

Liscard Group Practice - Staples B

Quality Report

Liscard Group Practice - Staples B

Liscard Group Practice

Victoria Central Health Centre

Wallasey

Merseyside

CH44 5UF

Tel: 0151 638 4764

Website: www.liscardgrouppracticewirral.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

This is the report of findings from our inspection of Liscard Group Practice – Staples B. The practice is registered with the Care Quality Commission to provide primary care services.

We undertook a planned, comprehensive inspection on 26 January 2015 at the practice location in Wallasey, Merseyside. We spoke with patients, relatives, staff and the practice management team including clinical staff.

The practice was rated overall as good.

Our key findings were as follows:

- Patients spoke well of the practice. They said they were treated with compassion, dignity and respect. Information was provided in ways useful to them to help them understand the treatment choices and the care available.
- Patient's needs were assessed and care was planned and delivered in line with current legislation and best practice guidelines.

- The practice provided care to its population that was responsive to their health needs. Patients were listened to and feedback was acted upon.
- The practice had been effective over many years with smoking cessation initiatives which had reduced smoking related illness in the patient population.
- The practice offered a range of services on site and in co-operation with others in order to provide safe, effective and responsive services to the local community.
- The practice was responsive in developing treatments; medical input into intermediate care and in support of patients with dementia.
- The practice had a good track record for maintaining adult and child safeguarding.

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?

The practice is rated as good for safe. Information and data from NHS England and the Clinical Commissioning Group (CCG) indicated that the practice had a good track record for maintaining patient safety. Staff demonstrated they were aware of their responsibilities to raise concerns and report incidents. They had received appropriate training to do so. There was evidence of lessons learned and these were shared with staff. Systems were in place to assess and reduce risk. Safety information was monitored and timely action taken where required.

Good



Are services effective?

The practice is rated as good for effective. National Institute for Health and Care Excellence (NICE) guidance was referenced and used. People's individual needs were assessed. Care was planned and considered in line with legislation and the promotion of good health. Staff had received relevant training and support. Clinical staff took the lead for management of various longer term conditions and offered services and treatments to meet patient needs. They had undertaken further training in relation to these roles. Effective multidisciplinary working was in place. There were effective working arrangements with community services and patient outcomes were carefully monitored.

Good



Are services caring?

The practice is rated as good for caring. Patients said they were treated with compassion, dignity and respect. Patients told us they felt involved in care and treatment decisions and they had confidence in their clinicians. We observed a patient-centred culture and found evidence that staff were motivated and provided compassionate care. Accessible information was provided to help patients understand the care and support available to them.

Good



Are services responsive to people's needs?

The practice is rated as good for responsive. It engaged with other local practices and the local Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients told us they had good access to the practice and appointments with a clinician. The doctors made home visits if needed. The services which the practice delivered took into account patients with complex needs for example, poor mental health, substance misuse, long term conditions and those living with dementia.

Good



Summary of findings

Are services well-led?

The practice is rated as good for well-led. The practice had clear vision and governance arrangements in place to safeguard the delivery and management of safe and effective services for patients. These systems were applied by leaders who encouraged all staff to make continual improvements to the quality of services, wherever possible.

The leadership team had implemented a vision for high quality care. It had contributed to the delivery of a locally provided intermediate care service to which it provided responsible medical services. It had also made specific contribution to the on-going development of services offering a model for quality end of life care. All of which had been achieved by a commitment to close working with other providers.

Good



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

The practice was rated as good for the care of older people. Information on healthy living and self-care was available in the in the surgery. Patients aged over 75 had a named GP. Staff who had worked at the surgery for a number of years, knew patients well and were aware of those patients with more complex health conditions. Other healthcare professionals such as district nurses and palliative care nurses were closely involved with the culture of the surgery ensuring that the care for older people was coordinated with other care services. The practice had a good working relationship with local care homes.

Good



People with long term conditions

The practice was rated as good for the care of patients with long term conditions. Patients with long term conditions were managed by the GPs. Regular reviews of long term conditions such as chronic heart disease, diabetes and chronic obstructive pulmonary disease were undertaken, with alerts identified on the practice system for when review of each patient's treatment and care was due.

Good



Families, children and young people

The practice was rated good for the care of families, children and young people. All staff had received adult and child safeguarding training appropriate to their role. Children and young people were treated appropriately and their consent to treatment obtained in accordance with current guidance. Antenatal, childhood immunisation clinics and mother and baby clinics were available. The practice monitored any non-attendance of babies and children at these clinics and worked in collaboration with health visiting services to follow up any concerns.

Good



Working age people (including those recently retired and students)

The practice was rated as good for the care of working age people (including those recently retired and students). The practice had a range of appointments available including pre-bookable and telephone consultations. Staff were mindful of the needs of this population group and would try to accommodate patients who were working by offering early or late appointments. Working age patients told us they were able to receive advice, or make an appointment, or attend an appointment at a suitable time for them.

Good



Summary of findings

People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including children and adults at risk of abuse, patients with dementia, terminally ill and those with a learning disability. The practice offered annual health checks for patients with a learning disability. By offering these patients longer appointments the practice allowed sufficient time within the patient consultation to ensure their health needs were fully addressed. Staff understood how to identify and safeguard vulnerable patients. The staff knew the practice patients well and were able to identify a patient who may be at risk.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice kept electronic registers to inform the clinicians and to deliver full assessments of patients' needs. The practice was able to signpost patients experiencing poor mental health to access support groups and organisations. The practice worked with various agencies, multi-disciplinary teams and mental health services to improve the experience of care and treatment of patients experiencing poor mental health, including those with dementia.

Good



Summary of findings

What people who use the service say

We spoke with nine patients during our inspection. We spoke with people from different age groups, who had varying levels of contact with the practice.

They told us the staff who worked there were polite and helpful. They also told us they were treated with respect and dignity and they found the premises to be clean and tidy at all times. Patients spoke positively about their GP. Patients told us they were happy with the appointments system.

We left Care Quality Commission (CQC) comment cards in the practice in the two week period leading up to the inspection. We received three completed comment cards.

We also reviewed the results of the 2015 GP patient survey. This is an independent survey run by Ipsos MORI on behalf of NHS England.

- 89% of respondents find it easy to get through to this surgery by phone

Local (CCG) average: **80%**

- 70% of respondents usually wait 15 minutes or less after their appointment time to be seen

Local (CCG) average: **67%**

- 89% of respondents say the last nurse they saw or spoke to was good at involving them in decisions about their care

Local (CCG) average: **88%**

- 83% of respondents say the last GP they saw or spoke to was good at involving them in decisions about their care

Local (CCG) average: **86%**

- 64% of respondents would recommend this surgery to someone new to the area

Local (CCG) average: **84%**

- 82% of respondents find the receptionists at this surgery helpful

Local (CCG) average: **90%**

Liscard Group Practice - Staples B

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP and a specialist advisor who was a practice manager.

Background to Liscard Group Practice - Staples B

Liscard Group Practice - Staples B is a partnership of two GP's. It is located in the Victoria Central Health Centre, which is a modern, purpose built building in which other healthcare providers are also located. The practice relocated to the health centre in 2009.

The practice provides medical services under the terms of a Personal Medical Services (PMS) contract and has a patient list size of 4050 patients.

The practice is part of Wirral Clinical Commissioning Group (CCG). The practice is located in an area that has above average socio-economic deprivation. The practice population is made up of a generally typical population profile for England.

The practice has three GPs one male and two female, supported by a locum GP as required. There is also a female practice nurse. The practice has one Practice Manager and six administration / reception staff.

The practice is involved in the training of fourth year medical students.

All facilities are accessible and located on the ground floor with disabled parking available on site.

Out of hour's services are provided by Wirral Community NHS Trust who provide this service at Arrow Park Hospital.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 26 January 2015. During our visit we spoke with a range of staff including GPs, the practice nurse, the practice manager, reception staff, and nine patients who used the service. We received three completed CQC comment cards which had been available in the practice for two weeks prior to our inspection.

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

Detailed findings

- 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)

Are services safe?

Our findings

Safe track record

The practice used a variety of material and data to make assessments, identify risks and improve safety for patients. For example, from feedback from patients, including any comments and complaints, reported incidents and national patient safety alerts. The staff we spoke with were able to describe to us their responsibilities to raise any concerns, and they knew how to report any incidents or near misses. Data from NHS England indicated that the practice had a good track record for maintaining patient safety. Clinicians explained to us how they completed incident reports and routinely carried out analysis of significant events as part of their on-going professional development. We looked at significant events from 2014 which had been analysed, reported and discussed with relevant staff.

We reviewed safety records and incident reports and how staff considered these for 2014. Records showed the practice had managed these consistently and could evidence maintaining a safe track record over time. The practice manager, clinical staff and any other relevant or involved staff investigated and reported the significant events. Documented evidence confirmed that incidents were appropriately reported. Action was taken to learn lessons and put measures in place to reduce the risk of the event recurring in the future. Staff told us how they actively reported any incidents that might have the potential to adversely impact on patient care. We were told there was an open and 'no blame' culture at the practice that encouraged staff to report adverse events and incidents.

The records documenting the management of complaints, incidents and significant events were discussed. The staff we spoke with were positive about the use of incident analysis and how this assisted them to develop the care provided.

Learning and improvement from safety incidents

The practice had systems in place for reporting, recording and monitoring significant events. Records of significant events that had occurred were kept and were discussed with us. Analysis had taken place and lessons learned were shared with staff through the practice intranet and email system. We saw changes in practice had been made as a result of lessons learned. For example, a monitoring system had been introduced which informed GPs if a patient

receiving certain medicines preventing blood from clotting were overdue their regular blood tests. This meant that action could be taken promptly and this monitoring system had reduced the total number of patients who were overdue their routine blood tests.

National patient safety and medicines alerts were shared with staff appropriately to ensure they were actioned.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review any safeguarding risk to children and vulnerable adults. Records confirmed that all staff had received safeguarding training to an appropriate level for their role. One GP took responsibility as practice lead for safeguarding. This included monitoring the implementation of processes and practices in relation to safeguarding. All GPs had been trained to level three. Level three training is for professionals who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding / child protection concerns.

Staff knew how to recognise the signs of abuse and were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns, and how to contact relevant agencies in and out of normal surgery hours.

Staff we spoke with knew who they should speak with in the practice if they had a safeguarding concern. The practice had comprehensive safeguarding policies and procedures for children and vulnerable adults. These were up to date and readily accessible to staff.

The secure practice computer patient record system made GPs aware of any relevant issues when patients attended for appointments. For example highlighting to the GP children subject to child protection plans and of other vulnerable patients.

The practice had a chaperone policy in place. Notices were displayed in the waiting area advising patients that they could request a chaperone during their consultation if they wished.

Patient's individual records were managed safely. Records were kept on an electronic system which collated all communications about the patient, including scanned copies of communication from hospitals.

Are services safe?

Medicines management

The practice had systems in place to monitor the prescribing of medicines and systems to ensure that treatments given were in line with national guidance. Patient medicine reviews were undertaken on a regular basis in line with current guidance and legislation depending on the nature and stability of their condition.

The practice had an electronic prescribing system but also used paper prescriptions on occasions; these were securely stored and managed. One of the GPs who was the prescribing lead regularly reviewed any alerts or guidelines and information was regularly updated on the practice's computer systems. Any changes were cascaded to staff by email alerts.

We saw the cold chain policy in place at the practice. The "cold chain" is a system of transporting and storing vaccines within a defined temperature range. Practice staff had received training in the delivery, storage and stock-rotation of vaccines. We saw that all medicines and vaccines were safely stored and in date. Fridges for storing vaccines were temperature controlled. Regular checks and records of the fridge temperature readings were in place.

The practice had processes for the safe disposal of medicines.

We looked at the emergency medicines kept at the practice. These medicines were routinely checked by the practice nurse. We saw these to be in date and they were ready for use. Medicines kept for use in an emergency were securely stored but accessible by clinicians if needed.

Cleanliness and infection control

We found the premises to be clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

There were processes in place to manage the risk of infection. We saw that all consultation and treatment rooms had suitable hand washing facilities. Examination couches were washable and clean. Curtains were labelled with the date they were changed and renewed. Instructions about hand hygiene and infection control were available throughout the practice with antibacterial hand gels in clinical rooms. We found protective equipment such as gloves were available in the treatment/consulting rooms.

We were told the practice did not use any instruments which required decontamination between use and that any

instruments used were for single use only. Procedures for the safe storage and disposal of needles and clinical waste were evident in order to protect the staff and patients from harm.

The practice manager and practice nurse shared the lead for infection control. Both had undertaken further training to enable them to provide advice on the practice infection control policy. Infection control training was undertaken by all staff. Appropriate levels of training and information updates were evident for staff with different roles (clinical and non-clinical). Staff understood their role in respect of preventing and controlling infection. For example reception staff could describe the process for handling specimens.

The practice had an infection control audit undertaken by the infection prevention and control service in July 2014. We saw the outcome report identified some improvement actions were required. These had been implemented and improvements had been made to the environment as a result.

Cleaning was carried out under contract and the cleaning standards and schedule was monitored.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

We saw records that confirmed the practice had regular checks carried out for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).

Equipment

All equipment was tested and maintained regularly and we saw equipment maintenance logs, contracts and other records that confirmed this. The estates department who managed the premises had contracts in place for annual checks of fire extinguishers and 'portable appliance testing'. We saw that annual calibration and servicing of medical equipment was up to date.

The premises were managed and maintained under contract by the estates department of the local NHS trust. We saw evidence in the form of contracts, service level agreements, risk assessments, compliance matrix and

Are services safe?

maintenance and check logs of the estates department ensuring the premises were well maintained and managed and that all statutory duties in respect of healthcare premises were undertaken.

Staffing and recruitment

The practice had three GPs and sessions from a regular locum GP. There was one Practice Nurse. The clinical members of staff were supported by six reception and administration staff and a Practice Manager. Staff reported that there were enough staff to meet the needs of patients. Staff provided cover for each other in the event of absences.

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. This included information about Disclosure and Barring Scheme (DBS) checks. The practice had a new employee checklist to ensure all relevant documentation and processes were carried out including proof of identification as well as ensuring staff received information regarding confidentiality and health and safety. We looked at recruitment documentation files which were well organised and found all necessary checks had been carried out. The practice also checked the annual professional registration status for clinical staff.

Monitoring safety and responding to risk

Procedures were in place to deal with medical emergencies. Emergency equipment was available and accessible. Emergency medicines were checked as required. Staff had received annual training in basic life support.

Accidents were recorded and investigated. Health and safety advice was sought via a contract with the organisation providing services to the building which was used by a variety of healthcare services. Risk assessments and annual reviews had been undertaken.

The practice had identified a fire marshal and a fire log was maintained. Fire extinguishers and alarms were checked and maintained.

Arrangements to deal with emergencies and major incidents

The practice had a comprehensive business continuity plan in place. This gave staff detailed guidance on how to deal with a range of emergencies that may impact on the daily operation of the practice. Risks covered a range of possible events such as power failure, adverse weather, unplanned sickness and access to the building. The document contained relevant contact details for staff to refer to. For example, details of who to contact in the event of a power failure. When we spoke with staff they were aware of the plan.

The practice had records of fire risk assessments which included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Emergency equipment was readily available and included a defibrillator and oxygen. Checks were undertaken to ensure they were ready for use and in date.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice had systems in place to ensure best practice was followed. This was to ensure that people's care, treatment and support achieved good outcomes and was based on the best available evidence. Treatment was based on nationally recognised guidance. These included the National Institute for Health and Care Excellence (NICE) guidance.

Patients we spoke with said they believed that they received care appropriate to their needs. They told us how they were involved in decisions about their care. New patient health checks were carried out and regular health checks and screenings were on-going in line with national guidance.

The GPs told us they led in specialist clinical areas including chronic disease management for conditions such as diabetes and chronic heart disease.

Discussion with the GPs confirmed that patients were being effectively assessed, diagnosed, treated and supported, whilst considering current guidance.

We found no evidence of discrimination when making care and treatment decisions. Interviews with GPs and nurses showed that the culture in the service was that patients were treated on the basis of need and that age, sex or race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

There were care plan templates in place for patients over 75 years and we were told that care plans were also in use for patients with a diagnosis of poor mental health. The purpose of these care plans was to help the practice to monitor patients at regular intervals. Electronic systems used alerts to highlight when patients were due for reviews and ensured they received them in a timely manner, for example, reviews of medicines and management of chronic conditions. The practice had effective systems to follow up and recall patients if they failed to attend appointments, for example, non-attendance at a child vaccination clinic.

The practice had systems in place for carrying out and completing clinical audit cycles. Examples of clinical audits we reviewed included "preventing stroke in people with

atrial fibrillation" (a heart condition) and "osteoporosis" (a condition that weakens bones). These audits ensured that patients received the medicines and levels of monitoring their conditions required.

One of the GP partners undertook minor surgical procedures within the practice in line with their registration and NICE guidance.

Effective staffing

The practice maintained a training matrix which recorded training received by staff and was used to plan annual mandatory training. This included basic life support, safeguarding, fire and infection control. We saw training certificates to verify that clinical staff had updated training. Staff confirmed that they were supported in identifying any training needs or personal areas for development and that protected learning time was made available.

GPs were up to date with their yearly continuing professional development requirements and either had been revalidated or had a date for revalidation. Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with NHS England.

Patients told us that they felt staff were confident in their roles and that staff seemed knowledgeable when discussing individual conditions or treatments.

The staff appraisal programme was on-going for the year 2014 / 2015. The practice manager told us, and staff we spoke with confirmed, informal supervision also took place. We saw the formal appraisal process included identification of learning needs.

Staff were supported by the clinical information updates available on the practice IT system.

Working with colleagues and other services

The practice had developed and used extensively in-house computer systems. These systems were used for the receipt, recording and communication of results, notifications and referrals. Systems were in place for handling and processing important information such as incoming blood tests ensuring that they were promptly reviewed by a GP.

Are services effective?

(for example, treatment is effective)

There were arrangements and protocols in place for following up on patients that had been referred to other services or discharged from hospital. Electronic systems were in place to ensure that clinicians communicated with patients to keep them informed.

There were processes in place to ensure other services were quickly notified of events which would impact or affect patient care, for example updating the out of hour's service in relation to patients receiving palliative care.

The practice had information available in relation to bereavement which was used to help families and friends.

GPs offered patients choices on where they could receive any planned treatment, and used the 'Chose and Book' system to facilitate this. The use and uptake of this was monitored by staff to check that patients had completed all actions required to confirm their appointment for planned treatment.

Clinicians demonstrated good working relationships with multi-disciplinary teams who worked in the community, as well as those working in secondary (hospital) care. This helped ensure patients accessed treatment and care that was 'joined up', and received appropriate advice and support when discharged from secondary care.

Information sharing

The practice made extensive use of computer systems to communicate internally and with other providers. They shared information with the out of hour's service regarding any patients with special needs. They communicated and shared information electronically wherever possible, whilst observing the provisions of the Data Protection Act 1998. We saw a variety of documentation which confirmed clear communication and good working relationships within the practice and with external services including reviews and joint decision making with regard to patient care.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were trained in the use of the different systems used to handle, manage and store patient records safely.

Consent to care and treatment

Staff told us about their understanding of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke to

understood the key parts of the legislation and were able to describe how they implemented it in their day-to-day work. They gave examples of when best interest decisions were made and mental capacity was assessed. Clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the capacity to consent to medical examination and treatment). The consent policy and procedures included Gillick competency and how to assess this and had links to further national and professional body guidance. One of the GPs was lead for the intermediate care service operating in a local nursing home and demonstrated knowledge and understanding of Deprivation of Liberty safeguards and their application relevant to patients receiving care and treatment in an in-patient care setting.

There were practice documents including policy, protocols and consent forms for specific treatments, immunisations or investigations. For example, for all minor surgical procedures and joint injections a patient's verbal consent was obtained and documented in the patient notes.

Health promotion and prevention

The practice helped patients to manage their own health and well-being. The practice offered services in line with national screening programmes, vaccination programmes, long term condition reviews and provided health promotion information to patients. They provided information to patients via the practice website and by leaflets and notices in the waiting area. The practice also offered health related messages on a TV screen, located in the patient waiting area. For example there was information about carer's support and childhood health. Staff we spoke with were knowledgeable about advisory and support services and how to help patients access them.

The practice had a long history, extending for almost two decades, of offering smoking cessation initiatives which had been effective and which had reduced rates of smoking associated conditions in the patient population.

The practice used the coding of health conditions in patients' electronic records and disease registers to plan and manage services. For example, patients on disease registers were offered review appointments with the nurse.

The practice offered a health check to all new patients registering with the practice and also offered NHS Health

Are services effective?

(for example, treatment is effective)

Checks to all its patients aged over 40. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for children's immunisations was close to the average for the local Clinical Commissioning Group (CCG). Seasonal flu immunisation rates for the over 65 group were slightly above average for the CCG. One of the initiatives that the practice had taken to improve uptake of flu vaccination in the over 65 patient group, was to provide a series of Saturday clinics, which some patients found easier to attend.

The practice had ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability who were all offered an annual health check. There were local health and support groups that the practice referred patients to, for example those who were elderly, had poor mental health or learning disability needs.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Administration and reception staff we spoke with were aware of the importance of providing patients with privacy, the importance of confidentiality and had received appropriate training. Computer screens at reception could not be viewed by patients or other visitors. Staff could take patient phone calls away from the main reception area to avoid being overheard. A small room was available off the main waiting area for patients to hold a private conversation with reception staff when required.

Consultations took place in purposely designed rooms with an appropriate couch for examinations and screens to maintain privacy and dignity. We observed staff were discreet and respectful to patients. Patients we spoke with told us they were always treated with dignity and respect.

We reviewed the most recent GP Patient Survey data available (January 2015) for the practice on patient satisfaction. Of the 90 patients who replied;

- 83% said the last GP they saw or spoke to was good at treating them with care and concern
- 90% say the last GP they saw or spoke to was good at giving them enough time
- 95% say the last nurse they saw or spoke to was good at giving them enough time

The practice offered patients a chaperone prior to any examination or procedure. Information about the chaperone service was displayed in the reception area and all treatment and consultation rooms.

Care planning and involvement in decisions about care and treatment

The GP National Patient Survey information for 2015 showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment, and generally rated the practice well in these areas.

For example the survey showed 87% that the last GP they saw or spoke to was good at listening to them. Also 82% said the last GP they saw or spoke to was good at

explaining tests and treatments. Overall, 83% said the last GP they saw or spoke to was good at involving them in decisions about their care. These results were in line with other practices in the local Clinical Commissioning Group (CCG).

Computer registers included logs of patient's carers, older people, patients suffering from mental health conditions or learning disabilities, chronic conditions, dementia or cancer.

The practice had a data protection and access to records policy that informed patients how their information was used and who may have access to information. Information was available for patients on the practice website.

Patient feedback in the three comment cards we received was positive.

Staff told us that translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

Patients told us they had enough time to discuss things fully with the doctor or nurse, they felt listened to and felt clinicians were empathetic and compassionate. Results from the GP National Patient Survey 2015 told us that 83% of patients said the last GP they saw or spoke to was good at treating them with care and concern, 95% said the last nurse they saw or spoke to was good at giving them enough time and 96% had confidence and trust in the last nurse they saw or spoke to.

The practice had developed a palliative care initiative which had been adopted by the local CCG. They had a palliative care register. Patient care plans and supportive information informed out of hours services and detailed any particular needs of patients who were receiving end of life care.

Staff told us that bereaved relatives known to the practice were offered support following bereavement. GPs and the practice nurse were able to refer patients to counselling services. The practice signposted carers to support led by community services.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We saw the practice was responsive to patients' needs and had systems in place to improve and maintain the levels of services provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice held information and registers about the prevalence of specific diseases within their patient population and patient demographics. This information was reflected in the services provided, for example screening programmes, vaccination programmes, specific services and reviews for elderly patients, those patients with long term conditions and mental health conditions.

The practice was responsive to the needs of older patients, those with long term conditions and mental health conditions and vulnerable patients. It offered home visits and extended appointments for those with more complex needs. This was to ensure patients had sufficient time within appointments to discuss and identify their on-going health care needs. Patients received relevant annual health checks and had care plans in place that were reviewed regularly.

Patients with dementia, learning disabilities and enduring mental health conditions were reviewed annually. They were encouraged to bring carers with them to these reviews. The practice had implemented the 'named GP' for patients over 75 to support continuity of care. The practice was proactive in contacting patients who failed to attend vaccination and screening programmes.

The practice had established a virtual Patient Participation Group (PPG) which was well publicised on the practice web site. However, it was comprised of just one member at the time of inspection. We spoke with the PPG representative who was very positive about the practice and it was hoped that the PPG would develop further.

Tackling inequity and promoting equality

We saw the practice was responsive to patients' needs and had systems in place to improve and maintain the levels of services provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. This was demonstrated by the layout of the Victoria Central Health Centre, which was fully accessible to all.

The practice demonstrated a good awareness of the Equality Act 2010. It ensured equal opportunities for access to services and treatments to all patients, avoiding discrimination on the grounds of age, gender, disability, status, orientation, race or religion.

English was the first language for the majority of the practice population. However, language line translation services were available for patients who spoke other languages. Staff told us this service had not been requested by patients for the last two years.

Clinical records identified patients with caring responsibilities and therefore staff were alerted to any special support or assistance they may need. Carers were given age and care related advice and support.

Telephone appointments were available.

Access to the service

The practice was open from 8am to 6.30pm Monday - Friday. Evening surgery hours were from 6.30pm - 8.30pm alternating between Mondays and Tuesdays on a weekly basis. Information was available to patients about appointments on the practice website and in the practice information leaflet. This information included who to contact for advice and for appointments out of normal working hours when the practice was closed. The practice offered pre-bookable and urgent (on the day) appointments and home visits if necessary. Appointments could be made in person, by phone or online, and booked up to one month in advance. Priority was given to children; babies and vulnerable patients identified as being at risk due to their health condition. These patients were always offered a same day or urgent appointment.

Appointments were tailored to meet the needs of patients, for example those with long term conditions and those with learning disabilities were given longer appointments. Home visits were made to care homes, older patients and other vulnerable housebound patients.

Patients we spoke with, comment cards returned and patient survey results told us patients were experiencing improved satisfaction with the appointment system

In the 2015 national GP Patient Survey;

- 89% of respondents find it easy to get through to this surgery by phone

Local (CCG) average: **80%**

Are services responsive to people's needs?

(for example, to feedback?)

- 69% of respondents with a preferred GP usually get to see or speak to that GP

Local (CCG) average: **62%**

- 70% of respondents usually wait 15 minutes or less after their appointment time to be seen

Local (CCG) average: **67%**

- 76% of respondents were able to get an appointment to see or speak to someone the last time they tried

Local (CCG) average: **88%**

- 68% of respondents describe their experience of making an appointment as good

Local (CCG) average: **79%**

Patients we spoke with told us that health issues were discussed with them and they felt involved in decision

making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about treatment they wished to receive.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England. There was a designated complaints lead in the practice. None of the patients we spoke with had needed to make a complaint about the practice but felt confident that they would be able to openly discuss any concerns with their doctor. There were five complaints recorded in 2014 which were documented, recorded and actioned appropriately.

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 in writing a clear vision and set of values which focussed on meeting the needs of patients and which had been clearly communicated with staff.

The Strategic Vision and Mission Statement reads:

"To provide high quality primary health care to our registered patients and to be an organisation with a high performing reputation"

There was evidence of short, medium and long term planning. For example, some time ago the partners began to develop efficiencies in communication and management of information within the practice by developing its in house use of information technology. Practice staff had developed flexible working in order to respond to the increase in practice work load. Clinical developments included the practice taking on the medical supervision of intermediate care beds providing medical services to up to 24 patients with the focus being on rehabilitation. The practice had been involved in the development of an end of life care initiative.

Practice support services such as human resources and practice finance and accounting had been contracted out to external providers to maintain practice focus on patient services.

Governance arrangements

The practice had a policies and procedures in place to govern its activity. These were available to staff on the computer system. Policies and procedures were dated, reviewed and up to date. Staff confirmed they had read them and were aware of how to access them.

There was a visible organisational and leadership structure with designated staff in lead roles. For example, there was a lead nurse for infection control; GP leads for safeguarding, respiratory illness, dementia, diabetes, anticoagulation, gynaecology, epilepsy, palliative care, learning disability and mental health. We spoke with staff and they were all clear about their own roles and responsibilities. They all told us there was an open culture within the practice. All staff indicated they felt part of a team. They all felt supported and knew who to go to in the practice with any concerns. They felt any concerns raised would be dealt with appropriately.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing at 92.4% for QOF in the year 2013/2014. We saw that QOF data was regularly monitored and notified to the team electronically and action plans were produced to maintain or improve outcomes.

Clinical audits were undertaken regularly by clinical staff. We looked at a selection of these. Generally they were completed with review of actions and improvements evident.

The premises management had arrangements in place for identifying and managing risks such as fire and security risk assessments. The service had a system in place for identifying and managing local risks within the practice. For example they had general environmental and health and safety risk assessments.

The practice did not hold regular in person practice meetings for all practice staff, instead relying on electronic communications. The practice held daily meetings for the GPs and Practice Manager. The practice held weekly in-house multidisciplinary team meeting (MDT). The MDT is a meeting of the group of professionals from one or more clinical disciplines who together make decisions regarding recommended treatment of individual patients. Multidisciplinary teams may specialise in certain conditions, such as cancer.

Leadership, openness and transparency

The practice made use of enhanced electronic communications and so did not hold many practice staff meetings. Staff told us that there was an open culture within the practice and they had the opportunity to raise issues electronically or with their line manager. There was a whistleblowing in place which was understood by all staff.

We reviewed a number of policies, for example being open, bullying and harassment, recruitment and selection policies which were in place to support staff. Policies were in date and relevant.

Staff felt confident in the senior leadership team's ability to deal with any issues, including serious incidents and concerns regarding clinical practice. Staff reported an open and no-blame culture where they felt able to report incidents and mistakes. All the staff we spoke with told us they felt they were valued, their views about how to develop the service were listened to and acted upon and

Are services well-led?

Good 

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

suggestions for improvements considered. The leadership of the practice was enthusiastic and motivated about the service they provided and valued the practice staff. There were fourth year medical students undertaking placements in the practice. These students were supported by the practice teams.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had set up a virtual patient participation group (PPG), but only one person was a participant at the time of the inspection. The practice retained an open invitation to patients via the web site to participate in the PPG. A patient participation report was prepared for 2013 / 2014 and the action plan arising from that was available on the website and recorded actions taken in response to this survey. The practice also sought feedback from its patients via a suggestion box which was available in the waiting area.

Staff told us that they felt engaged and considered their views were reflected in the planning and delivery of services.

Management lead through learning and improvement

The GPs had completed their annual appraisals. One GP partner had completed revalidation and one GP partner was due to complete revalidation in May 2015. Revalidation is the process where doctors demonstrate to their regulatory body, The General Medical Council (GMC), that they were up to date and fit to practice.

The practice nurse was registered with the Nursing and Midwifery Council, and as part of this annual registration was required to update and maintain clinical skills and knowledge. We saw evidence of updated training and learning undertaken.

We were told by the GPs they regularly attended local clinical meetings facilitated by the local Clinical Commissioning Group (CCG). Similarly the practice manager regularly attended meetings with other practice managers to provide support and share good practice.

The system to review policies and procedures was efficient with a central register of policies and evidence of a review procedure. There was a central register of training that staff had undertaken, or were due to complete.