

Thurrock Health Centre




Quality Report

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

Ratings

Overall rating for this service		Good	
Are services safe?		Good	
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 carried out an announced comprehensive inspection at Thurrock Health Centre, which provides a service to registered patients as well as a walk in centre, on 20 May 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective and responsive and caring services. It was also good for providing services for older people, people with long term conditions, families, children and young people, working aged people (including those recently retired and students), people whose circumstances make them vulnerable and people with mental health (including people with dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses including those related to patients who accessed the walk-in centre. Improvements were needed in how safety alerts and significant events were acted on and monitored.
- Patients' needs were assessed and care was planned and delivered following best practice guidance and referrals to secondary care services were made in a timely way.
- The practice provided a walk –in service 365 days each year from 8am to 8pm. They had robust arrangements for liaising with patients registered GPs, the local out-of-hours service and safeguarding teams. Information about patients was shared appropriately between these teams.
- Patients we spoke with said they were treated with empathy, compassion, dignity and respect. They said that they were listened to and involved in making decisions about their care and treatment. Results from the National GP Patient Survey 2015 indicated lower levels of satisfaction and negative comments about how staff engaged with them. The practice was reviewing this feedback and acting on this to improve patient experiences.
- Information about services and how to complain was available and easy to understand and complaints were handled and responded to appropriately.
- Appointments were flexible to meet the needs of all patients. Some patients reported longer waiting times

Summary of findings

to be seen and difficulties in accessing appointments. The practice had responded to this by regularly monitoring waiting times and introducing a triage system to help improve access to appointments.

- The practice had good facilities and was well equipped to treat patients and meet their needs.

- There was a clear leadership structure and staff were supported by management. The practice sought feedback from staff and patients.

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 providing safe services. Safety alerts and serious incidents were acted on and learned from to improve patient safety. The premises and equipment was suitable and safe, and risks to patient and staff safety were identified and well managed. The practice was clean and there were effective infection control procedures in place. Medicines were stored, handled and disposed of safely. Staff were recruited robustly and employed in appropriate numbers and trained to treat patients safely.

Good



Are services effective?

The practice is rated as good for providing effective services. Data made available to us showed that most patient outcomes were similar to other practices in the local area in relation to assessing and treating patients with long term conditions, vaccination and screening programmes. Treatment was planned and delivered in line with local and national guidance for GP practices. The practice staff worked with multidisciplinary teams including community nurses, health visitors and social workers to improve outcomes for patients and ensure that they received coordinated care and support as needed.

Good



Are services caring?

The practice is rated as good for providing caring services. Data from the National GP Survey 2015, Friends and Family Test and NHS Choices showed that patients rated the practice lower than others in the area for several aspects of care. Patients expressed lower levels of satisfaction for how they were treated by GPs and nurses, their involvement in their care and treatment and being listened to. The practice had taken on board these comments and had developed plans to help improve patient satisfaction. Patients we spoke with during the inspection said they were treated with dignity and respect and they were involved in decisions about their care and treatment. The practice considered the needs of patients and their families when patients were receiving palliative care and nearing their end of their life and supported families following bereavements.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and monitored and changed access to services to meet these needs. Walk-in services were available each day, including weekend and bank holidays whereby patients, including those who were not registered at the

Good



Summary of findings

practice could be seen by a nurse or GP without an appointment. The practice premises were easily accessible to patients including those with physical disabilities or impairment. Information was available to assist patients to raise complaints and or concerns. Complaints were investigated and responded to appropriately.

Are services well-led?

The practice is rated as good for being well-led. It had a clear vision and strategy to meet the individual needs of patients taking into consideration the health care needs of the local population. The practice sought and acted on the views of patients and staff to make improvements to the services provided. There was a clear leadership structure and staff felt supported by management. Learning and improvement was promoted through a system of audits and reviews.

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

accountable GP who was responsible for their care and treatment and a full range of screening and vaccinations were available. The practice identified patients who were at risk of avoidable unplanned hospital admissions and planned care in conjunction with other health and social professionals to prevent these. Regular multidisciplinary team meetings were held with other health and social care professionals to support patients and ensure that they received coordinated care and treatment.

Home visits and medicines dispensing services were provided based upon patients' circumstances and needs.

Good



People with long term conditions

This practice is rated as good for the care of people with long term conditions. The practice had effective arrangements for making sure that people with long term conditions had regular health and medication reviews. The practice offered a number of clinics including clinics for diabetes, asthma, Chronic Obstructive Pulmonary Disease, heart disease, peripheral vascular disease and some recurrent eye conditions. When patients required referral to specialist services, including secondary care, patients were offered a choice of services, locations and dates. These referrals were made in a timely way and monitored to ensure that patients received the treatments they needed.

Good



Families, children and young people

The practice is rated as good for the population group of families, children and young people. Appointments were flexible and walk-in services were available each day. Ante-natal and post-natal checks were available. The practice monitored the physical and developmental progress of babies and young children and weekly drop in sessions were held at the practice with the health visitor. Appointments for children were made available outside of school hours. There were arrangements for identifying and monitoring children who were at risk of abuse or neglect.

There was information available to inform mothers about all childhood immunisations, what they are, and at what age the child should have them as well as other checks for new-born babies. Staff proactively followed up patients who failed to attend appointments for routine immunisation and vaccination programmes. Information and advice on sexual health and contraception was provided during GP and nurse appointments.

Good



Summary of findings

Working age people (including those recently retired and students)

The practice is rated as good for the population group of working-age people (including those recently retired and students). Appointments were flexible with telephone consultations, pre-booked appointments and a daily walk-in service up to 8pm each day. NHS health checks for patients aged between 40 and 75 years were available and promoted within the practice and on their website. Nurse led clinics were provided for well patient health checks.

Good



People whose circumstances may make them vulnerable

This practice is rated as good for the care of people living in vulnerable circumstances. The practice recognised the needs of people who were vulnerable such as travelling communities and homeless people, those with, alcohol or substance misuse issues, and those with learning disabilities. The practice worked with the health visiting team to engage with travelling communities and promote health screening and childhood immunisations. Staff were trained and understood their responsibilities to report concerns about the welfare of patients to the appropriate agencies.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). People experiencing poor mental health had received an annual physical health check. The practice regularly worked with multidisciplinary teams to support people experiencing poor mental health including those with dementia. The practice carried out dementia screening services and referrals were made to specialist services as required. The practice had suitable processes for referring patients to appropriate services such as psychiatry and counselling, including The Improving Access to Psychological Therapies (IAPT) and referrals to Child and Adolescent Mental Health Services (CAMHS) as required.

Good



Summary of findings

What people who use the service say

We gathered the views of patients from the practice by reviewing data available from NHS Choices and the National GP Patient Survey results published in January 2015. Prior to our inspection we also sent CQC 'Tell us about your care' comment cards to the practice for distribution amongst patients in order to obtain their views about the practice and the service they received. We received 24 completed 'Tell us about your care' comment cards. All of the patients who completed these expressed satisfaction with the care and treatments and service they received.

We spoke with six patients on the day of the inspection, including two patients who not registered at the practice

and were accessing the walk-in services. Patients we spoke with told us that they were very happy with the practice. They commented on the helpfulness of staff and the ease of access to appointments both routine and urgent. Patients who used the walk-in service told us that they were extremely happy with the treatment they received. They told us that the service was very valuable and served the local community well.

The results from the National GP Survey 2015 and NHS Choices were less positive. Patients rated the practice lower than others locally and nationally in respect of the appointments system and their involvement in making decisions about their treatment.

Thurrock Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a Care Quality Commission practice manager specialist advisor and a Care Quality Commission GP specialist professional advisor.

Background to Thurrock Health Centre

Thurrock Centre is located in a purpose built health centre situated on Grays High Street in Essex. The practice provides services for approximately 7,500 patients living within the Grays and Tilbury area. The practice holds both General Medical Services (GMS) and Alternative Provider Medical Services (APMS) contracts and provides GP services co-commissioned by NHS England and Thurrock Clinical Commissioning Group. A walk-in service is available to patients who are not registered at the practice. This service is provided between 8am and 8pm every day including weekends and public holidays. Patients can be seen by a GP or nurse for acute (new) conditions or where they experience deterioration in their health. A range of treatments are provided to walk-in patients including wound dressings, minor injuries or emergency contraception. The walk-in service does not provide reviews of existing long term conditions, medication reviews, vaccines or repeat prescriptions and patients are advised to see their own GP for these.

The practice population is higher than the national average for younger people and children under four years and similar for working aged and recently retired, and lower for older people aged over 75 years. Economic deprivation

levels affecting children, older people and unemployment were higher than the practice average across England. Life expectancy for men and women are in line the national averages. The practice patient list has a higher than national average of working aged people who are unemployed.

The practice is managed by College Health Limited which also provides GP services in Maidstone and Medway in Kent.

The practice is open between 8am and 8pm on each day including weekend and bank holidays offering a walk-in service.

The practice has opted out of providing GP services to patients outside of normal working hours such as evenings, weekends and public holidays. Unscheduled out-of-hours care is provided by NHS 111 services and patients who contact the surgery outside of opening hours are advised of how to contact this service. This information is also available on the practice website.

Why we carried out this inspection

We inspected Thurrock Health Centre 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.

Detailed findings

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

How we carried out this inspection

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

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

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 including NHS England and Thurrock Clinical Commissioning Group (CCG) to share what they knew. We carried out an announced inspection on 20 May 2015. During our inspection we spoke with a range of staff including GPs, nurse practitioners, practice nurses, the practice manager, reception and administrative staff. We reviewed policies, procedures and other documents in relation to the management and day-to-day running of the practice. We spoke with patients who used the service, including those who were accessing the walk-in centre. We talked with carers and family members. We reviewed comment cards, NHS Choices and National GP Patient Survey results where patients and members of the public shared their views and experiences of the service.

Are services safe?

Our findings

Safe Track Record

The practice had policies and procedures for reporting and responding to accidents, incidents and near misses including those that related to the treatment of patients who were accessing the walk-in centre. The practice had reporting procedures in place for ensuring that any relevant information in respect of the treatment of patients who were registered with other GP practices was shared appropriately in the event of a safety incident. Staff we spoke with told us that they were aware of the procedures for reporting and dealing with risks to patients and concerns. They told us that they were supported to raise concerns and that the procedures within the practice worked well.

There were systems for sharing patient safety alerts received from the Medicines and Healthcare Products Regulatory Agency (MHRA)). These alerts have safety and risk information regarding medication and equipment often resulting in the review of patients prescribed medicines and/or the withdrawal of medication from use in certain patients where potential side effects or risks are indicated.

The practice manager told us that MHRA and other relevant alerts were forwarded to the GPs for review and to identify patients who may be affected. GPs including locum GPs we spoke with were able to demonstrate that they received and acted on these alerts.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents, accidents and near misses including those that related to the treatment of patients who were registered with other GPs and were accessing the walk-in centre. The practice manager told us that in the event of a safety incident these were analysed, learning shared with staff and relevant information would be shared electronically or by mail with the patients registered GP.

Staff we spoke with said that the practice had an open and 'no blame' culture and they would record, and report any significant or untoward event to their line manager. We saw that reporting forms were available on the computerised system and hard copies were also available and staff were

aware of where to find these. We reviewed the 24 significant events recorded and investigated within the previous 12 months. We found that these had been investigated and discussed during dedicated significant event meetings and learning from where things had gone wrong was shared with staff. Records we viewed showed that safety incidents and events were regularly reviewed to ensure that any learning had been imbedded in practice to improve safety outcomes for patients.

Reliable safety systems and processes including safeguarding

The practice had suitable policies and procedures in place to identify risks to vulnerable children, young people and adults. There were suitable procedures in place for sharing information with patients' GPs where they were registered elsewhere and accessing the walk-in centre. The practice had a reporting form to alert the local social services team when a child who was known to the team, such as looked after children, those on protection plans, children with learning disabilities and those who were known to the Children's and Adolescent Mental Health Services (CAMHS) attended the walk-in centre. This helped to ensure that information about children's safety and welfare was shared appropriately.

All staff at the practice had undertaken appropriate safeguarding children and adults training. The practice had a dedicated lead nurse who had oversight of the child safeguarding arrangements and met each month with local health visitors to review any ongoing concerns. Staff we spoke with were aware of the practice procedures for protecting vulnerable patients. They knew how to identify signs of potential abuse or neglect in children, older and vulnerable patients and who to report these concerns to. Staff were aware of the practice whistleblowing policy and their responsibilities for reporting concerns externally such as referring concerns to the local safeguarding team if appropriate. Staff had access to a flow chart to assist them in making referrals to the most appropriate agency such as the safeguarding team or the police.

Information about vulnerable patients was shared with staff appropriately. There was a system to highlight vulnerable patients on the practice's electronic records. GPs were appropriately using the required codes in electronic records to ensure risks to vulnerable adults and children and young people who were looked after (under the care of the local authority / in foster care) or on child

Are services safe?

protection plans were clearly flagged and reviewed. Information was used to make staff aware of any relevant issues when patients attended (or failed to attend) appointments. Records showed that information was shared between the appropriate agencies including local social services, the police and health visitors and these professionals were invited to six weekly meetings to discuss individual cases where appropriate.

The practice had a chaperone policy, which was available and easily visible in the waiting room and consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Records showed that all staff who undertook chaperone duties had been trained and appropriate checks. Discussions with staff evidenced that they understood their roles and responsibilities.

Medicines Management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There were written procedures in place for the receipt, handling and storage of temperature sensitive medicines such as vaccines to ensure that medicines remained effective and suitable for use. The actual, maximum and minimum temperatures of fridges used to store medicines were monitored daily. This helped identify any issues with the storage of medicines such as vaccines and other medicines which required cold storage to ensure that they did not exceed those recommended by the medicine manufacturer.

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

Systems were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. We found that blank prescription pads were logged and audited so that risks of misuse were minimised.

The GPs discussed the arrangements for the management of high risk medicines which may have serious side-effects. GPs told us that patients who were prescribed these

medicines had regular blood tests carried out. They told us that patients who were prescribed high risk medicines were reviewed every three months and repeat prescriptions were authorised on this basis.

The practice had robust policies and procedures in place for prescribing medicines for patients who were registered with other GPs and who were accessing the walk-in centre. Controlled medicines such as some sleeping tablets and strong painkillers were not prescribed for these patients unless it was deemed a necessity in which case a small number of medicines would be prescribed to cover the period until the patient could access the GP with whom they were registered. GPs told us that if they had concerns they would attempt to contact the patient's registered GP or refer the patient to the local out-of-hours service.

Cleanliness & Infection Control

The practice had policies and procedures in place to protect patients and staff against the risk of infections. These included procedures for dealing with bodily fluids, handling and disposing of clinical waste, dealing with needle stick injuries and managing risks associated with Legionella (a germ found in the environment which can contaminate water systems in buildings). Records showed that all staff had infection prevention and control training. The practice had an identified infection control lead nurse who had undertaken appropriate training.

Patients we spoke with during the inspection told us that they found the practice was always clean and that they had no concerns. We observed the premises to be visibly clean and tidy. Hand sanitising gels were available for patient use. Hand washing sinks with liquid soap, sanitising gel and paper towel dispensers were available in treatment rooms and toilet facilities, as were posters promoting good hand hygiene. We saw records to confirm that patient disposable privacy curtains were changed on a regular basis. We saw that the practice had arrangements to segregate and safely store clinical waste including disposable instruments and needles at the point of generation until it was disposed of.

Staff were provided with appropriate personal protective equipment including disposable gloves and aprons. Spillage kits were available for cleaning and disposing of body fluids and staff we spoke with were aware of where to locate these when needed. Records showed that all clinical staff underwent screening for Hepatitis B vaccination and

Are services safe?

immunity. People who are likely to come into contact with blood products, or are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of blood borne infections.

We saw there were cleaning schedules in place for daily, weekly and periodic cleaning tasks for general and clinical areas. Records were kept to show when cleaning had been carried out and these were audited on a weekly basis. The practice had arrangements for monitoring the infection control procedures and regular infection control audits were carried out to test the effectiveness of the procedures in place to protect staff and patients against the risks of infection. Following audits action plans were put in place, reviewed and updated to show that any areas for improvement were dealt with promptly.

GPs carried out minor surgical procedures such as skin excisions and joint injections. We saw that single use disposable instruments were provided for all procedures and staff were trained in aseptic techniques to minimise the risks of infections. Records showed that audits were carried out in respect of surgical procedures to help monitor and minimise the risks of infections.

Staff recognised patients who may be more vulnerable and susceptible to infections, such as babies, young children, older people and patients whose immune systems may be compromised due to illness, medicines or treatments. Advice and information was provided so as to help patients protect themselves against the risks of infections.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We found that the practice had sufficient stocks of equipment and single-use items required for a variety of diagnostic and screening procedures, such as blood tests, respiratory, diabetes and well person procedures. Records we viewed showed that all equipment was tested and maintained regularly. All portable electrical equipment was routinely tested. All diagnostic equipment such as weighing scales, spirometer, thermometers, ear syringe and the fridge thermometer were calibrated in line with the manufacturer's instructions so as to ensure that this equipment was fit for use. Through discussion with staff and a review of records we saw that equipment was replaced as needed.

Staffing & Recruitment

The practice had suitable and robust procedures for recruiting new staff to help ensure that they were suitable to work in a healthcare setting. We reviewed five staff records for staff including GPs, nurses and administrative staff and found that these procedures had been followed. Appropriate checks including proof of identification, employment references and security checks through the Disclosure and Barring Service (DBS) had been carried out for all staff. Pre-employment interviews had been carried out and checks made to ensure that GPs and nurses had appropriate qualifications and effective registration with the appropriate professional body, such as the Nursing and Midwifery Council (NMC) for nurses and the General Medical Council (GMC) for GPs. These checks helped to ensure that staff employed were suitable to work with vulnerable people. Inductions were in place for new staff so that they could familiarise themselves with their roles and responsibilities.

There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The practice experienced difficulties in recruiting GP and nursing staff and had an active advertisement campaign. Locum GP cover was used to support the GPs at the practice. There was a staff rota in place and staffing levels were reviewed to ensure that actual staffing levels and skill mix were in line with planned staffing requirements. The practice had arrangements for providing staff cover in the event of unplanned absence due to illness and planned leave. We saw that the practice had reviewed its busiest times and allocated extra staff to cover these. Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring Safety & Responding to Risk

The practice had robust arrangements for identifying and managing risks to staff and patients. There was a detailed health and safety policy, which staff were aware of. Risks were identified through a variety of assessments, which covered fire safety, security of premises and records, medicines management, staffing levels and untoward issues which may impact on the running of the practice. These assessments were reviewed on a regular basis to ensure that the practice environment, equipment and staff practices were safe.

The practice had policies and procedures in place for recognising and responding to risks to patients. Staff we

Are services safe?

spoke with told us that they were aware of these procedures. For example staff had access to policies and procedures for treating any sudden deterioration in patients including children and treating patients in the event of a mental health crisis. Staff were able to demonstrate that they were aware of the correct action to take if they recognised risks to patients. For example staff described how they would escalate concerns about an acutely ill or deteriorating child or a patient who was experiencing a mental health crisis.

Arrangements to deal with emergencies and major incidents

The practice had policies and procedures in place to manage medical emergencies which included treatment of patients who were accessing the walk-in centre. Records showed that all staff had received training in basic life support. Staff we spoke with including receptionists were able to demonstrate that they would act promptly in the event of a patient experiencing any deterioration in their health while on the premises. Staff told us that they would alert clinical staff to the emergency and call an ambulance if required.

Emergency medicines and equipment were available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in

an emergency). The practice was also equipped with diagnostic equipment including a 12 lead electrocardiogram and Doppler machine. There were also four emergency nebuliser machines and medicines to treat an acute exacerbation of asthma or chronic obstructive pulmonary disease (COPD). Nurses checked emergency equipment each month and these checks were recorded. All emergency medicines we checked were in date.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice such as loss of power, adverse weather conditions, staff shortages or other circumstances that may affect access to the building or a disruption of the service. The plan described staff roles and responsibilities in the event of any untoward event. Staff we spoke with were aware of the plan and what action to take should the need arise. We saw that the plan contained relevant details and contact numbers to assist staff. Any changes to the plan were communicated at the weekly practice meetings and through email communications. There were robust arrangements for assessing and managing risks of fire within the practice. Regular fire alarm tests and evacuation drills were carried out. Staff were trained in fire safety procedures. Records showed that fire safety equipment including extinguishers and alarms were tested and serviced regularly.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We saw that patient care and treatment was delivered in line with recognised best practice standards and guidelines including the National Institute for Health and Care Excellence (NICE), Clinical Commissioning Group guidelines and policies. Staff told us that information and any changes in legislation or national guidelines were shared during regular clinical staff meetings. Records we viewed confirmed this. New patients were offered health checks when they joined the practice and staff proactively contacted patients where appropriate to attend for regular health checks and reviews.

GPs had lead roles for a number of long term conditions including heart disease, respiratory conditions and diabetes. They served as a source of expertise for colleagues in the practice and were responsible for ensuring new developments or specific clinical issues were discussed at the relevant practice meetings. There were a number of clinics held at the practice including those for patients with asthma and chronic obstructive airways disease, family planning, minor surgery and diabetes. The nurse practitioner and practice nurses supported this work through nurse led clinics which allowed GPs to focus on patients with more complex healthcare needs.

All GPs we spoke with used national standards guidance for patients with suspected cancers to be referred and seen within two weeks. We saw that regular discussions were held between GPs to discuss patient care and appropriate pathways for medical conditions such as diabetes and gastro-intestinal conditions. This helped ensure that appropriate referrals were made to secondary care services where appropriate.

Staff told us that information relating to patients who accessed the out-of-hours services and patients' test results were reviewed by GPs on a daily basis. We saw that when patients were discharged from hospital, their discharge summary letters were reviewed and patients' records were updated with any changes in medicines or planned treatment.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, summarising patients' records, managing child and adult protection alerts and medicines management. Information was shared widely with staff and other healthcare professionals.

The practice participated in enhanced services commissioned by NHS England. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract in order to improve outcomes for patients). The practice kept registers of patients with learning disabilities, those receiving palliative care and patients who were identified as vulnerable or at risk of unplanned hospital admissions. Patients had care plans and the practice held regular multidisciplinary meetings. These were well attended by external professionals such as the community nursing team to help ensure that patients were treated and supported appropriately according to their assessed needs. We found that the practice was performing in line with local and national targets for the uptake of all childhood vaccinations and immunisations, flu vaccinations and women's cervical screening. For example 81% of women between the age of 25 years and 65 years had a cervical screening test performed within the previous five years compared with 82% nationally. Data showed that 95.5% of children aged 12 month had their meningitis C vaccination compared to the local CCG average 94.5%, and 93.5% of children aged 24 months which was the same as the CCG average.

Data we reviewed showed that the practice's performance in assessing and treating of patients with long term conditions such as diabetes, asthma, chronic respiratory diseases and heart disease was generally in line with the local Clinical Commissioning Group (CCG) and national averages. For example data we reviewed for 2013/14 showed that the percentage of patients with diabetes, on the register, who had a record of an albumin:creatinine ratio test in the preceding 12 months was 90% compared to 86% of patients nationally. These checks help to identify conditions associated with diabetes such as kidney disease. We saw that the practice also performed similar to other GP practices nationally for other checks and reviews for patients with diabetes.

For the same period we saw that the percentage of patients with atrial fibrillation, measured within the last 12 months, who were treated with anti-coagulation drug therapy or an

Are services effective?

(for example, treatment is effective)

anti-platelet therapy was 100% compared to the national average of 98%. This helps to reduce the risk of blood clots and strokes in patients with this heart condition. Data also showed that 91% of patients with a mental health condition such as schizophrenia had an agreed care plan in place. This was higher than the national average which was 86%.

The practice had a system in place for carrying out clinical audits, a process by which practices can demonstrate ongoing quality improvement and effective care. We saw that a number of clinical audits had been carried out including one which monitored the prescribing of a specific medicine for patients with type 2 diabetes. The results of the audit showed that prescribing was in line with NICE guidelines. Other clinical audits were conducted including one which monitored the risks associated with prescribing medicines to lower cholesterol to treat high blood pressure and angina. There are risks associated with the combined use in some patients. The two cycle audit showed that risks had been monitored and alternative medicines prescribed where this was appropriate and in line with current guidance.

The practice protocol for repeat prescribing was in line with national guidance and staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. The practice were performing in line with others in the CCG area for medicine prescribing such as use of frontline antibiotics and use of non-steroidal anti-inflammatory medicines NSAIDs (used to treat inflammatory conditions such as arthritis).

Effective staffing

The practice employed staff who were suitably skilled and qualified to perform their roles. All GPs were up to date with their yearly continuing professional development requirements. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England). The practice employed a number of locum GPs who worked regularly. There was a detailed locum GP induction pack in place and those locums staff we spoke with said that they were supported and mentored in their roles.

All clinical and non-clinical staff had clearly defined roles within the practice and were able to demonstrate that they were trained to fulfil these duties. All staff undertook annual appraisals of their performance from which learning and development needs were identified. Records viewed showed that staff had individual personal development plans in place. Staff we spoke with were positive about the peer support arrangements and working relationships between all members of staff within the practice. The practice also had systems in place for identifying and managing staff performance and providing support and further training to assist staff should they fail to meet expected standards.

Working with colleagues and other services

The practice worked with other service providers, including social services, the local hospital trust and community services to meet patients' needs and support patients with complex needs. There were clear procedures for receiving and managing written and electronic communications in relation to patients' care and treatment. Correspondence including test and X-ray results, letters including hospital discharge, out-of-hour's providers and the 111 summaries were reviewed and actioned on the day they were received. All staff we spoke with understood their roles and felt the system in place worked well. The practice worked with the local out-of-hours service making and accepting referrals for patients who accessed the walk-in centre where this was appropriate.

The practice held monthly multidisciplinary team meetings to which the relevant community health and social care professionals were invited to review and plan care and treatment for patients such as those who with life limiting illnesses and vulnerable patients. The out-of-hour's service had access to appropriate information to assist doctors to treat patients as needed when the practice was closed. The practice engaged with the local Clinical Commissioning Group for support and advice on issues relating to primary medical services.

Information Sharing

The practice had systems to share information with staff, patients and other healthcare providers. Staff used an electronic patient record to coordinate, document and manage patients' care. The practice also had procedures for sharing information with the registered GPs of patients who accessed the walk-in centre. Information regarding

Are services effective?

(for example, treatment is effective)

patient treatment provided was shared electronically where these GPs had access to the computerised system and where they did not have access this information was sent by courier or mail.

All staff were fully trained on the electronic record system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The practice used several electronic systems to communicate with other providers. For example, there were facilities for sharing patient records between GP practices when a patient registered or deregistered. The community nursing team and health visitors had access to the patient records where patients had consented to the sharing of their medical information. Electronic systems were also in place for making referrals to secondary care services such as specialist consultants. Staff reported that the systems were easy to use.

The practice had ensured the electronic Summary Care Records were completed and accessible on line. Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or outside of normal hours. Information about the sharing of patient information was available on the practice website and in written leaflets which were readily available.

Consent to care and treatment

The practice had policies and procedures in place for obtaining a patient's consent to care and treatment where patients were able to give this. The policy covered obtaining and documenting consent for specific interventions such as minor surgical procedures and vaccinations. GPs and nurses we spoke with had a clear understanding of these procedures and told us that they obtained patient's consent before carrying out physical examinations or providing treatments. We saw that where a patient's verbal consent was given this was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. Consent procedures included information about people's right to withdraw consent.

Staff we spoke with understood the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties to

meet the requirements of these legislations when treating patients. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they and/or their carers were involved in agreeing, where they were able to do so. All clinical staff we spoke with demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 years who have the legal capacity to consent to medical examination and treatment). Patients we spoke with confirmed that their treatment, options available, risks and benefits had been explained to them in a way that they could understand. They told us that their consent to treatment was sought before the treatment commenced.

Health Promotion & Prevention

There was a wide range of information leaflets, booklets and posters about health, social care and other helpful topics in the waiting room with dedicated patient information boards. These included information to promote good physical and mental health and lifestyle choices including advice on diet, smoking cessation, alcohol consumption and substance misuse. There was information available about the local and national help, support and advice services. Information about the range of immunisation and vaccination programmes for children and adults, including MMR, shingles and a range of travel vaccinations were well signposted throughout the practice and on the website.

The practice offered a full range of health checks. All newly registered patients were offered routine medical check-up appointments. Patients between 40 and 74 years old who had not needed to attend the practice for three years and those over 75 years who had not attended the practice for a period of 12 months were encouraged to book an appointment for a general health check-up. Data we viewed for 2013/14 showed that the practice performed at or above the local and national averages for the uptake of standard childhood immunisations, seasonal flu vaccinations, cervical screening (smear tests) and annual health checks for patients with one or more long-term health condition such as diabetes and respiratory diseases and those with learning disabilities.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Each of the six patients we spoke with during our inspection and 24 of the 25 patients who completed comment cards said that all staff were caring and that staff listened to them and took their views and concerns into consideration. The results from the practice patient survey in 2014 showed that 96% of patients said that staff were helpful and welcoming. We reviewed the most recent data available for the practice on patient satisfaction. This included information from the 2015 National GP Patient Survey. 74% of patients who responded said that the receptionists were helpful. 56% said the last GP who they saw were good at treating them with care and concern and 72% said that nurses did. These results were lower in comparison to GP practices both locally and nationally. The practice had reviewed these comments and had developed plans to improve patient experiences and satisfaction.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Privacy curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We saw that reception staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager who would investigate.

Care planning and involvement in decisions about care and treatment

Each of the six patients we spoke with on the day of our inspection told us that they felt they were listened to and involved in discussions about their care and treatment. They told us that health issues were discussed in a way that they could understand and they felt listened. Patients told us that they had sufficient time during consultations to make an informed decision about the

choice of treatment they wished to receive. Patient feedback on the 25 comment cards we received was also positive in respect of GPs and nurses listening and involving them in their care and treatment.

We reviewed information from the 2015 National GP Patient Survey. 72% of patients who responded to the survey said that the last GP they saw or spoke with was good at giving them enough time and listening to them. This was lower than local and national averages which were 84% and 89% respectively. 65% of patients said that the GP was good at explaining tests and treatments. This was also significantly lower than GP practices both locally and nationally. The practice reported that they experienced some staffing issues with GPs leaving the practice. They were monitoring their practices to help improve patient experiences.

The practice had policies and procedures for supporting people who may have difficulties accessing services. Staff were aware of these. They also told us that they actively engaged with patients from the travelling communities in the area to improve patient access to the practice within this population group. Discrimination was avoided when making care and treatment decisions and GPs said that the culture in the practice was that patients were cared for and treated based on need and the practice took account of a patient's age, gender, race and culture as appropriate.

Patient/carer support to cope emotionally with care and treatment

Patients who we spoke with during the inspection told us that staff were caring and that they offered emotional support as needed. We saw that the practice worked proactively with other health and social care providers including local hospice services to enable patients who wished to remain living in their homes when their health deteriorated. We saw that patients receiving palliative care had a detailed care plan, which was regularly reviewed. Information was shared with relevant health care providers, including the out-of-hours service to ensure that patients received appropriate care as they approached their end of life. The practice had procedures for supporting bereaved families and where families experienced bereavement their GP contacted them by telephone and appointments or home visits were arranged as needed.

The practice had policies and procedures in place for identifying and support patients who voluntarily spent time looking after friends, relatives, partners or others due to

Are services caring?

illness or disability. Patients who were carers for others were identified at registration and provided with

information to ensure they understood the various avenues of support available to them. Information in the patient waiting room, told patients how to access a number of support groups and organisations within the local area.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood the different needs of the population it served and acted on these to plan and deliver appropriate and responsive services. The practice regularly monitored its patient population; comments and complaints received, and reviewed its services to meet patients' needs.

The appointments system was flexible with pre-booked and on the day appointments. A walk-in service for patients who were not registered at the practice was available between 8am and 8pm 365 days each year. The practice was commissioned to see 45 patients each day in the walk-in centre and regularly saw between 50 and 60 patients daily. The walk-in centre treated 19984 patients between March 2014 and April 2015. Patients who were registered at the practice could also access the walk-in centre and the practice manager told us that a number of patients chose to do this even when 'on the day' appointments were available.

Tackling inequity and promoting equality

The practice understood and responded to the needs of patients with diverse needs and those from different ethnic backgrounds and patients whose circumstances made them vulnerable or hindered access to services. All staff had undertaken training in equality and diversity. The practice population included patients from travelling communities and patients with learning and physical disabilities. The practice offered a full range of health checks and access to telephone consultations, walk in appointments and home visits.

The practice had access to language translation services where required to support patients whose first language was not English. A hearing loop system was available to support patients who used hearing aids and devices. The premises and services were suitable to meet the needs of patients with physical disabilities for example there was step free access and practice was accessible via an automatic door. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice as well as baby changing facilities.

Access to the service

Details about how to make reschedule and cancel appointments and access to the walk-in centre was available to patients on the practice website. Appointments were available between 8am and 8pm and patients could be seen by a nurse practitioner or a duty GP without an appointment. Appointments could be booked up to six weeks in advance by telephone, online or in person. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed they referred to the NHS 111 out-of-hours service.

The practice manager told us that they regularly reviewed the demand for appointments including the walk-in service. We saw records that showed that demand during busier periods such as weekends and public holidays was regularly reviewed and extra staff were employed to cover these based on previous demand.

Patients we spoke with during the inspection, including two patients who were not registered at the practice and were attending the walk-in centre told us that they were happy with the appointment system and that they could usually see or speak with their preferred GP and same day appointments for urgent treatments if needed. Six of the 24 patients (25%) who completed comment cards reported difficulties in making appointments or seeing their preferred GP. The majority of patients were happy with the appointments system and a number of patients reported improvements in the system within the past 12 months.

We reviewed the data from the most recent National GP Patient Survey 2015. 90% of patients who participated said that they were happy with the practice opening times. This was higher than the local (72%) and national (75%) averages. Patients were less satisfied with waiting times and access to appointments. 60% of respondents said that they found it easy to contact the practice by telephone. This was lower than the local (75%) and national (72%). 69% said that they got an appointment the last time they tried and 71% said that the appointment was convenient. These were both lower than local and national averages. The practice also performed lower when compared to other GP practices both locally and nationally in relation to patient satisfaction around waiting times and patients saying that they could see or speak with their preferred GP. The results from the practice patient survey were similar to

Are services responsive to people's needs?

(for example, to feedback?)

the national patient survey with 70% of patients reporting positively about their overall experience of making an appointment and 68% saying that their waiting times were not too long.

The practice was addressing the issues raised by patients. Extra staff had been deployed to answer the telephones, particularly in the mornings. A morning triage system had been introduced to help prioritise patients' needs and to signpost to other services where this was appropriate. Waiting times were continually monitored and the practice was reviewing the number of hours lost due to patients failing to attend booked appointments. This equated to approximately 40 to 45 hours each month. This information was shared with patients in its regular patient newsletter.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns including complaints made in respect of the walk-in service. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. Patients were provided with information to help them understand the complaints procedure and to raise complaints or concerns. This information included details

of how a complainant could escalate their concerns to the NHS England and the Health Services Ombudsman, should they remain dissatisfied with the outcome or if they felt that their complaints had not been dealt with fairly. Patients we spoke with were aware of the process to follow if they wished to make a complaint. Patients we spoke with said that they had not needed to make a complaint about the practice.

We looked at a sample of complaints received by the practice within the past 12 months and the practice responses to these. We saw that where complaints related to treatment that statements were obtained from the GP or nurse in question as part of the investigation into the concern and that this information was included within the response. Complaints were acknowledged and responded to within the appropriate timeframe. The majority of complaints related to access to appointments and waiting times. These were responded to in an open and transparent way and apologies given where this was appropriate.

We saw that complaints made about the walk-in service were reviewed and all complaints were periodically analysed to identify trends or themes and any learning outcomes were acted on and shared with staff.

Are services well-led?

Good 

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

Our findings

Vision and Strategy

The practice had a clear vision to deliver and maintain high quality responsive healthcare delivered by an experienced and dedicated healthcare team. The practice vision and strategy was displayed on their website and within the patient information leaflet. Staff we spoke with were aware of the vision and values for the practice and told us that they were supported to deliver these.

The practice was active in focusing on outcomes in primary care. We saw that the practice had recognised where they could improve outcomes for patients and had been making changes accordingly through work with the local Clinical Commissioning Group, conducting reviews and listening to staff and patients. At the time of our inspection the walk-in service had been reviewed by the Commissioners and the service was due to cease this service from March 2016. The practice provided information and updates about the planned closure of the service to patients in a regular newsletter, via the patient participation group and on the practice website.

Governance Arrangements

The practice had a number of policies and procedures in place to govern its activity and these were available to staff. We looked at a sample of these policies and procedures, including those related to medicines management, infection control, staff recruitment and training, fire safety and patient confidentiality. These policies were bespoke to, up to date and reflective of the management and day-to-day running of the practice.

The practice used a number of clinical and non-clinical audits and reviews to monitor and improve the services provided. Areas for improvement, where identified from complaints and analysis of significant events, were shared with staff to secure improvements. The practice data from local and national quality schemes such as QOF to benchmark performance. The Quality and Outcomes Framework (QOF) is the annual reward and incentive programme detailing GP practice achievement results. QOF is a voluntary process for all practices in England and awards practices achievement points for managing some of the most common chronic diseases including diabetes,

coronary heart disease and chronic obstructive pulmonary disease. We saw that the practice had achieved 96% of the available points for 2014/15 demonstrating that they were providing good outcomes for patients.

Leadership, openness and transparency

There was a clear leadership structure with named members of staff in lead roles in several areas of patient care including medicines management and unplanned hospital admission avoidance. Staff also took lead roles in infection control, safeguarding vulnerable patients and fire safety and health and safety. Staff we spoke with were clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns. There was good communication between clinical and non-clinical staff. The practice held a range of regular clinical and non-clinical staff meetings to discuss any issues or changes within the practice.

Seeking and acting on feedback from patients, public and staff

The practice sought and acted on feedback from patients on a regular basis. It monitored the results of the NHS Friend and Family Test, National GP Survey and NHS Choices data. They reviewed comments made by patients and developed action plans to address any issues where these were raised.

The practice had an active Patient Participation Group (PPG). A PPG is made of practice staff and patients that are representative of the practice population who are involved in discussions and decisions about the range and quality of services provided by the practice. We spoke with two members of the PPG and they told us that the practice was open to and acted on, where possible, the suggestions made by the group. The PPG carried out patient surveys and the results from these were made available to patients, as they were displayed in the patient waiting area and on the practice website. The results from the most recent survey, carried out in 2014 and action arising from this were shared with patients by way of a regular newsletter.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they were supported to actively contribute and give their feedback, comments and suggestions.

Management lead through learning and improvement

Are services well-led?

Good 

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

The practice had management systems in place which enabled learning and improved performance. We spoke with a range of staff, all of whom confirmed that they received annual appraisals where their learning and development needs were identified and planned for. Clinical staff told us that the practice supported them to maintain their professional development through training

and mentoring. All the staff we spoke with told us that the practice was very supportive of training and that they had protected time for learning and personal development and access to appropriate training. Regular clinical meetings were held learning outcomes from reviews, complaints and serious incidents were shared widely and followed up to help ensure that learning was imbedded into practice.