French Weir Health 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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out our inspection of French Weir Health Centre on 21 July 2015 specifically to follow up on the findings of our last inspection carried out on 4 and 11 November 2014. The report for this inspection was published on 30 April 2015.

Overall we found the practice is rated as good with examples of safe recruitment practices and other aspects of safe patient treatment and support. Patients reported high levels of satisfaction with the practice during our inspection.

Our key findings were as follows:

There were reliable systems, processes and practices in place to keep people safe and safeguarded from abuse for example;

- There were systems, processes and practices put in place and communicated to staff that were identified as essential to keep people safe. Staff were trained and made aware of these systems, processes and practices. The systems, processes and practices were monitored and improved when required.
- Recruitment processes and policy were robust and recruitment was carried out in accordance with the policy for all employee appointments.
- There were arrangements in place to safeguard adults and children from abuse that reflect relevant legislation and local requirements. Staff demonstrated they understood their responsibilities and adhered to the practices safeguarding policies and procedures.
- Patients were treated with dignity and respect by a staff team who understood patients' needs.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe. Recruitment processes were robust and were supported by up to date policies and practices which ensured patient safety.

Summary of findings

What people who use the service say

We spoke with two patients visiting the practice during our inspection and saw the results of the last patient participation group survey dated 31st March 2015. The practice also shared the recent findings from their 'friends and family' survey which showed 94.65% of patients were likely or extremely likely to recommend the practice to others. We looked at the practices NHS Choices website to look at comments made by patients (NHS Choices is a website which provides information about NHS services and allows patients to make comments about the services they received). We also looked at data provided in the most recent NHS GP patient survey which showed 94.7% of patients described their experience of the practice as good.

The majority of comments made or written by patients through feedback and testimonials were positive and praised the care they received. For example, about receiving the right treatment at the right time, about seeing a named doctor at most visits and about being involved in the care and treatment provided. We heard and saw that patients generally found good access to the practice and appointments were easy to obtain. We observed that telephones were answered after a brief wait. The most recent GP survey showed 87.6% of patients described their experience of getting through to the practice as easy compared to a Clinical Commissioning Group average of 79.5%% and a national average of 74.4%.

We saw a range of thank you cards sent to GPs in the practice. These all thanked staff for their safe and caring approach and their support at times of emotional need.

Patients told us their privacy and dignity was respected during consultations and they found the reception area was sufficiently private for most discussions they needed to make. Patients had been attending the practice for over 10 years and told us they were always treated well. The GP survey showed 100% of patients said they had confidence and trust in the last GP they saw or spoke with compared to a Clinical Commissioning Group average of 97% and a national average of 95%.

French Weir Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector who had remote access to advice from a specialist advisor**.**

Background to French Weir Health Centre

French Weir Health Centre, French Weir Avenue, Taunton, Somerset, TA1 1NW; is located just off Staplegrove Road, close to the town centre of Taunton. The Practice area includes all of the following geographical areas. To the North, Bishops Lydeard, East Lydeard, Yarford and Kingston St Mary. To the East, Kingston St Mary, Rowford, Cheddon Fitzpaine. To the South East, Obridge to Chritchard Parkway, Billetfield, Mary Street. The West bounday of Vivary Park Golf Course North toward Trull Post Office. To the South West, Comeytrowe Road, West to Rumwell, North to Hillfarrance. And to the West, Hillfarrance, Cotford St Luke, Tatham and Bishops Lydeard.

There is level access into the practice and to all patient accessible areas; toilets are accessible with facilities for patients with disabilities. There is parking on site. There are a range of administrative and staff areas including a training area. The practice is a registered GP training location.

There are nine partners in the practice equating to eight whole time employees. Each GP holds a patient list and has a 'buddy' GP who knows the patients of their buddy. Five GP's are female and four are male. A female registrar GP is also currently working in the practice. In addition there is a nurse practitioner, five practice nurses and three health care assistants. The practice also employs a team of reception and administrative staff who are supported by a practice manager and reception and secretarial manager.

The practice has a General Medical Services GMS contract to deliver health care services; the contract includes enhanced services such as extended opening hours, alcohol services, dementia services and the childhood vaccination and immunisation scheme. This contract acts as the basis for arrangements between the NHS Commissioning Board and providers of general medical services in England.

The practice is open between 8:30 am and 6:30 pm each day with extended hours until 8:00 pm on Monday, Tuesday and Thursday evenings. The practice is also open on Saturday mornings between 8:30 am and 12:00 midday. All extended hours and Saturday appointments are for pre-booked appointments; full details of opening hours are on the practices website. The practice has opted out of providing out-of-hours services to their own patients. This service is provided by Northern Doctors Urgent Care and patients are directed to this service by the practice during out of hours.

Why we carried out this inspection

We carried out a focused 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 follow up on 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.

Detailed findings

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?

The focus for this inspection was specifically around the safe domain.

Before visiting, we reviewed a range of information we hold about the practice. We carried out an announced visit on 21 July 2015.

We talked with a small number of staff employed in the practice. This included one GP, one practice nurse, the practice manager and seven administrative/reception staff. We spoke with two patients who visited the practice during our inspection.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality with regard to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. We reviewed significant event investigation records. Staff we spoke with were aware of their responsibilities to raise concerns and how to report incidents and near misses. For example, where a patient required assistance from staff in the waiting area and required assistance to be moved to a treatment room. The lack of equipment to safely move the patient was reported to the management team; as a result a new stretcher had been purchased and staff had received training to use it.

We reviewed safety records and incident reports and minutes of meetings where these were discussed for the last 12 months. The summary log showed the actions taken in response to each event. Similar evidence supported the way complaints had been managed The records associated with these events and the minutes of continual medical education (CME) meetings showed the practice had managed these consistently over time and so could evidence a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last 2 years and were reviewed regularly. A slot for significant events was on the practice continual medical education (CME) meeting agenda. A dedicated meeting occurred approximately every six weeks to review actions from past significant events and complaints. Other agenda items included safeguarding vulnerable patients, including children. There was evidence appropriate learning had taken place for all practice staff and that findings were disseminated to relevant staff. Staff including GPs and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to contribute. There were similar arrangements for the reception and administrative staff to discuss and learn from events which affected them.

We were made aware that incident forms were available on the practice intranet or from the practice manager. Staff could also raise concerns by email. Once completed these were sent to the practice manager who used a system to oversee, manage and monitor them. Evidence of action taken as a result was available for example, a revised template and guidance for long-acting reversible contraception was placed on the patient record system (Emis Web) following an unplanned pregnancy.

National patient safety alerts were disseminated by one of the GP partners to practice staff where relevant. Staff we spoke with were able to give examples of recent alerts relevant to the care for which they were responsible. Recent examples included, resources to support the prompt recognition of sepsis and the rapid initiation of treatment and risk of harm relating to interpretation and action on protein creatinine ratio results in pregnant women. They also told us alerts were discussed in the CME meetings to ensure all staff were aware of any relevant to their practice and where action needed to be taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked staff about their most recent training, they knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

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

child protection plans. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority.

A chaperone policy was in place and this was visible on the waiting room noticeboard and in consulting rooms. This information was available in nine different languages, including Polish, the main other language spoken locally. Chaperone training had been undertaken by all GPs and nursing staff. If nursing staff were not available to act as a chaperone health care assistants (HCAs) were also available. All HCAs had undertaken training and understood their responsibilities when acting as chaperones including where to stand to be able to observe the examination. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Families, children and young people from disadvantaged circumstances including families currently living in parenting observation and support units were supported by the practice. They were monitored during routine appointments and referrals made to relevant organisations such as safeguarding teams or children's services where concerns were observed.

The practice had a system in place for identifying children and young people with a high number of A&E attendances. A weekly report was provided to the practice and these reports were reviewed and discussed by the GP partners. Information from these meetings were shared with health visitors and community teams which ensured patient safety. The named GP for children attended child protection case conferences, reviews and serious case reviews where appropriate. Reports were sent if they are unable to attend.

The practice had a system in place which ensured older people, families, children and young people and vulnerable people had reviews where they were diagnosed with co-morbidities (two or more diseases existing at the same time in the body) or took multiple medicines. These reviews took place annually but did not always take place at the same time. The practice was currently reviewing this system to help reduce the number of times patients needed to attend the practice.

We saw the practice had recently structured GPs and support staff to work in teams in support of continuity of patient care and to free up GP time through personal assistant support. We heard how all GPs were aware of the patients on the practices list of most vulnerable patients. All care plans for patients on this list were reviewed in line with changes in their conditions or circumstances. Each patient had their own copy of the care plan, this ensured patient safety as it could be shared with ambulance and hospital staff in emergency situations.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a nurse with lead responsibility for infection control to provide advice about the practice infection control policy and carry out staff induction training. All staff received induction training about infection control specific to their role, this training was annually updated. We saw evidence the lead nurse had carried out audits for the last and previous year and that improvements identified for action were completed on time. Practice meeting minutes detailed the findings of the audits and day to day observations were discussed.

An infection control policy and supporting procedures were easily available for staff to refer to. This enabled the practice to plan and implement control of hygiene measures. For example, we saw personal protective equipment including disposable gloves, aprons and coverings were available and used by staff during patient consultations. Staff were able to describe how they would use these measures in order to comply with the practice's infection control policy. There was also a policy for needle stick injury. We saw from staff records that the records of Hepatitis B checks were complete for all clinical staff.

Hand hygiene technique signage was displayed in staff and patient toilets. Hand washing sinks with wall mounted hand soap, hand gel and warm air hand dryers or hand towel dispensers were available in toilets and treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the

environment which can contaminate water systems in buildings). We saw the practice had carried out regular checks of water supplies in line with this policy in order to reduce the risk of infection to staff and patients.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. This had been reviewed and updated since our last inspection. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, two references, evidence of qualifications, immunisation checks such as hepatitis B, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Newly appointed staff had this expectation written in their contracts.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix met planned staffing requirements.

We reviewed staff training records and saw all staff were up to date with attending mandatory courses such as annual basic life support and safeguarding vulnerable patients. A good skill mix was noted amongst the doctors with GPs having additional diplomas in asthma, obstetrics and gynaecology, family planning, cardiology and dermatology. All GPs were up to date with their annual continuing professional development requirements and all had either been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Staff interviews confirmed the practice was proactive in providing training and funding for relevant courses for example, emergency first aid updates. As the practice was a training practice, doctors who were in training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for advice and support.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, in the administration of vaccines, cervical cytology and disease management and prescribing. Those with extended roles for example, seeing patients with long-term conditions such as asthma, chronic obstructive pulmonary disease (COPD), diabetes and coronary heart disease were also able to demonstrate they had appropriate training to fulfil these roles.

The partners had recognised the difficulties of recruitment and retention of GPs and other staff. To support recruitment and retention the practice allowed GPs to take a six week sabbatical every four years. Locum GPs were employed to stand in for the GPs absence. Additionally the practice provided financial support and bursaries for GPs to attend training courses and personal development opportunities. Following a recent staff restructure administrative and reception staff were also supported to gain new skills and responsibilities. For example, customer service training, medical secretary training and learning to support lesbian, bisexual and gay patients.

We were shown a clear leadership structure which had named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for child protection. We spoke with a number of staff on duty during our inspection and they were all clear about their own roles and responsibilities. They all told us they felt highly valued, well supported, listened to and knew who to go to in the practice with any concerns or suggestions for improvement. We heard how all partners had an 'open door' policy to encourage staff to discuss concerns or suggestions and saw how staff met informally at break times.

Good

Are services safe?

We saw from minutes that team meetings were held regularly, at least monthly with reception/admin meetings held fortnightly. Staff told us there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy, a named responsible person and relevant health and safety at work notices were displayed for staff.

Identified risks were included on a risk log. Each risk was assessed, rated and mitigating actions recorded which reduced and managed the risks. Risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager had drawn staff attention to the need to ask all visitors, such as contractors, to the practice to read the health and safety notices at the rear of the visitors signing in book.

We saw staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, where a patient had become unwell in the waiting area we saw records which showed staff had responded in line with procedures. An emergency assistance button on the practices computer system was pressed to summon all staff, a nurse took charge of the situation and the patient was made comfortable before being moved to a more private area for treatment.

For patients with long term conditions there were emergency processes in place. Staff gave us examples of referrals made for patients who had a sudden deterioration in health and told us about the positive outcomes for the patients' health as a result of the referral. For example, a patient who appeared to have had a minor stroke.

We heard about examples of how staff responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment or where they referred patients to other local support services. The practice monitored repeat prescribing for patients who received medicines for mental health needs. For example, checking with consultants following referrals to mental health services to ensure doses remained the same for repeat medicines to reduce the risk of inappropriate prescribing.