Windmill Health Centre

Quality Report

Windmill Health Centre
Mill Green View
Leeds
West Yorkshire
LS14 5JS
Tel: 0113 273 3733
Website:
www.windmillhealthcentre.nhs.uk

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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

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Overall summary

Letter from the Chief Inspector of General Practice

We inspected this practice on the 7 October 2014 as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

We found that the practice had made provision to ensure care for people was safe, caring, responsive, effective and well lead and we have rated the practice as good overall.

Our key findings were as follows:

Patients were satisfied with the approaches adopted by staff and said they were caring and helpful. They felt the clinicians were professional, empathetic and compassionate. We had a number of comments from patients who told us that the GPs took their time to listen to them.

- The practice offers flexible appointment times and is open for early morning appointments from 7 am two days per week and one late evening until 8.30 pm. The practice also offers telephone consultations and an online appointment and prescription service. Patients told us that the online system for booking appointments is straightforward and appointments are available to book one week ahead. They also said that an appointment can usually be made with a GP of their choice and they can get an appointment the same day if necessary.
- The practice has a clear vision to deliver high quality care and promote good outcomes for patients. We found that the visons and values are embedded within the culture of the practice and are being achieved. There are good governance and risk management measures in place. We found that the provider listens to patient comments and takes action to improve their service.
- We looked at how well services are provided for specific groups of people and what good care looks like for them. We found that the practice actively monitors patients. We saw that they make arrangements for older patients and patients who

Summary of findings

have long term health conditions to be regularly reviewed and to attend the practice for routine checks. We found that appointments provide flexibility for patients who are working.

We saw some areas of outstanding practice including:

- The practice held a weekly multi-disciplinary meeting with attendance from the GPs, community matron, district nurse and health visitor. Information relating to risk factors for the patients' health and welfare was shared and action plans to minimise risk were agreed. To ensure that records were up to date, the discussions and actions required were recorded directly onto patient records during the meeting.
- The practice had identified patients they considered to be at high risk of deterioration or admission to hospital due to the complexities of their health needs. Individual plans of care had been developed for these patients. The care plans were provided to patients to assist them to identify the signs and symptoms and when additional medical support may be required. The care plans contained the actions to take to ensure a timely response to their needs and relevant contact details for support. These patients' needs and effectiveness of the care plans were also discussed at the weekly multi-disciplinary meeting. We saw that there was effort on all parts of the team to ensure that all that could be done for the patients was done. It was acknowledged that patients may have contact with several GPs and other multidisciplinary staff and the discussions between all the parties were recorded in the notes to ensure a seamless service. The multi-disciplinary, timely and open nature of the meetings together with accessibility of the information meant that the care was both caring and effective.

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

- The provider should improve infection control prevention and control by ensuring the cleanliness of the building is maintained and policies and procedures in relation to sharps boxes are implemented consistently.

The risks of cross contamination had not been considered during hand washing in consulting rooms that do not have taps which meet relevant guidance.

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

Most aspects of the service were safe. The practice was clean and reasonably maintained. Effective systems were in place to provide oversight of the safety of the building. The medicines were stored and administered properly. Patients were supported by practice staff, who were able to ensure patients received appropriate treatment and support.

However there were areas of infection control practice which required improvement.

Are services effective?

Good

The service was effective. Care and treatment was considered in line with current published best practice guidelines. Patients' needs were consistently met and referrals to secondary care were made in a timely manner. Healthcare professionals ensured that patient's consent to treatment was obtained appropriately at all times. The team made effective use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff.

Are services caring?

Good

The service was caring. All the patients who completed CQC comment cards, and those we spoke with during our inspection, were very complimentary about the practice. They said they found the staff to be kind and compassionate and felt they were treated with respect. The practice had a well-established patient participation group and people from this group told us they were actively involved in ensuring patient centred approaches to care were at the forefront for the practice.

Are services responsive to people's needs?

Good

The service was responsive to patients' needs. The practice had a clear complaints policy and responded appropriately to complaints about the service. The practice was proactive in seeking the views of patients and had responded to suggestions that improved the service and improved access to the service. The practice conducted regular patient surveys and had taken action to make suggested improvements.

Are services well-led?

Good

The service was well led. The leadership team were effective and had a clear vision and purpose. There were systems in place to drive continuous improvement. Governance structures were in place and there were systems in place for managing risks.

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 made appropriate provision which ensured care for older people was safe, caring, responsive, effective and well-led.

Information from the Quality and Outcomes Framework (QOF), which is a national performance measurement tool, showed that the practice was appropriately identifying and monitoring patients in this population group. The practice actively reviewed the care and treatment needs of older people and ensured each person who was over the age of 75 had a named GP. There were systems in place to ensure that older people had regular health checks.

The practice provided some health care services to people in their own homes to support those who had difficulty attending the surgery. For example, one of the health care assistants had been trained to take blood samples and provided visits for people in their homes to take blood samples for routine tests. The practice also employed an additional practice nurse to assist with flu vaccinations in people's own homes.

We found that the practice was accessible to patients with mobility difficulties and there was an allocated parking space for disabled patients.

The practice had an information board in the waiting area which displayed information and contact details for carers support. The practice web site provided information which included support available and benefits information and links to carers agencies. Staff we spoke with were knowledgeable about local support networks.

People with long term conditions

Outstanding

The practice made provision to ensure care for people with long term conditions was safe, caring, responsive, effective and well-led.

Information from QOF data showed that the practice was appropriately identifying and monitoring patients in this population group. The practice actively reviewed the care and treatment of people with long-term conditions and had identified patients they considered to be at high risk of deterioration or admission to hospital due to the complexities of their health needs.

The practice held a weekly multi-disciplinary meeting with attendance from the GPs, community matron, district nurse and health visitor. Information relating to risk factors for the patients'

health and welfare was shared and action plans to minimise risk were agreed. To ensure that records were up to date, the discussions and actions required were recorded directly onto patient records during the meeting.

The practice had identified patients they considered to be at high risk of deterioration or admission to hospital due to the complexities of their health needs. Individual plans of care had been developed for these patients. The care plans were provided to patients to assist them to identify the signs and symptoms and when additional medical support may be required. The care plans contained the actions to take to ensure a timely response to their needs and relevant contact details for support. These patients' needs and effectiveness of the care plans were also discussed at the weekly multi-disciplinary meeting. We saw that there was effort on all parts of the team to ensure that all that could be done for the patients was done. It was acknowledged that patients may have contact with several GPs and other multidisciplinary staff and the discussions between all the parties were recorded in the notes to ensure a seamless service. The multi-disciplinary, timely and open nature of the meetings together with accessibility of the information meant that the care was both caring and effective.

The practice held regular clinics for a variety of complex and long-term conditions such as respiratory disease and diabetes. There were systems in place to ensure that patients were called for routine health checks and non-attendance was monitored and acted on through phone calls or letters to the patient.

We saw that there was a well-developed practice web site with a wide variety of health information for patients. For example, information relating to long term conditions such as diabetes and chronic obstructive pulmonary disease (COPD) was available and links to relevant organisations was also displayed.

We also saw that information for patients was displayed on notice boards in the reception area and throughout the practice and a number of health and social care information leaflets were also available.

The practice was accessible to patients with mobility difficulties. There was an allocated parking space for disabled patients.

People with long term conditions told us they felt well supported and said that their health condition was well managed.

Families, children and young people

Good

The practice made provision to ensure care for families, children and young people was safe, caring, responsive and effective.

Summary of findings

Information from QOF data showed that the practice was appropriately identifying and monitoring patients in this population group. This showed the practice actively reviewed the care and treatment needs of this patient group, including families and children with long-term conditions.

The practice provided family planning clinics, childhood immunisations and maternity services. We were told same day appointments would be made available for a child less than five years of age when requested.

Information which may indicate a risk for children was shared and monitored at the weekly multi-disciplinary meeting.

We saw that there was a well-developed practice web site with a link for patients to access the NHS choices pregnancy care planner. This gave the patients information about all the stages of their pregnancy from conception to the first few weeks after their baby's birth.

The GP told us that following reconfiguration of health visitor services their mother and baby clinic was to be moved out of the practice. However the practice had decided to continue to hold a weekly baby clinic with a GP for their patients.

Working age people (including those recently retired and students)

Good

The practice made provision to ensure care for working age people and those recently retired was safe, caring, responsive and effective.

The practice offered early morning appointments from 7 am two days per week and one late evening where appointments were available until 8.30 pm. The practice also offered telephone consultations and an online appointment and prescription service. Patients told us that the online system for booking appointments was straightforward and appointments were available to book one week ahead.

Routine health checks were available and staff had a programme in place to make sure no patient missed their regular reviews for their condition such as diabetic, respiratory and heart disease checks.

People whose circumstances may make them vulnerable

Good

The practice made provision to ensure care for people in a vulnerable circumstance was safe, caring, responsive and effective.

Staff offered support to patients to assist them access their services, such as access to translation services**,** sign language services and extended appointments. Fact sheets in different languages were also available on the practice website. These were written to explain

Summary of findings

the role of UK health services and the NHS to newly-arrived individuals seeking asylum. They covered issues such as the role of GPs, their function as gatekeepers to the health services, how to register and how to access emergency services.

The practice had identified patients they considered to be at high risk of deterioration or admission to hospital due to the complexities of their health or social care needs and the practice had a register of patients aged 18 and over with learning disabilities. Information which may indicate a risk for vulnerable adults and children was shared and monitored at the weekly multi-disciplinary meeting.

An additional nurse was employed to assist with providing flu vaccinations in the community for patients who had difficulty accessing the surgery and one of the health care assistants had been trained to take blood samples and provided visits for people in their homes to obtain blood for routine tests.

The practice had a specific notice board for carers which displayed information and contact details for carers support.

People experiencing poor mental health (including people with dementia)

Good

The practice made provision to ensure care for people who experienced a mental health problem was safe, caring, responsive and effective.

Information from QOF data showed that the practice was appropriately identifying and monitoring patients in this population group. For example, the practice had identified people who had mental health needs and patients living with dementia. The data showed that patients received relevant health checks and support.

Patients who were identified as being at risk due to their complex health or social care needs were monitored at a weekly multidisciplinary meeting. The GP we spoke with told us how they had worked closely with other agencies to support a patient with mental health needs who accessed local health services on a daily basis. This involved regular meetings with the patient to discuss their needs and offer support.

Summary of findings

What people who use the service say

We received 13 CQC comment cards and spoke with three patients on the day of our visit. We spoke with people from different age groups and with people who had different physical needs and those who had varying levels of contact with the practice.

The patients were complimentary about the care provided by the clinical staff and the overall friendliness and behaviour of all staff. They felt the doctors and nurses were competent and knowledgeable about their treatment needs and they said they were given a very professional and efficient service. They said that their long term health conditions were monitored and they felt supported.

Patients said all the staff treated them with dignity and respect and told us the staff listened to them and put them at ease and were very helpful.

Patients said the practice was very good and felt that their views were valued by the staff. They were complimentary about the appointments system and its ease of access and the flexibility provided.

Patients told us that the practice was always clean and tidy.

Prior to the inspection we received information from Health watch. Healthwatch is an organisation which voices people's concerns and provides feedback to service providers and commissioners. Through local engagement they collect vital data on how and why people use services in their area. They told us that they had received six comments from patients between March and August 2014 regarding the care received by patients and access to appointments. They told us all the comments were very positive.

We also received information from the National Patient Survey. The information below is taken from the 2013 GP Patient Surveys. People registered at general practices across England were asked how easy or difficult it is for patients to see or speak to a doctor at their practice. The results for this practice are depicted below.

The proportion of patients who would recommend their GP surgery 81.8% - In the middle range

GP Patient Survey score for opening hours 82.7% - As expected

Percentage of patients rating their ability to get through on the phone as very easy or easy 89.3% - Among the best

Percentage of patients rating their experience of making an appointment as good or very good 84.7% - In the middle range

Percentage of patients rating their practice as good or very good 93.6% - Among the best

We also saw from the NHS Choices website that two comments had been received and these recorded very positive comments about the care patients had received and the access to appointments. These patients had scored the practice five stars.

Areas for improvement

Action the service SHOULD take to improve

The provider should improve infection control prevention and control by ensuring the cleanliness of the building is maintained and policies and procedures in relation to sharps boxes are implemented consistently.

The risks of cross contamination had not been considered during hand washing in consulting rooms that do not have taps which meet relevant guidance.

Outstanding practice

The practice held a weekly multi-disciplinary meeting with attendance from the GPs, community matron, district nurse and health visitor. Information relating to risk factors for the patients' health and welfare was

shared and action plans to minimise risk were agreed. To ensure that records were up to date, the discussions and actions required were recorded directly onto patient records during the meeting.

The practice had identified patients they considered to be at high risk of deterioration or admission to hospital due to the complexities of their health needs. Individual plans of care had been developed for these patients. The care plans were provided to patients to assist them to identify the signs and symptoms of when additional medical support may be required. The care plans contained the actions to take to ensure a timely response to their needs and relevant contact details for support. These patients' needs and effectiveness of the care plans were also discussed at the weekly multi-disciplinary meeting. We saw that there was effort on all parts of the team within the action plans to ensure that all that could be done for the patients was done. It was acknowledged that patients may have contact with several GPs and other multidisciplinary staff and the discussions between all the parties were recorded in the notes to ensure a seamless service. The multi-disciplinary, timely and open nature of the meetings together with accessibility of the information meant that the care was both caring and effective.

Windmill Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC inspector and a GP specialist advisor.

Background to Windmill Health Centre

Windmill Health Centre is a single storey, purpose built building situated in the centre of a residential area. The building was built in 1960 and has been modified since then to provide a range of consulting and treatment rooms with supporting administrative areas. The practice provides Personal Medical Services (PMS) for 7993 patients under a contract with NHS England, Leeds.

There are six permanent GPs three male and three female and four practice nurses. There are also three health care assistants. An experienced team of administrative and reception staff support the practice. This includes a practice manager, seven reception staff, two secretaries and four administrators.

Normal working hours are Monday, Wednesday and Friday 8 am – 6 pm, Tuesday 7 am – 8.30 pm and Thursday 7 am – 6 pm.

Patients have access to primary care services such as health visitors and district nurses and a pharmacy in the neighbouring building.

Patients can access Out of Hours services by telephoning the NHS 111 service.

Windmill Health centre is a GP training practice.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew.

Detailed findings

We carried out an announced visit on 7 October 2014. During our visit we spoke with a range of staff including two GPs, two practice nurses, one health care assistant and one administrator, two receptionists and two secretaries. We also spoke with three patients who used the practice including a member of the practice's patient forum.

We observed communication and interactions between staff and patients both face to face and on the telephone within the reception area. We reviewed 13 CQC comment cards where patients and members of the public had shared their views and experiences of the practice. We also reviewed records relating to the management of the practice.

We also attended a multi-disciplinary meeting held in the practice during our site visit.

Are services safe?

Our findings

Safe Track Record

We found that the practice used information from different sources, including patient safety incidents, complaints and clinical audit to identify incidents. The practice had systems in place to record, monitor and learn from incidents which had occurred within the practice. Staff were able to give examples of incidents that had occurred and the processes used to report and record these. We saw records of incidents, investigation and actions taken to minimise risks of reoccurrence. We also found that staff, as a team, were involved in developing procedures to improve practice where incidents had occurred. For example, one member of staff told us how they had been involved in developing procedures to ensure that patients had received and had attended appointments following an urgent referral to secondary care such as the hospital. This was in response to an incident where a patient had not received an appointment from a secondary care service following GP referral.

The practice held a weekly multi-disciplinary meeting with attendance from the GPs, community matron, district nurse and health visitor. Information relating to risk factors for the patients' health and welfare was shared and action plans to minimise risk were agreed.

Learning and improvement from safety incidents

The practice had systems in place to learn from incidents which had occurred within the practice. We were told, and we saw from records, incidents were investigated and then discussed at all levels of the practice and any learning points were actioned. For example, we were told by GPs and staff incidents were initially discussed at the practice weekly business meeting attended by GPs and the practice manager and any agreed actions were alerted to staff as required by the practice manager.

Staff told us incidents and any actions taken were also discussed and reviewed as a team at an annual significant event meeting. Any further actions to improve practice were then agreed and procedures updated as required. The staff group valued this involvement and felt their views were taken into account. Staff were able to tell us how practice had changed to minimise risks of reoccurrence following incidents. For example, a staff member described how practice had been changed for the management of repeat prescriptions following an incident of over prescribing.

We saw the system used to record significant events also prompted a six month review to reflect on each incident to ensure the effectiveness of the actions taken.

Reliable safety systems and processes including safeguarding

The practice had a dedicated safeguarding lead. We saw that information was available to all staff which advised staff how to escalate any safeguarding concerns and relevant contact details were readily available. The staff we spoke with were aware of how to escalate any concerns regarding safeguarding. One person described the action they had taken when they were concerned about a child, the description indicated that they were able to recognise risk and act appropriately. Records showed staff had received training in safeguarding both adults and children. Clinical staff had all received level 2 training in safeguarding. The practice manager told us that they were aware that GPs should have level 3 training and the GP with the safeguarding lead role was booked on the next available training date in January 2015. The practice manager said that they had discussed the lack of availability of level 3 training with the local Clinical Commissioning Group (CCG). Information which may indicate a risk for vulnerable adults and children was shared and monitored at the weekly multi-disciplinary meeting.

Procedures for chaperoning patients were in place. Staff had received training in this area and appropriate recruitment checks had been completed for this role. Notices were displayed in the practice explaining the chaperoning procedures.

A system was in place to respond to safety alerts from external sources which may have implications or risk for the practice. These included NHS England, Medicines and Healthcare Products Regulatory Agency (MHRA) and National Patient Safety Agency (NPSA). A hard copy of the alerts and guidance was maintained and was easily accessible to staff. The practice manager told us that as alerts came into the practice she checked these for relevance to their practice and ensured required actions were taken. Records of action taken in response to alerts were recorded.

Are services safe?

The staff had received training in health and safety, first aid and fire safety procedures.

The appointments systems allowed a responsive approach to risk management. For example, where there were no appointments available for people on the same day, a triage system was managed by the GP on duty. We were also told same day appointments would be made available for a child less than five years of age.

Medicines Management

Medicines were kept in a secure storage area, which could only be accessed by clinical staff.

Any changes in guidance about medicines were communicated to clinical staff by the practice manager.

We checked the refrigerators where vaccines were stored. We looked at a selection of the vaccines stored and found they were within the expiry date. Logs of the temperature checks of the fridges used to store vaccines were maintained. Following a recent breach in the cold chain we saw that appropriate action had been taken to minimise risks to patients and additional equipment had been purchased to reduce the risk of any further breach.

We also saw that medicines for use in emergencies were well organised and accessible to staff. The records showed that the medicines were routinely checked and systems were in place to clearly identify the medicines expiry date to staff who may access the medicines.

There was a dedicated "prescribing team" within the reception staff group who dealt with prescription matters to reduce the risk of errors. Requests for repeat prescriptions were taken by e-mail, online, post, via the local pharmacy or at the reception desk. To minimise risks ordering prescriptions via the phone was not encouraged and only available by prior agreement for some patients who were housebound. Repeat prescriptions were signed by the GP who usually saw the patient or by the GP who had last seen the patient. Where an incident had occurred relating to repeat prescriptions requests, systems had been put in place to minimise this risk. Staff were aware of these systems and could describe the processes used.

We saw that medicine reviews were carried out and that the clinical system also prompted repeat medicine reviews. There were procedures in place for GP reviews and the monitoring of patients on long term medicine therapy. For example, patients prescribed one group of medicines were monitored by one GP and there were specific computer systems in place to assist in this task which also identified non-attendance for appointment's and tests.

We saw that health check due dates were documented on prescriptions to remind patients to book an appointment.

Cleanliness & Infection Control

The practice had an infection control policy and guidelines in place. This provided staff with information regarding infection prevention and control, including hand hygiene, managing clinical waste and environmental hygiene. One of the nurses had a lead role for infection control in the practice and staff had completed training in infection prevention and control. We observed appropriate use of personal protective equipment when staff were dealing with specimens brought to the practice by patients. An external audit of the infection control processes had been completed in 2011 and an internal audit had been completed in 2013. Action plans had been implemented to address most identified shortfalls. However we found some infection control policies and procedures were not consistently followed and systems to check adherence to policies and procedures were not always completed.

The practice employed domestic staff and cleaning frequency schedules were available for all areas but records were not completed to identify which tasks had been completed when and by whom. The practice manager informed us that monthly checks of the standards of cleaning were undertaken but also informed us records of these checks were not completed. We observed most of the consulting and treatment rooms were visibly clean and reasonably maintained with adequate storage. However we did observe a collection of dust on some surfaces such as cupboard tops, horizontal blinds and privacy curtain rails in three consulting rooms.

We saw that hand gel dispensers and instructions about hand hygiene were available throughout the practice. However hand washing facilities in the consulting rooms did not meet Health Technical

Memoranda (HTM) 64 specification and design guidance in relation to taps. This had previously been identified in the external audit in 2011 and replacement of the taps was included in the 2013 infection control audit action plan

Are services safe?

although no date for completing the work required was identified. The GP we spoke with could not tell us when this work was planned and could not describe the processes in place to minimise risk of cross contamination.

We also saw that some flooring had been replaced with washable hard floors although this did not meet relevant guidance, such as the Department of Health, Health Building Note 00-10: Part A – Flooring. This document states that in clinical areas there should be a continuous return between the floor and the wall. For example, coved skirting's with a minimum height of 100 mm to allow for easy cleaning.

The practice manager told us she was aware of the relevant guidance and due to the design of the buildings electrical circuits and plumbing systems, flooring and taps as stated above could not be fitted without major works to the whole building. The practice manager told us that quotes for works to the present building had been obtained but there were no plans in place for this work to be completed in the short term. The manager told us discussions had been held with NHS England and its predecessor organisation since 2012 about the provision of a new building.

The practice had procedures in place for the safe storage and disposal of needles and other sharps and waste products. However we found that these procedures were not always being followed in relation to dating and signing the boxes used for disposal of needles and sharps when they were put into use. This issue had been identified in the 2013 infection control audit and an action plan had been put in place to improve practice which included weekly checks. However the weekly checks had not been completed on a consistent basis and the last check had been completed on the 15 September 2014.

Equipment

Emergency drugs and equipment were stored in an accessible place and some emergency medicines were available to clinical staff in each surgery.

A defibrillator and oxygen were readily available for use in a medical emergency and were checked each day to ensure they were in working condition. Safety notices relating to equipment were displayed appropriately.

We saw that equipment had up to date portable appliance tests (PAT) completed and systems were in place for the routine servicing and calibration of equipment, where needed.

Staffing & Recruitment

We found that there were policies and procedures in place to support the recruitment of staff although these were basic and did not cover essential checks such as disclosure and barring service (DBS) and professional registration checks such as nurse's registration with the Nursing and midwifery Council (NMC). However when we looked at a sample of staff recruitment files we found appropriate pre-employment checks had been completed. Records showed ongoing checks of staff registration with professional bodies, such as the NMC which confirmed they were able to continue to practice and DBS checks had been completed for staff as appropriate to their role.

We were told by the GP that they used previous trainees as locums or they were arranged via Yorkshire Medical Chambers or a locum agency as necessary. A locum pack was available on the practice intranet in each surgery, which provided the locum GP with relevant and up to date information about the policies and procedures in the practice,

Staff told us there were sufficient staff employed by the practice to provide cover for sickness and holidays.

We received positive comments about the staff and patients told us they found all the staff to be caring and helpful.

Monitoring Safety & Responding to Risk

The practice had developed clear lines of accountability for all aspects of care and treatment. The GPs and nurses were allocated lead roles in areas such as safeguarding, information governance and infection control.

A system was in place to respond to safety alerts from external sources which may have implications or risk for the practice. These included NHS England, Medicines and Healthcare Products Regulatory Agency (MHRA) and National Patient Safety Agency (NPSA). A hard copy of the alerts and guidance was also maintained and was easily accessible to staff. The practice manager told us they ensured alerts were actioned as required.

The staff had received training in health and safety, safeguarding vulnerable adults and children, chaperoning patients and fire safety procedures. Procedures to support practice were in place and accessible to staff.

Are services safe?

The appointments systems in place allowed a responsive approach to risk management. For example, where there were no appointments available for people on the same day, a triage system was managed by the GPs.

The practice held a weekly multi-disciplinary meeting with attendance from the GPs community matron, district nurse and health visitor. We observed, during attendance at a meeting, that information relating to risk factors for the patients' health and welfare was shared and action plans to minimise risk were agreed. To ensure that records were up to date, the discussions and actions required were recorded directly onto patient records during the meeting.

The practice had identified patients they considered to be at high risk of deterioration or admission to hospital due to the complexities of their health needs. Individual plans of care had been developed for these patients. The care plans were provided to patients to assist them to identify the signs and symptoms of when additional medical support may be required. The care plans contained the actions to take to ensure a timely response to their needs and relevant contact details for support. These patients' needs and effectiveness of the care plans were also discussed at the weekly multi-disciplinary meeting.

Arrangements to deal with emergencies and major incidents

Business continuity plans were in place to deal with emergencies that might interrupt the smooth running of the practice such as power cuts and adverse weather conditions. There were joint working procedures with nearby practices to ensure business continuity.

We found that the practice ensured that the clinical staff received regular cardiopulmonary resuscitation (CPR) training. Staff who would use the defibrillator were regularly trained to ensure they remain competent in its use.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could outline the rationale for their treatment approaches and they had access to and were familiar with current best practice guidance. For example, the nurses undertaking travel vaccination used up to date websites for information and guidance. They showed us clear personalised information leaflets for the patients identifying the rationale for the recommended treatment and also further health promotion advice

The staff we spoke with and evidence we reviewed confirmed that these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We saw that the practice had identified individual's needs in relation to their physical and mental health needs and developed specific care plans to support them.

We also found that patient's needs were kept under review and information relating to patients changing needs was shared at multidisciplinary meetings.

Patients told us that they felt the GPs listened to them during consultations.

Management, monitoring and improving outcomes for people

We found that individual plans of care had been developed for patients with complex needs. The care plans were provided to patients to assist them to identify the signs and symptoms of when additional medical support may be required. The care plans contained the actions to take to ensure a timely response to their needs and relevant contact details for support. The effectiveness of the care plans were also reviewed and discussed at the weekly multi-disciplinary meeting.

The practice had a system in place for completing clinical audit cycles to monitor outcomes for patients following assessment or treatment. Examples of clinical audits included cancer diagnosis, end of life care and outcomes of joint injections. The practice had also taken part in a clinical commissioning group survey to look at admissions to the local accident and emergency department.

We found that staff had been proactive in improving systems to ensure that patients were seen within two weeks when GPs had made urgent referrals to secondary care such as hospitals. Staff told us they followed up referrals to ensure that an appointment had been made for the patient and monitored attendance at the appointments.

A patient told us their health had been closely monitored by their GP following an admission to hospital and they had worked together when making decisions about their care and treatment.

Information from the quality and outcomes framework (QOF), showed that the practice was appropriately identifying and monitoring patients with long term health conditions.

Effective staffing

From our review of staff training records, we found staff completed an induction programme relevant to their role and training considered to be essential, such as fire awareness, information governance and safeguarding adults and children. Staff told us they also had access to additional training related to their role and for personal development. For example, a health care assistant told us they were receiving additional training to extend their skills and a receptionist told us they had expressed an interest in secretarial work and they were undertaking training for this role.

We saw from a review of staff files that internal annual appraisals were completed for nursing, health care and administration and support staff. Appraisals were completed by the person's line manager and included the individual's review of their own performance, feedback from the line manager and planning for future development.

We also saw that there was a formal monitoring system in place to ensure that healthcare professionals employed at the practice had up to date professional registration with professional bodies such as the Nursing and Midwifery Council (NMC).

Many of the staff had worked at the practice for a number of years and they told us they enjoyed their work and felt well supported.

Are services effective?

(for example, treatment is effective)

Working with colleagues and other services

Staff told us that everyone worked as a team in the practice and all the staff we spoke with felt they were listened to and involved in the running of the practice. There were clear lines of accountability and staff understood their role.

The practice used a computer system which enabled staff to complete a number of tasks electronically. This system enabled staff to communicate that a task was required to be completed. For example, reception staff could send a task to the GP to review repeat prescription requests and the GP could send a referral task to the secretary. Information received into the practice was scanned onto the individual patient records and tasks were highlighted electronically for the GPs to review. This system also enabled timely transfer of information with out of hour's services.

Staff told us they had regular meetings and were able to describe the content of the discussions in the meetings and any actions taken in response. However the manager told us these were not recorded so we were unable to verify the content of the discussions and any actions taken.

Information Sharing

Staff had access to systems relevant to their role and all staff had access to up to date practice policies and procedures stored on the computer systems. Staff told us they were kept informed by the practice manager if there had been any changes to policies and procedures. We saw that computer systems were easy to navigate. We also saw that the practice had a library of reference books and copies of procedures such as the local multi-agency safeguarding procedures.

The practice worked with other health professionals to share information relating to patient care during weekly multi-disciplinary meetings.

The practice nurses told us they were supported to attend local meetings such as the Clinical Commissioning Group (CCG) nurse and health care assistants' meetings.

Consent to care and treatment

We saw that appropriate consent to treatment had been obtained and consent forms were scanned onto computerised patient records.

Training records showed that the majority of GPs, nurses and health care assistants and three reception staff had received training in mental capacity and consent.

Clinicians we spoke with showed an understanding of mental capacity and issues relating to gaining to consent.

Health Promotion & Prevention

We saw that there was a well-developed practice web site with a wide variety of health information for patients. For example, information relating to long term conditions such as diabetes and chronic obstructive pulmonary disease (COPD) was available and links to relevant organisations was also displayed. There was also a link for patients to access the NHS choices pregnancy care planner from the website which gave the patients information about all the stages of their pregnancy from conception to the first few weeks after their baby's birth.

We also saw that information for patients was displayed on notice boards in the reception area and throughout the practice and a number of health and social care information leaflets were also available.

The practice also offered a range of services to support patients such as disease management and health promotion clinics which included asthma, diabetes, family planning and routine health checks.

The practice provided immunisations for travel and also provided this service for patients from other practices. We saw from patient records that there was a clear rationale for the advice given and copies of the information provided to patients was stored on the patient records.

The GP told us that following reconfiguration of health visitor services their mother and baby clinic was to be moved out of the practice. However the practice had decided to continue to hold a weekly baby clinic with a GP for their patients.

The lead GP told us that they employed an additional nurse for a short period of time every year to assist with providing flu vaccinations in the community for patients who had difficulty accessing the surgery.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Patients told us they were satisfied with the approaches adopted by staff and found them to be caring and helpful. They said they felt clinicians were professional, empathetic and compassionate. We had a number of comments from patients who told us that the GPs took their time to listen to them.

We observed staff interactions with patients in the waiting area and on the telephone to patient, kind and respectful.

The waiting area was close to the reception area and patients could be overheard speaking to reception staff. However patients could speak with reception staff in private in another room if required and notice to inform patients of this was displayed.

Consultations took place in purposely designed consultation rooms with an appropriate couch for examinations and curtains to maintain privacy and dignity. There were signs explaining that patients could ask for a chaperone during examinations if they wanted one and staff had received chaperone training.

Care planning and involvement in decisions about care and treatment

Patients told us they were involved in planning their care and told us they felt fully informed about their care and treatment. One patient described the approach to planning care as working together with their GP.

We attended a multidisciplinary meeting which was held weekly in the practice. We observed that care plans for patients with complex needs were detailed, reviewed regularly and monitored for effectiveness.

Staff told us that where patient's first language was not English they could have access to language line via the telephone or an interpreter service to assist during the consultation. They also said they had close links with the signing service and gave an example of how they had worked with the signing service on home visits to patients with a hearing impairment. Fact sheets in different languages were also available on the practice website. These were written to explain the role of UK health services and the NHS to newly-arrived individuals seeking asylum. They covered issues such as the role of GPs, their function as gatekeepers to the health services, how to register and how to access emergency services.

We saw that there was a well-developed practice web site with a wide variety of health information for patients with links to relevant organisations.

Patient/carer support to cope emotionally with care and treatment

Patients told us they felt supported by the practice. Patients with complex needs were provided with a detailed plan of care which would enable them to monitor their symptoms and access timely and appropriate care.

The practice had a specific notice board for carers which displayed contacts for carers support and information. The practice website also prompted people to register with the practice that they were a carer so that they could be added to the practice list of carers. This enabled the practice to monitor their health and welfare and for the practice to try to be flexible with appointments around their caring commitments. The practice website contained a link to NHS choices website which gave a wide variety of information for carers including contact details and benefits advice.

The GP we spoke with told us how they had worked closely with other agencies to support a patient with mental health needs who had accessed local health services on a daily basis. This involved regular meetings with the patient to discuss their needs and offer support.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found that the practice was accessible to patients with mobility difficulties. There was an allocated parking space for disabled patients.

Staff said they had access to translation services for patients who needed it. The reception staff also told us that they were familiar with patients who may need additional support and when these patients booked an appointment they ensured additional time was allowed for the appointment if required.

The practice held regular clinics for a variety of complex and long-term conditions such as respiratory disease and diabetes. There were systems in place to ensure that patients were called for routine health checks and non-attendance was monitored and acted on through phone calls or letters to the patient.

People with long term conditions told us they felt well supported and said that their health condition was well managed.

The practice had an active Patients' Forum which met twice a year. We spoke with a member of the forum who told us they had been involved with planning patient surveys and developing an action plan following feedback. For example, they told us that as a result of feedback from surveys the parking for patients with a disability had been improved.

Tackling inequity and promoting equality

A GP told us they provided services to support those who had difficulty attending the surgery. For example, one of the health care assistants had been trained to take blood samples and provided visits for people in their own homes to obtain blood for routine tests. The practice also employed an additional practice nurse to assist with flu vaccinations in people's own homes.

The GP told us that, following reconfiguration of health visitor services, their mother and baby clinic was to be moved out of the practice. However the practice had decided to continue to hold a weekly baby clinic with a GP for their patients.

Staff said they had access to translation services for patients who needed it. The reception staff also told us that they were familiar with patients who may need additional support and when these patients booked an appointment they ensured additional time was allowed for the appointment if required.

The practice had improved parking for patients with a disability.

Access to the service

The annual patient forum reports showed action plans to improve access to the service had been implemented following annual patient surveys. For example, following the 2012 survey, the telephone system was reviewed and changed to improve patient access. .

Patients registered at general practices across England were asked in the 2013 GP patient surveys how easy or difficult it was for patients to see or speak to a doctor at their practice. Positive results were recorded from this survey for this practice. For example, the percentage of patients rating their ability to get through on the phone as very easy or easy was 89.3% which was among the best and 84.7% rated their experience of making an appointment as good or very good which was in the middle range. The score for opening hours was 82.7% which was as expected.

Patient comments about access to services were also recorded on the NHS Choices web site and Health watch had received comments from six patients between March and August 2014. The comments relating to care and access to appointments at the practice were all positive

We found that the practice offered early morning appointments from 7 am two days per week and one late evening where appointments were available until 8.30 pm. The practice also offered telephone consultations and an online appointment and prescription service. Patients told us that the online system for booking appointments was straightforward and appointments were available to book one week on advance. They also said that an appointment could usually be made with a GP of their choice and they could get an appointment the same day if necessary. They said that surgery generally ran on time and reception staff always explained any delays. We observed that when a patient made an appointment a text message would be sent to the patient as a reminder of the appointment made.

Information about appointment times were displayed at the practice and on the practice website.

Are services responsive to people's needs?

(for example, to feedback?)

There were processes in place for home visits by the GPs, practice nurses and health care assistants. These included routine visits for blood to be taken for tests and flu vaccinations.

The practice web site was well developed and easy to navigate. It provided a wide range of information about the practice, policies and procedures, i.e. complaints and data protection procedures, health information including information about long term conditions, family health, and specific information relating to men's, women and children's health and a pregnancy planner. The web site also contained information relating to the patient forum group, survey results and action plans. However some patients we spoke with were not aware the practice had a web site.

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.

Prior to the inspection the practice manager sent us a summary of the complaints received since November 2013. This showed that five complaints had been received. The information indicated that prompt responses were provided to patients and detailed investigations were completed where required.

During the site visit we reviewed how these complaints were documented and stored. We saw that initial complaints were stored as a paper file and scanned onto individual computerised patient records which were held separately from the clinical record. Investigation reports and responses to the patient were also stored on individual patient records. We also saw that a comments box and complaints forms were available at reception.

Staff told us that the practice manager would advise them if there were any required actions arising from complaints and procedures would be updated as necessary.

During our visit a patient brought a concern to our attention which they were going to discuss with their GP. With the patient's consent, we also brought this to the attention of the practice lead GP. They checked the concerns had been recorded and acted upon. They told us they would also review the concerns for any learning and action points.

Are services well-led?

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

Our findings

Vision and Strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values within the practice statement of purpose. This document stated the overall purpose of Windmill Health Centre was to provide high quality, patient focused care for the local population. Their aims to achieve this included, understanding the needs of patients and involving them in decisions about their care, working with patients to improve their long term health and providing services which support them to do this, continually striving to review performance so that they can ensure they provide safe and effective care and developing a culture of continuous improvement where staff are encouraged to be involved in the running of the practice.

Our discussions with staff and patients indicated that these visons and values were embedded within the culture of the practice and were being achieved.

We found there was a well-established management structure with clear allocation of responsibilities and all the staff we spoke with understood their role. We found that the senior management team and staff challenged existing arrangements and looked to improve the service being offered. All the staff we spoke with felt that the practice delivered a high quality of service and told us the practice was patient centred. A patient who had been registered at the practice for many years told us that the practice continuously looked to improve.

Governance Arrangements

There was a governance framework to support the delivery of the good quality care. Staff were clear about their roles and understood what they are accountable for. All the staff we spoke with commented positively on how all the staff worked together as a team. Staff told us the GPs and the practice manager were very approachable and they said their opinions were taken into account. Some GPs and nurses had lead roles in areas such as safeguarding, infection control and governance.

There were assurance systems and performance measures, which were reported and monitored, and action was taken to improve performance. Patients and staff views were sought through surveys and the patient forum and were taken into consideration. A member of the patient forum said that the management listened and acted upon survey findings.

Clinical and internal audits were used to monitor quality and systems in the practice and to identify where action should be taken. There were arrangements for identifying, recording and managing risks although we found these were not always implemented consistently in some infection control procedures.

We found that there were induction and initial training programmes for all staff and ongoing appraisal. Staff told us that they found their appraisals to be a very positive experience. The practice provided training for doctors who were seeking a career in general practice.

Leadership, openness and transparency

The practice manager and lead GP understood the challenges to good quality care and listened to patients and staff. The lead GP told us that they had tried to develop an open and friendly culture and felt that this was one of the practice strengths. This was confirmed by the staff who all spoke very positively about the practice and the management.

Staff told us the management were visible and approachable. They said the manager had an open door policy and encouraged them to be involved in problem solving solutions. Staff told us they felt supported, respected and valued.

The staff told us the practice focused on the needs and experience of people who used services and shared learning experiences to improve outcomes for people.

The member of the patient forum told us that they felt listened to and said the practice worked with the patient forum to improve.

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

The practice had a well-established patient forum group and from a review of the minutes of their meetings we found this group were very effective and engaged.

We found, from records and discussion with a member of the group, their views were listened to and used to improve the service. We also found they had been involved in designing practice surveys; making decisions about how

Are services well-led?

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

best to get feedback from patients and plans for acting on the outcome of the surveys. However some of the patients we spoke with were not aware of the patient forum and they said they would have been interested in joining the group.

The annual patient participation reports showed action plans had been implemented. For example, following the 2012 survey, the telephone system was reviewed and changed to improve patient access. Following the 2013 survey improvements were made to the car park to improve access for patients with a disability and systems to communicate with patients was improved.

The staff and the patient forum member said they found the GPs very approachable and open to their ideas to improve the practice. Staff told us they were actively encouraged to be involved in developing methods to improve practice and outcomes for patients. They told us they were kept informed about any learning points from incidents and complaints.

Management lead through learning & improvement

We saw that an induction programme was completed by new staff and the majority of staff had completed essential training. Essential training for all staff included; fire awareness, information governance and safeguarding vulnerable adults and children. Staff also had access to additional training related to their role and for personal development. We saw that a training matrix for all staff employed in the organisation was in place and up to date. Personal development plans were discussed at appraisal and staff confirmed these were implemented.

We saw that the practice had regular meetings. However only attendance was recorded and the manager informed us that detailed records of meetings were not completed. We could not therefore verify the content of the discussions or any actions taken as a result of the discussions. The lead GP told us that any incidents were discussed at the practice weekly business meeting. Nurses told us they discussed incidents at their monthly meetings and other staff we spoke with told us any learning points for complaints or incidents in the practice were discussed at their monthly staff meeting. They told us they were also involved in annual significant event meetings where, as a team, they discussed any incidents that had occurred and they were encouraged to consider any areas where practice could be improved.

Patient admissions to hospital were discussed and reviewed at the weekly multidisciplinary meetings and the practice had been involved in an external audit of admissions to accident and emergency.