffed. A daily bulletin was sent to all staff at the beginning of each day to inform them of any actual or potential issues.

Emergency medicines were available, such as for the treatment of cardiac arrest and anaphylaxis, and all staff knew their location. Processes were in place to check emergency medicines were within their expiry date.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

All clinical staff we interviewed were able to describe how they accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local health commissioners. They were able to demonstrate how these are received into their practice and disseminated via their computer system as assigned tasks, or via email.

Treatment was considered in line with evidence based best practice, and we saw minutes or clinical staff meetings where new guidelines and protocols were discussed. All the GP's interviewed were aware of their professional responsibilities to maintain their knowledge.

The practice aimed to ensure that patients had their needs assessed and care planned in accordance with best practice. For instance, we saw one clinical review of antibiotic prescribing, which had identified that antibiotics had been prescribed in the correct circumstances for all patients looked at, although occasionally not for the optimum recommended time, so learning had taken place in accordance with best practice.

Practice nurses told us they managed specialist clinical areas such as diabetes, heart disease and asthma. This meant they were able to focus on specific conditions and provide patients with regular support based on up to date information. Care was planned to meet identified needs and was reviewed. For instance, all patients with Chronic Obstructive Airways disease were reviewed, and factors which may make the disease worse identified early. Where appropriate, anticipatory medicines were provided to ensure early treatment. Stroke patients were offered a six month post stroke review. Work had been undertaken to identify those at risk of developing diabetes, and early reviews offered. Active monitoring of patient outcomes took place through clinical audit and the quality and outcomes framework.

Staff were able to demonstrate how care was planned to meet identified needs using best practice templates, and how patients were reviewed at required intervals to ensure their treatment remained effective. The practice kept up to date disease registers for patients with long term conditions such as asthma and chronic heart disease which were used to arrange annual, or as required, health reviews. They also provided annual reviews to check the health of patients with learning disabilities and mental illness.

For example patients with diabetes were having regular health checks, and were being referred to other services or discussed at multi-disciplinary meetings when required. Feedback from patients confirmed they were referred to other services or hospital when required. National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. All GP's we spoke with used national standards for referral, for instance two week referrals for patients with suspected cancer were done there and then, and other routine referrals were done within seven days.

The practice could produce a list of those with learning disabilities or who were in need of palliative care and support. The practice had identified their 2% of most vulnerable patients and were producing care plans for these. Patients requiring palliative care or with new cancer diagnoses were discussed at regular multi-disciplinary care meetings to ensure their needs assessment remained up to date. Minutes of the meetings were emailed if a GP could not attend to ensure they remained up to date.

We saw no evidence of discrimination when making care or treatment choices, with patients referred on need alone.

Management, monitoring and improving outcomes for people

The practice routinely collected information about people's care and outcomes. It used the Quality and Outcome Framework (QOF) to assess its performance and undertook regular clinical audits. Latest QOF data from 2012-2013 showed the practice performed at or above average for clinical indicators compared to the CCG area, and had an overall rating of 99.5%, above the England average. The data showed the practice provided support to patients with long term conditions such as diabetes, asthma, and chronic heart disease. For instance, 96.5% of people with dementia had been reviewed in the last 15 months. Nursing staff monitored uptake of childhood immunisations.

The Practice has a system in place for completing clinical audit cycles. Examples of clinical audits included

Antibiotic prescribing, review of efficacy of joint injections and a review of indicators in patients at high risk of

Good

Are services effective?

(for example, treatment is effective)

developing diabetes. A future date was included for re-audit to gauge the success of any changes, or past data to see whether the practice was improving. The team was making use of clinical audits tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved. We saw minutes of meetings where clinical complaints were discussed and the outcomes and practise analysed to see whether they could have been improved. The practice did not participate in proactive peer review with other local practices, but did work with the CCG to assess clinical outcomes for the local area and had a named GP lead for this area.

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. Clinical staff also checked that all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. The IT system flagged up when patients needed to attend for a medication review before a repeat prescription was issued, and when people needed to attend for routine checks related to their long term condition.

Effective staffing

The practice manager took the lead for training and staff were sent reminders when essential training was due. We saw evidence that all GP's had undertaken annual external appraisals and had a date for revalidation, an assessment to ensure they remain fit to practice. All other clinical staff had been appraised in the last year and had learning needs identified and plans to address these. Continuing Professional Development for nurses was monitored as part of the appraisals process.

The recruitment policy of the practice showed that relevant checks were made on qualifications and professional registration as part of the process. On starting, staff commenced an induction comprising health and safety, incident reporting and fire precautions, in addition to further role specific induction training. The policy stated that the effectiveness of the training would be followed up to ensure the person's understanding. There was protected learning time once a month as part of a CCG initiative where staff could access learning on different subjects.

We saw that the mandatory training for all staff included fire awareness, information governance, safeguarding and infection control. This was completed online during protected learning time. Staff also had access to additional training related to their role. We confirmed that staff had the knowledge and skills required to carry out their roles.

Staff said they felt confident in their roles and responsibilities, and were encouraged to ask for help and support, and were able to give examples of when they had asked, for instance, a GP or nurse for additional clinical support if they felt unsure.

Staff were given yearly appraisals where learning and support needs were identified, and we saw examples where staff had been given extra support. Appraisal included performance review, key achievements, areas for improvement and training, and areas for personal development. Nursing staff held regular clinical supervision and discussion meetings, where a GP also attended. A nurse practitioner attended GP clinical meetings in order to feed back to the rest of the nursing team. There were no regular supervision sessions on a one to one basis for all staff members, although staff did say they felt confident in raising concerns or issues.

There were Human Resources (HR) policies and procedures in place to support poor or variable performance amongst staff, and we saw where members of staff had been supported and adjustments made to their role.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases, for instance regular meetings were held with district nurses and hospice staff to identify and discuss the needs of those requiring palliative care, or those who would require it. People with new cancer diagnoses or whose conditions had recently changed were also discussed. The practice was involved in the cancer GOLD standards framework, an external training and accreditation scheme for those approaching end of life.

Health monitoring of patients with long term conditions was discussed at weekly clinical meetings to discuss and review treatment strategies and any required actions or changes.

Good

Are services effective?

(for example, treatment is effective)

The practice had worked with safeguarding colleagues previously, but GP's said time constraints prevented them from routinely attending safeguarding meetings.

One partner in the practice took responsibility for patients in nursing homes, and carried out regular visits and visits post discharge from hospital. This helped ensure better integrated care and provided the patient with one point of contact, although this process was not replicated for learning disability homes in the area to provide vulnerable people with continuity of care.

There was a local practice manager's forum which was attended, however GP's did not routinely attend clinical audit or best practice sharing meetings with other local practices.

Information from out of hours services was disseminated by reception staff to the appropriate GP who checked as a first task each morning. The practice kept 'do not resuscitate' and advance decision registers to reflect patient's wishes, and this information was made available to out of hours providers. The practice used an electronic end of life care co-ordination system called EPAC, which meant that other providers such as ambulance crews and hospital staff could view and access information about a patient.

Blood results, discharge letters and information from out of hours providers was generally received electronically and disseminated straight to the relevant doctor, or where necessary a procedure for scanning documents was in place. There was a system to ensure scanned documents were not sent to a doctor who was on leave, and the GP's operated a buddy system to check each other's results if one was off. The GP recorded their actions around results or arranged to see the patient as clinically necessary.

Information Sharing

Information was shared between staff at the practice by a variety of means. A daily electronic bulletin and tasks highlighted any urgent issues; there was a weekly practice meeting where patients were discussed, and a monthly practice meeting for all staff.

For patients requiring a two week referral the GP's filled in the referral forms straight after the consultation, while all routine referrals were completed within seven days. GPs told us they could ring hospital consultants to discuss urgent appointments. Referral letters and results were generally received electronically and then sent directly to the relevant GP. Paper based information was scanned within timescales according to the practice policy, and then checks took place by reception staff to ensure these went to the correct GP or a covering GP if one was absent. GP's told us they had a productive relationship with local hospitals, and that information sharing had improved. There was a shared system with the out of hours provider to enable information to be shared in a timely manner and as appropriate.

Consent to care and treatment

We found that staff were aware of and had received training around the Mental Capacity Act 2005, and were able to describe key aspects of the legislation and how they implemented it. For instance, we saw examples in care plans where people had recorded advance decisions about their care or their wish not to be resuscitated. We saw examples of where those with a learning disability or other mental health problems were supported to make decisions, and where advocate details were recorded.

If someone had lasting power of attorney concerning a patient this was recorded on the computer and in the patients plan.

There was a practice policy on consent to support staff and staff knew how to access this, and were able to provide examples of how they dealt with a situation if someone hadn't been able to give consent, including escalating this for further advice to a senior member of staff where necessary

Staff were able to discuss the carer's role and decision making process. Verbal consent was documented on the computer as part of a consultation. Consent forms and patient leaflets were available on the practice computer system for invasive procedures such as coil fitting, which detailed risks, benefits and potential complications, which allowed patients to make an informed choice.

Health Promotion & Prevention

The practice offered all new patients a consultation to assess their past medical history, care needs and assessment of risk. The needs of new patients were assessed and a plan of the person's ongoing needs to stay

Good

Are services effective?

(for example, treatment is effective)

healthy was developed. Advice was given on smoking, alcohol consumption and weight management. Smoking status was recorded and patients were offered advice or referral to other service.

We found that the staff proactively assessed patients to identify any potential problems that may develop. For example patients over the age of 45 were offered health assessments which would support the early identification of health problems such as diabetes. Staff proactively used patient contact at routine appointments or clinics to offer other health promotion services such as flu jabs or health checks.

Patient Participation Group minutes and the practice annual report showed practice 'focus areas', for instance one objective was to increase uptake for the National Bowel Cancer Campaign. 100% of patients who had not responded to initial contact were followed up with a letter from the practice advising screening.

The practice was also working towards increasing early diagnosis of Chronic Obstructive Airways disease by undertaking additional screening tests, and ordering extra equipment to help increase the number of earlier diagnoses. Similarly, over 2000 patients had been tested for diabetes and found 594 in the "pre diabetes" range. The practice was then engaged in contacting these patients and offering lifestyle advice and recommending an annual blood test.

The practice had carried out an Additional Winter service pilot, which involved contacting and reviewing all patients aged 65+ who had been discharged from hospital following an acute admission. This allowed the practice to consider any support or action which could prevent readmission and improve quality of life for the patient.

In addition to routine immunisations the practice offered travel vaccines, and flu vaccinations in line with current national guidance.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice in patient satisfaction. The 2012-13 National Patient Survey of 121 people showed that 83.5% or people described their overall experience as good or very good, above the average for the CCG area, with 82.4% saying they would recommend the practice to someone else. 88% said they were treated with care and respect by the doctor.

From the practice annual survey of 332 responses in January 2014, 83% of patients would recommend the practice to friends or family, 80% were satisfied with their visit to the practice and the overall the feedback of good or excellent was 80%.

Patients completed 50 comment cards to provide us with feedback on the practice, and we spoke to a further 13 patients on the day. The majority of people said they found the doctors, nurses and other clinical staff to be caring, empathetic and professional, and treated them with dignity and respect. Many people highlighted examples of where they felt they had received particular good care, and many patients had stayed with the practice for a number of years.

Negative feedback from a minority of people included that they felt the doctors rushed them during consultations. A minority of people also complained they felt some reception staff to be rude, although praised all staff for their care and compassion.

The dignity and privacy of patients in the reception area was a concern raised by a number of patients on the day, and was also raised during the practice patient survey. A number of people stated they could be overheard at reception, and we also observed this on the day, both that patients could be heard at reception, and also patients could overhear reception staff speaking to patients on the phone. There was not a dedicated room where patients could request to speak to someone in private, although the senior GP partner advised there was usually a spare treatment or consulting room available. We found this service was not widely advertised in reception, and people did not always know they could ask for this service. This was reflected in the national patient survey, with only 64% of people saying they were happy with the level of privacy at reception. Reception staff reported they tried to keep their voices at a lower volume and kept the reception windows closed in an effort to maintain privacy.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were in use in treatment and consulting rooms to maintain patients' privacy and dignity during investigations and examinations.

Care planning and involvement in decisions about care and treatment

Seventy per cent of people in the national patient survey said they were involved in decisions about their care. The templates used on the computer system for people with long term conditions supported staff in helping to involve people in their care, and nursing staff were able to provide examples of where they had discussed care planning and supported patients to make choices about their treatment, for instance the decision of diabetic patients whether to start taking insulin.

People said the GP's explained treatment and results in a way they could understand, and they felt able to ask questions, and felt sufficiently involved in making decisions about their care. Staff told us there was a translation service available for those whose first language was not English, and we saw details for this service, although awareness of this service varied among some staff we spoke to.

Patient/carer support to cope emotionally with care and treatment

Patients said they were given good emotional support by the doctors, and were supported to access support service to help them manage their treatment and care. Comment cards filled in by patients said doctors and nurses provided a caring empathetic service, and some highlighted when they had been given additional care and support through bereavement.

In the most recent practice survey, 84% of people said they felt the doctor listened to them effectively, and 79% said they were shown consideration. GP's referred people to counselling services where necessary, and the practice website contained links to support organisation such as Carers Direct and links to charitable services where patients could search under their local area.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice held information about the prevalence of specific diseases. This information was reflected in the services provided, for example screening programmes, vaccination programmes and reviews for patients with long term conditions. These were led by CCG targets for the local area, and the practice engaged regularly with the CCG to discuss local needs and priorities. Longer appointments could be made available for those with complex needs and there was a chaperone policy available. When the local family planning clinic had closed, the practice used its extended opening hours to offer a walk in sexual health and family planning clinic, fulfilling a local need.

The local nursing home had a named GP to provide continuity of care for residents there. We discussed with the practice how this may also benefit residents at local residences for those with learning difficulties. The practice was proactive in monitoring those who did not attend for screening or long term condition clinics, and made efforts to follow these up. The practice were aware that there was a wait to access some mental health services in the area, so following referral to a service, the patient would be offered repeat appointments with a GP as a stop-gap until they could access the full service.

For some regular medications when patients were stable on a dose the doctor could at their discretion and subject the regular reviews provide larger quantities of each medicine as a repeat item. This cut down the number of times a patient needed to contact or attend the surgery for medicines.

The facilities and premises were appropriate for the services which were planned and delivered, with sufficient treatment rooms and equipment available.

Tackling inequity and promoting equality

The building accommodated the needs of people with disabilities, incorporating features such as ramped access, automatic doors and level thresholds. All treatment/ consulting rooms and patient toilets were on the ground floor. The practice had engaged an Access Officer from the Local Authority to provide them with advice following feedback from the PPG about disabled parking spaces. These recommendations had then been acted on.

There was a practice information leaflet available in reception. There were no leaflets available in large print or other languages, although the practice had not identified a need for these. People were able to request them specifically. There was information displayed in reception about a telephone interpreting service, although awareness of this was low in reception staff. There was a hearing loop available, but this was unplugged and the sign was obscured. The practice said they had unplugged it in response to privacy concerns at reception, but no alternatives had been explored. In response to feedback from the PPG, the practice was in the process of changing much of their signage into a more visible format for the visually impaired.

Access to the service

Patients had to telephone or call at the surgery to make appointments, although repeat prescriptions could be ordered online. The practice had extended opening hours in response to patient feedback, and was open from 7am on Tuesdays and Fridays across both sites. Monday evening provided extended hours until 8pm, when patients could either attend walk-in or book an appointment. During these times patients could access a mix of doctors, nurse practitioners, nurses & health care assistants, or a family planning and sexual health clinic. Patients could either attend at the Oulton or Rothwell surgeries to suit. Opening times and closures were advertised on the practice website, with an explanation of what services were available.

The practice had increased the number of walk in appointments and phone appointments to allow more people to access the service by a variety of means. Longer appointments for multiple conditions were available. A small number of appointments were blocked out each day for urgent conditions, or patients could attend the walk-in clinic between 8.30-9.30am to either wait for a slot or be given an estimated time to return.

This was in response to patient feedback about the long waits at walk-in clinics, although some patients we spoke to said it was inconvenient having to attend twice, especially for those with children or mental health issues. Many patients expressed dissatisfaction at accessing the service, as pre-booked appointments could be up to a month in advance, it was difficult to get through on the phone on the day, or they had to wait at walk-in. We

Good

Are services responsive to people's needs?

(for example, to feedback?)

witnessed one patient having to wait 50 minutes until eventually leaving the surgery, and staff were not able to say whether it had been clearly explained how long they would have to wait.

We discussed this with the provider, who said they were disappointed as this was not a normal reflection of how the walk-in clinics generally ran.

The practice said some of these issues were due to very high 'did not attend' rates among patients, and had introduced a text message reminder service for patients, which had significantly reduced these rates, freeing up appointments for other patients. More telephone appointments had also been made available, for doctors to triage whether an urgent appointment may be needed, and home visits were available according to clinical need.

Other patients said access had improved recently and they did not have trouble getting an appointment or seeing the doctor of their choice. The practice was still in the process of assessing the effect of changes to the walk-in system to try to make it more accessible, and this was being discussed in conjunction with the PPG.

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. Information on how to complain was contained in a patient information pack in reception, and staff were able to signpost people to this.

The practice carried out a patient survey using an external organisation in January 2014. An action plan was then drawn up and discussed with the PPG to look at the lowest results. Results of this survey were displayed in reception. Information on how to make a complaint was available in a practice folder in reception, although there was no suggestion box for people to leave feedback.

We looked at eight complaints from the period October 2013 - March 2014, and could see that these had been responded to with a full explanation and apology. Details of the ombudsman had been made available.

The practice summarised and discussed complaints with staff at a specific complaints meeting every six months, and was able to demonstrate changes made in response to feedback, including a walk in surgery each day, 48 hour release appointments, and pre-bookable appointments up to four weeks in advance.

Although some learning points and actions had been identified, there was not always a detailed root cause analysis of how to prevent the situation happening again. For instance, one investigation highlighted to need for better communication of practice policies, as one person had not been offered a pre-bookable appointment. The action point was staff were to be reminded of policy, but there was no detailed analysis of why the incident had occurred in the first place, for instance a possible lack of staff training at induction.

People we spoke to said they would feel comfortable raising a complaint if the need arose.

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 recently developed a clear mission statement and staff were aware of this, the mission being to provide excellent health care with respect, confidentiality and compassion. The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice had carried out an analysis of strengths, weaknesses, opportunities and threats. Some objectives for the practice were not necessarily strategic and measurable, in that they were 'to continue to provide a good service', and staff did not have specific individual objectives via their appraisal which fed in to corporate objectives, objectives being 'to respond quickly to calls and patients' rather than specific measurable targets. However, in other areas, an action plan had been produced following the patient survey with specific targets such as disability access improvements and increasing available appointments.

Governance Arrangements

Staff were clear on their roles and responsibilities, and felt able to communicate with doctors or managers if they were asked to do something they felt they were not competent in. A daily bulletin was circulated each day to all staff with risks, issues and alerts they needed to be aware of.

All internal audits were conducted using the electronic system Intradoc. Audits on subjects such as infection control, equipment checks, repeat prescribing and website reviews were recorded with a status and review date. Each audit had a specific member of staff with allocated responsibility and the system flagged audits that were due or not yet started. Each audit linked to further detailed tasks and additional actions. Once audits were complete they were annotated with a completed date and actions taken, and a new audit date was automatically set. This allowed the provider an at a glance overview of quality monitoring procedures.

The practice used the Quality and Outcomes Framework (QOF) to measure performance. The QOF data for this practice showed was performing in line or above national standards, and the practice regularly reviewed its results and how to improve. The practice had identified lead roles for areas of clinical interest, safeguarding, or management tasks, and had produced an action plan for the future.

There was a systematic programme of clinical audit, subjects selected from QOF outcomes, from the CCG, following an incident of from the GP's own reflection of practice. These subjects were then re-audited after a specified period of time to gauge improvement.

From our discussions with staff we found that they looked to continuously improve the service being offered. We saw evidence that they used data from various sources including incidents, complaints and audits to identify areas where improvements could be made.

Leadership, openness and transparency

Staff said they felt happy to work at the surgery, and that they were supported to deliver a good service and good standard of care. Staff described the culture at the practice as open and honest, and said they felt confident in raising concerns or feedback.

GP partner's described a major business strength of having a strong, cohesive staff team, and this was echoed by staff who described strong supportive team working within their areas. There was a clear chain of command where supervisors were informed by managers. Staff said they could input ideas and suggestions prior to change happening.

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

There was an active Patient Participation Group (PPG) with minutes, annual patient survey reports and action plans published on the practice website for the practice population to read. The PPG was patient led and had appointed their own chair. The practice was actively advertising to recruit younger members to the group to ensure it was representative of the practice population.

We saw several examples from PPG minutes and the patient survey where the practice had made changes, for instance, creating more capacity for pre-bookable appointments. Where suggestion could not be implemented the practice explained why, for instance late night blood appointments could not be made available due to the necessity of having samples picked up by a certain time of day. The action plan completed from the patient survey included a 'You said- we did' section, which included some completed actions such as increasing the number of available telephone consultations.

Are services well-led?

Good

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

There was also a patient representative group network where PPG's could meet with those of other practices. The practice arranged for a representative from the Clinical Commissioning Group (CCG) to come and talk to the group about setting up a Locality Patient Representative Group Network to include members from all CCG practices. These meetings are ongoing to allow the practice to be more involved with developing patient services in the wider community.

Staff told us they felt confident giving feedback, and this was recorded through staff meetings or the appraisal process. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. These was a whistleblowing policy which was available to all staff.

Management lead through learning & improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. We saw that all the doctors and relevant staff were able to attend a 'protected learning time' session on one afternoon each month. We looked at three staff files which showed that appraisals took place where staff could identify learning objectives and training needs.

The practice was a training practice and had a medical student in training at the time of inspection. The practice had completed reviews of significant events and other incidents, and shared these with staff via team meeting discussions to ensure the practice improved outcomes for patients. Staff told us the culture at the practice was one of continuous learning and improvement.