Marine Lake Medical Practice

Quality Report

Grange Road,
West Kirby,
Wirral,
Merseyside, CH48 4HZ
Tel: 01516259171
Website: www.wkhcwirral.nhs.uk

Date of inspection visit: 7 January 2015
Date of publication: 09/04/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This is the report of findings from our inspection of Marine Lake Medical Practice. The practice is registered with the Care Quality Commission (CQC) to provide primary care services. We undertook a planned, comprehensive inspection on 7 January 2015 and we spoke with patients, relatives, staff and the practice management team.

The practice was rated as **Good.**

Our key findings were as follows:

- Staff understood and met their responsibilities to raise concerns and report incidents, risks and near misses. Lessons were learned and communicated widely to support improvement. There were enough staff to keep people safe.
- Patient's needs were assessed and care was planned and delivered in line with current legislation. Staff received training appropriate to their roles and further training needs have been identified and planned.
- Patients were treated with compassion, dignity and respect and they were involved in care and treatment decisions.
- The practice reviewed the needs of their local population, the practice were responsive to patients' needs and wishes.
- The practice had clear leadership, staff felt supported by management. There were systems in place to monitor and improve quality and identify risk. This included good engagement with patients.

There were areas of practice where the provider needs to make improvements.

The provider should:

- Ensure action plans are drawn up for patient safety incidents and patient complaints so that closer monitoring can take place at each risk management meeting.
- Ensure that all patient complaints are responded to within an acceptable timescale.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The service was rated as good for safety. Information from NHS England and the Clinical Commissioning Group (CCG) indicated the practice had a good track record for maintaining patient safety. Effective systems were in place to oversee the safety of the building and patients. Staff took action to learn from any incidents and to safeguard patients and when appropriate made safeguarding and child protection referrals. Improvements were needed to ensure action plans were drawn up for patient safety incidents and patient complaints so that closer monitoring can take place at each risk management meeting.

Are services effective?

Good

The practice was rated as good for effective. Data showed patient outcomes were at or above average for the locality. National Institute for Clinical and Healthcare Excellence (NICE) guidance was referenced and used routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff had received training appropriate to their roles and further training needs have been identified and planned. The practice undertook annual appraisals and personal development plans for all staff. Multidisciplinary working was evidenced.

Are services caring?

Good

The practice was rated as good for caring. Data showed patients rated the practice higher than others practices for several aspects of care. Patients told us during the inspection they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also observed that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice was rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice with a named GP for continuity of care. The practice had good facilities and was well

Summary of findings

equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded appropriately to issues raised. There was evidence of shared learning from complaints with staff.

Are services well-led?

Good

The practice was rated as good for well-led. The practice had a clear vision and strategy to deliver care and staff were clear about their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures in place to govern activity and regular quality monitoring meetings were taking place. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice was rated as good for the care of older people. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of older people in its community and had a range of enhanced services, for example in dementia and end of life care. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with more immediate needs.

People with long term conditions

Good

The practice was rated as good for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients that had a sudden deterioration in health. When needed longer appointments and home visits were available. All patients had a named GP and structured annual reviews to check their health and medication needs were being met. For those people with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice was rated as good for the provision of services to families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. For example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. If needed appointments would be given on the same day for all children under five years. We were provided with good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Working age people (including those recently retired and students)

Good

The practice was rated as good for services provided to working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students, had been identified and the practice had adjusted the services it

Summary of findings

offered to ensure these were accessible, flexible and offer continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice was rated as good for services provided to people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with learning disabilities. The practice carried out annual health checks for people with learning disabilities. The practice offered longer appointments for people with learning disabilities and they supported the work of volunteer support groups for patients with learning disabilities across the community.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice was rated as good for services provided to people experiencing poor mental health (including people with dementia). Annual health assessments took place including checks on patients physical health needs. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had in place advance care planning for patients with dementia.

The practice had sign-posted patients experiencing poor mental health to various support groups and voluntary sector organisations including MIND and SANE. The practice had a system in place to follow up on patients who had attended accident and emergency where there may have been mental health needs. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We received 12 completed patient CQC comment cards and spoke with six patients who were attending the practice on the day of our inspection. We heard how staff treated them with dignity and respect, they were helpful and approachable. The comments cards reported that it was difficult to get a routine appointment for a GP of their choice. Patients told us there were problems with the repeat prescription system, with patients having to attend a number of times before the prescription was ready. We heard mixed feedback for the telephone triage system for urgent appointments. Some patients said it was working well and others were concerned about using the system. Mostly people felt they were given enough time when they saw the GP and practice nurse. Good examples were described to us for the prompt referral of patients for hospital care.

Patients told us the practice had compassionate staff, particularly when dealing with patients and relatives who had suffered bereavement. They reported helpful and caring GPs, reception and practice staff.

Areas for improvement

Action the service SHOULD take to improve

Ensure action plans are drawn up for patient safety incidents and patient complaints so that close monitoring can take place at each risk management meeting.

Ensure that all patient complaints are responded to within an acceptable timescale.

Marine Lake Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector and the team included a GP and a Practice Manager.

Background to Marine Lake Medical Practice

Marine Lake Medical Practice is registered with the Care Quality Commission to provide primary medical services. This is a GMS contracted service within the centre of West Kirby. The practice has recently formed from what was previously three individual GP practices. They have a complete primary health team consisting of doctors, practice nurses, health care assistants, reception secretarial and administration staff and pharmacy technicians. There are thirteen GP partners, twelve GPs and the Practice Manager.

The total practice list size for Marine Lake Medical Practice is 16,945. The practice is part of NHS Wirral Clinical Commissioning Group (CCG). The practice is situated in an area that has lower than average areas of deprivation. The practice population is made up of a higher than national average population aged over 65 years and a lower than national average of younger aged patients.

The practice is open Monday to Friday from 8.00hrs to 18.30hrs with extended hours as part of their PMS contract. Patients can book appointments in person, online or via the phone. The practice provides telephone consultations, pre bookable consultations, urgent consultations and home visits. The practice treats patients of all ages and provides a range of medical services.

From data we reviewed as part of our inspection we saw that the practice outcomes are in line with those of neighbouring practices within the area. The practice keeps up to date registers of those patients with learning disabilities, mental health conditions and those in need of palliative care. Multi-disciplinary team meetings were in place to support these patient groups.

Why we carried out this inspection

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

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

Detailed findings

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

Before our inspection we carried out an analysis of the data from our Intelligent Monitoring System. We also reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We reviewed the practice's policies, procedures and other information the practice provided before the inspection. The information reviewed did not highlight any significant areas of risk across the five key question areas. We carried out an announced inspection on 7 January 2015.

We reviewed all areas of the practice including the administrative areas. We sought views from patients face-to-face, looked at survey results and reviewed CQC comment cards left for us on the day of our inspection.

We spoke with the practice manager, registered manager, GP partners, practice nurses, administrative staff and reception staff on duty. We spoke with patients who were using the service on the day of the inspection.

We observed how staff handled patient information, spoke to patients face to face and talked to those patients telephoning the practice. We discussed how GPs made clinical decisions. We reviewed a variety of documents used by the practice to run the service. We also talked with carers and family members of patients visiting the practice at the time of our inspection.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. Reports from NHS England indicated the practice had a good track record for maintaining patient safety and during our inspection we found good systems to monitor this.

The practice manager and GPs discussed significant events and showed us documentation to confirm that incidents were appropriately reported. We saw how these were discussed at practice and GP partner meetings to ensure patient safety lessons were disseminated to all staff.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. Staff reported an open and transparent culture when accidents, incidents and complaints occurred. Staff were trained in incident and accident reporting. There was an accident and incident reporting policy and procedure to support staff with which they were familiar. They told us they felt confident in reporting and raising concerns and felt they would be dealt with appropriately and professionally. Of the events that had occurred, we were satisfied that appropriate actions and learning had taken place. However we noted that formal action plans were not in place for individual incidents that had occurred. All incidents were monitored at regular practice meetings and we saw from the actions that had taken place all staff involved had used the information for shared learning and to make improvements when needed.

National patient safety alerts were shared by email to practice staff. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. They also told us alerts were discussed at practice and partner meetings to ensure all were aware of any relevant to the practice and where action needed to be taken.

We saw how complaints made were used by the practice to learn and improve patient safety and experience. From the review of complaint investigation information, we saw that the practice had learnt from the patient experience and appropriate actions had been put in place. For example complaints made about the repeat prescription processes in place.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible. The practice had completed a safeguarding children audit in July 2013. The results were shared with the local designated nurse for safeguarding children and an action plan was put into place for areas they required further improvements.

There was a current local policy for child and adult safeguarding. This referenced the Department of Health's guidance. Staff demonstrated knowledge and understanding of safeguarding. They described what constituted abuse and what they would do if they had concerns. They had undertaken electronic learning regarding safeguarding of children and adults as part of their essential (mandatory) training modules. This training was at different levels appropriate to the various roles of staff. The practice had a dedicated GP appointed as a lead in safeguarding vulnerable adults and children and this GP had been trained to enable them to fulfil this role. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services. However, we noted that minutes of safeguarding meetings were brief in detail and improvements were required. There was a chaperone policy in place and posters were up to notify patients of this service.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an

electronic system which collated all communications about the patient including scanned copies of communications from hospitals. Patient records were backed up daily and the data is stored securely offsite. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant and on-going issues when patients attended appointments. For example children subject to child protection plans and older vulnerable patients with dementia. This enabled staff to instantly recognise patients individual needs and circumstances.

Medicines management

The practice had clear systems in place for the management of medicines. There was a system in place for ensuring a medication review was recorded in all patients' notes for all patients being prescribed four or more repeat medicines. We were told that the number of hours from requesting a prescription to availability for collection by the patient was 48 hours or less (excluding weekends and bank/local holidays). The practice met on a quarterly basis with the local area team's medicines manager and CCG pharmacists to review prescribing trends and medication audits. Notes of these meetings showed how good practice was discussed and action plans were put into place relating to the prescribing of particular medicines. We observed effective prescribing practices in line with published guidance. Information leaflets were available to patients relating to their medicines.

Clear records were kept when any medicines were brought into the practice and administered to patients. Medicine refrigerator temperatures were checked and recorded daily and were cleaned on a monthly basis or as needed if there was a spillage. The refrigerator was adequately maintained by the manufacturer and staff were aware of the actions to take if the fridge was out of temperature range for the safe storage of medicines.

The practice had a Medicines Management Team of three staff members. Their role was to ensure that patients received medications promptly and safely particularly for repeat prescriptions. They had an oversight of the repeat prescribing of controlled drugs and they reported monthly on medicines management issues. We saw how their role included involvement when incidents or complaints had occurred relating to medicines and the prescribing of drugs. For instance patients had complained about delays when picking up prescriptions for certain medicines. The practice reported these concerns as an incident, several meetings took place with senior GP partners to review the repeat prescribing process and steps were put in place to ensure errors and inconvenience for patients was addressed.

The practice had the equipment and in-date emergency medicines to treat patients in an emergency situation. We saw that emergency medicine, including medicines for anaphylactic shock, were stored safely yet were accessible. We observed that there was a system for checking the expiry dates of emergency medicines on a monthly basis or more regularly if used. We reviewed the bags available for doctors when doing home visits and found they held routine medicines for use in patients' homes.

Cleanliness & infection control

The practice nurse was the lead for infection control. They had undertaken basic training in infection control and obtained support and guidance from the local teams as needed. There was a current infection control policy with supporting policies and guidance. The practice had completed an external infection control audit in July 2014 and actions plans had been put into place to make improvements.

The environment was clean and tidy and equipment was well-maintained with cleaning schedules for each area. We saw appropriate segregated waste disposal for clinical and non-clinical waste. Contracts were in place for waste disposal and clinical waste was stored securely. We saw equipment for example, bed trolleys, ECG machines, and dressing trolleys to be clean and tidy. The practice had a cleaning schedule to ensure the equipment remained clean and hygienic at all times but cleaning staff did not always sign to show their work was completed.

The practice undertook a number of sessions for minor surgical procedures each week. An audit of minor surgery had been undertaken during January to June 2014, we saw good results and an action plan for some improvements had been implemented. We saw that the treatment room was well equipped and single use equipment such as dressing packs and surgical instruments were in place. The practice used single use equipment for invasive procedures

for example, taking blood and cervical smears. Hand wash and alcohol hand sanitizer dispensers were situated in all the relevant rooms. A needle stick/inoculation injury flowchart protocol was displayed in all treatment rooms where the risk to staff of acquiring an infection from this type of injury was more prevalent. Sharps containers were stored in each treatment and consultation room. We saw these containers were stored on worktops and benches away from the floor and out of reach of children. We found that legionella testing had been carried out at the practice.

Equipment

The practice had systems in place to ensure regular and appropriate inspection, calibration, maintenance and replacement of equipment. Suitable equipment which included medical and non-medical equipment, furniture, fixtures and fittings were in place. Staff confirmed they had completed training appropriate to their role in using medical devices. We saw evidence that clinical equipment was regularly maintained and cleaned.

Staffing & Recruitment

The practice had a recruitment policy in place. Appropriate pre-employment checks were undertaken and completed before employment of staff, such as references, medical and fitness checks. Staff were able to describe their recruitment process and told us that they had submitted all the required information and appropriate disclosures. Whilst these systems were in place we noted that applications for a Disclosure and Barring Service (DBS) check were not completed for a small number of reception staff due to changes in the practice provider for this. These staff did not include staff with chaperoning responsibilities. The practice manager brought this to our attention and had taken action to have these completed. Contracts of employment were also not signed by newly recruited staff.

There was a system in place to record professional registration such as for the General Medical Council (GMC) and the Nursing Midwifery Council (NMC). We saw evidence that demonstrated professional registration for clinical staff was up to date and valid.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. Patients however reported problems with getting an appointment to see their GP as they needed it. Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness. The staff worked well as a team and as such supported each other in times of increased demand for services. The practice manager and GPs maintained and reviewed the rota for clinicians and we saw they ensured that sufficient staff were on duty to deal with expected demand including home visits.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there as an identified health and safety representative.

Risk assessments were in place. For example a risk assessment process had been used when the new triage system had been introduced to the practice. Each risk was assessed, rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager had shared the recent findings from an infection control audit with the team.

The practice nurse and pharmacy technicians monitored medications to ensure they were always available and in date. The review of the emergency treatment bag showed appropriate equipment and drugs for emergency use. Staff confirmed they had received regular cardiopulmonary resuscitation (CPR) training and training associated with the treatment of anaphylactic shock.

The practice used electronic record systems that were protected by passwords and smart cards on the computer system. Historic paper records were stored securely in the office area.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records we saw confirmed equipment

Good

Are services safe?

was checked regularly. There was an emergency incident procedure in place. Staff could describe how they would alert others to emergency situations by use of the panic button on the computer system.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned staff absences and access to the building. The document also contained relevant contact details for staff to refer to.

A fire risk assessment had been undertaken that included actions required for maintaining fire safety standards. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken and equipment checks were undertaken.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence and from local commissioners. We saw minutes of practice meetings where new guidelines were shared and discussed with staff, the implications for the practice's performance. Any impact on patients was discussed and required actions agreed. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate. We spoke with senior staff who confirmed that when new guidance was issued changes were made to the template assessment documents used by nurses for chronic disease management.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work which allowed the practice to focus on specific conditions. The practice clinicians worked together as a team, daily meetings took place to discuss any potential referrals to hospital or any complex patients' cases. National data showed the practice was in line with referral rates to secondary and other community care services for all conditions.

We saw how the practice had used a risk profiling review to ensure those more vulnerable patients had their needs assessed and a documented care plan was put in place. They had identified specific patient groups such as patients with complex or end of life needs. Individual care plans were developed which included community services and they were shared with the patient and their families.

We reviewed data from the local CCG, relating to the practice's performance for antibiotic prescribing which was not comparable to similar practices across the area. The practice had looked at their prescribing and had promoted the use of the local antimicrobial guidelines to clinicians but at the time of our visit they were unable to get a definitive reason for this. Regular monitoring reports were used by the practice supplied by their own Management Medicines Team (MMT). Reviews and decisions were made based on the monthly reports. The practice used computerised tools and templates to support nurses to undertaken annual or more regular patient assessments for new patients and patients with a chronic disease. Systems were in place to ensure that all patients discharged form hospital had their care reviewed, in particular their medications. The practice had experienced problems in the timely receipt of hospital letters and importantly the timely changes to medications. We saw that the MMT were working closely with the doctors to improve this.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed the culture in the practice was that patients were referred on the basis of need and that age, sex and race was not taken into account in this decision-making. All staff had received equality and diversity training.

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, child protection alerts management and medicines management. The information staff collected was then collated by the practice manager and the senior management team to support the practice to carry out clinical audits.

A clear audit programme was in place. Examples of audits included a number of medication audits/reviews along with audits of minor surgery infection rates. These were completed audits with dates set for re auditing. We saw that clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). The practice had also recently reviewed their management of Chronic Obstructive Respiratory Disease (COPD) and this led to improvements being made to the template used by the team making clinical decisions and assessments more robust.

The practice used the information they collected for the Quality and Outcomes Framework (QOF) and their performance against national screening programmes to monitor outcomes for patients. For example the practice maintained a register of all patients in need of palliative care and support.. The practice performed better than the average practice in ensuring regular multi-disciplinary team meetings took place for these patients to ensure their

Good

Are services effective?

(for example, treatment is effective)

needs were met. This practice was not an outlier for any QOF (or other national) clinical targets. Good results were also shown for patients with a long term medical condition. The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes comparable to other practices in the area and in some areas they were achieving higher performance.

The team was making use of clinical audit tools, staff supervision and appraisal and practice meetings to assess the performance of clinical staff. The staff we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit per year.

The practice had systems in place to ensure that patients receiving repeat prescriptions had been reviewed by the GP. This was a core function of the Medicines Management Team (MMT) who ensured appropriate checks and tests had taken place before a repeat prescription was provided to patients. For example patients needing a drug named Methotrexate need regular blood tests to monitor the dosage they should be prescribed for each repeat prescription. If they had not attended for this test, the MMT would contact the patient to arrange this before a repeat prescription was issued. Staff had systems in place to ensure that all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP prescribed those medicines which may conflict with a patients health condition, or medicines the patient was already taking. We were shown evidence to confirm that following the receipt of an alert the GPs had reviewed the use of the medicine in question and where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. A good skill mix was noted amongst the doctors with some having additional diplomas and certificates in specific areas of disease. All GPs were up to date with their yearly continuing professional development requirements and all had either been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses. Nursing staff we spoke with told us the practice was very supportive when training and regular updates were needed. As the practice was a training practice, GP registrars (doctors who were in training to be qualified as GPs) were given extended appointments within which to see patients, for example, appointments of 30 minutes duration, and had access to a senior GP throughout the day for support. Feedback from those trainees we spoke with was positive.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, the senior practice nurse was also a clinician and they had enhanced skills to assess, diagnose and prescribe treatment for patients. Other practice nurses had completed training to undertake other roles such on administration of vaccines, or cervical cytology or assessing patients with long term chronic disease needs. These staff members were appropriately trained and supported to do this and to keep their skills up to date.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries and information from out of hours providers were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in the passing on, reading and actioning of any issues arising from communications with other care providers on the day they were received. The GP seeing these documents and results was responsible for the

Good

Are services effective?

(for example, treatment is effective)

action required. The systems had been improved in recent months due to a number of incidents that had occurred with patient records and letters. All staff we spoke with understood their roles and felt the system in place worked well. The practice had a system in place to ensure all patients discharged from hospital were seen and their conditions reviewed.

The practice worked closely with other health and social care providers in the local area. The GPs and the practice manager attended various meetings with management and clinical staff from practices across the CCG. These meetings were used to share information, good practice and national developments and guidelines for implementation and consideration.

The practice attended various multidisciplinary team meetings at regular intervals to discuss the needs of complex patients, for example those with end of life care needs, children at risk, older frail patients and those with mental health and learning disabilities. These meetings were attended by community staff such as district nurses, health visitors, social workers and palliative care nurses. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hour's provider to enable patient data to be shared in a secure and timely manner. Information was shared in this way with hospital and other healthcare providers. We saw that all new patients were assessed and patients' records were set up. This routinely included paper and electronic records with assessments, case notes and blood test results. We saw that all letters relating to blood results and patient hospital discharge letters were reviewed on a daily basis by doctors in the practice. When patients moved between teams and services, including at referral stage, this was done in a prompt and timely way.

We found that staff had all the information they needed to deliver effective care and treatment to patients. For emergency patients, patient summary records were in place. This is an electronic record that is stored at a central location. The records can be accessed by other services to ensure patients can receive healthcare faster, for instance in an emergency situation or when the practice is closed.

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and delivery of their duties in line with this. 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 practice. They gave examples in their practice of when best interest decisions were made and mental capacity was assessed prior to consent being obtained for an invasive procedure. This was important as the practice had a high population of patients living in a care home setting, many of whom had a diagnosis of dementia. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for patient vaccinations, and to record a parent's written consent for treatment of children.

Health promotion and prevention

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant / practice nurse. The GP was informed of all health concerns detected and these were followed-up in a timely manner. Practice data shows that for health promotion indicators the practice achieved higher than the national and comparable CCG practices.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. The IT system prompted staff when patients required a health check such as a blood pressure check and arrangements were made for this. Patient and population group registers were in place to enable the practice to keep a register of all patients requiring additional support or review, for example patients who had a learning disability or a specific medical condition such as diabetes. Practice records showed that those who needed regular checks and reviews had received

Good

Are services effective?

(for example, treatment is effective)

this and the IT system monitored the progress staff made in inviting patients for their annual health review. This included sending letters and telephone calls to patients to remind them to attend their appointments.

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 all immunisations was above average for the CCG, and again there was a clear policy for following up non-attenders by the named practice nurse. Lifestyle and weight management clinics were held at the practice.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Staff we spoke with were aware of the importance of patient privacy and of confidentiality. We observed staff were discreet and respectful to patients despite the reception area being open plan. Patients told us that there had been improvements in how reception staff treated and responded to patients in recent months and they welcomed this. We observed that privacy and confidentiality were maintained for patients using the service on the day of the visit.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Screening curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. However the main treatment room was set up to treat two patients at a time with a curtain between each. This reduced the opportunity for ensuring patient privacy and confidentiality. We were told the practice had to use the room in this way because of high patient demand. Staff were aware of problems this could pose and tried to ensure patient confidentiality was maintained.

The practice offered patients a chaperone prior to any examination or procedure. Information about having a chaperone was displayed in the reception area. Patients we spoke with told us they were always treated with dignity and respect and that staff were caring and compassionate. We found that staff knew the majority of their patients well and patients told us the practice had a family feel to it.

Care planning and involvement in decisions about care and treatment

Patients we spoke with felt confident they had been involved in any decisions about their treatment and care. We looked at the Quality Outcomes Framework (QOF) information and this showed adequate results for patients reporting that the nurse of doctor was good or very good at involving patients in decisions about their care.

We found that staff were clear about how to ensure patients were involved in making decisions and the requirements of the Mental Capacity Act 2005 and the Children's Act 1989 and 2005.

The practice had an 'access to records' policy that informed patients how their information was used, who may have access to that information, and their own rights to see and obtain copies of their records.

Patient/carer support to cope emotionally with care and treatment

Patients were positive about the care they received from the practice. They commented that they were treated with respect and dignity. Patients we spoke with told us they had enough time to discuss things fully with the GP but they had difficulty making an appointment with the GP of their choice. They told us all the staff were compassionate and caring.

We saw that the reception staff treated people with respect and tried to ensure conversations were conducted in a confidential manner. Clinical staff had various ad hoc methods of supporting bereaved patients. Some would contact them personally. The reception staff were knowledgeable in support for bereaved patients. They were familiar with support services and knew how to direct patients to these.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was accessible and responsive to patients' needs and had systems in place to maintain the level of service provided. Practice staff were clear about the needs of their local population and they took on board the views and experiences of patients and feedback from their Patient Participation Group (PPG). Capacity and demand was monitored by the practice manager to ensure there were enough appointments to meet patients' needs. This had led to changes in the appointment systems and how the GPs time was arranged for home visits.

Most of the staff had worked at the practice for some time so continuity of care could be achieved. The practice used an IT based system which enabled them to target specific patient groups to ensure their needs and reviews were identified and monitored. We saw how appointments were identified for particular patient groups. For example patients with a complex or chronic disease would be given longer appointment times if needed. Where possible they would see their named GP or practice nurse to ensure continuity of care. When patients were too ill to attend the practice home visits would be undertaken by the GPs.

The local Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

There had been very little turnover of staff during the last three years which enabled good continuity of care and accessibility to appointments with a GP of choice. However a number of patients we talked with told us getting an appointment with a GP of their choice was difficult. The practice had acknowledged that patients were not always able to get an appointment with their named GP but alerts had been added to the IT system to ensure high risk patients such as patients at end of life would if possible receive continuity of care. We found the practice undertook a high number of home visits to patients unable to attend the practice. This included visits to a number of patients living in local care homes.

We met with members of the Patient Population Group (PPG) during our visit and they told us how the practice was a listening practice who took on board the comments and suggestions the group made. They said the practice had undergone a number of significant changes in merging three GP practices. They acknowledged that at times this had been a challenge for instance with the development of the telephone triage system for urgent appointments. The group had mixed feedback for the success of this but importantly they all agreed they had worked closely with the practice team to discuss any concerns and make suggestions for their improvement. The group reported their concerns for vulnerable patients who might not be able to use a triage system to access an urgent appointment.

The practice had achieved and implemented the Gold Standards Framework for end of life care. They had a palliative care register and had regular internal as well as multidisciplinary team meetings to discuss patient care and support for the family or carer of those patients. Regular meetings took place with the community nursing teams to ensure the possible changing needs of these patients were monitored closely. We saw the practice worked collaboratively with other agencies and regularly shared information (special patient notes) to ensure good, timely communication of changes in care and treatment. This included the Out of Hours service to ensure they had the full information they needed for safe treatment of patients within the out of hours period.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example they had a high population of older patients living in care homes. The practice undertook a high number of home visits; review of data before our inspection showed this to be more than GP practices of a similar size. The practice arranged GP working patterns and availability amongst the doctors to facilitate this.

The practice had access to online and telephone translation services. The practice provided equality and diversity training via e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last twelve months and that equality and diversity was regularly discussed at staff appraisals and team events. We found that staff were aware of local services (including voluntary organisations) that they could refer patients to. Patient's information sign posted patients and families to welfare and benefits advice organisations.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The premises and services had been adapted to meet the needs of people with disabilities. The practice was all on the ground floor fully accessible to the patient in a wheelchair. Staff told us that the practice actively supported people who have been on long term sick leave to return to work, they gave examples for how this had been achieved.

Access to the service

Patient appointments were available from 8.00 am to 6.30pm on weekdays In addition the practice held early morning surgeries to ensure working patients could access an appointment. If a patient required an urgent or same day appointment the reception staff would 'triage' this call and a GP would call the patient to assess their need in the first instance. The patient would receive advice over the telephone or they would be given an appointment to come into the practice on the same day. This was a new development for the practice and we heard mixed feedback from patients using this service. Whilst many patients were happy they could speak with a GP, concerns were raised for patients who might get anxious and frustrated with a new telephone system that was too complicated for them.

The practice had a comprehensive website which included this information. This also included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances.

We saw good evidence of how practice staff worked with out-of-hours services and other agencies to make sure patients' needs were met when they moved between services. We saw that when needed a patient appointment with other providers such as a hospital referral would be made during the patient's consultation with the GP. This was undertaken after the appropriate tests and examinations had been completed by the practice. We heard from patients that following discharge from hospital the GP and practice staff had been very supportive.

Patients we spoke with raised concerns that they were not satisfied with the appointments system in place. We heard how they could not see a doctor on the same day unless they reported their needs as an emergency. They told us it took a long time to get an appointment with the GP of their choice and when they attended the practice they experienced long waits without an explanation why. The comments made by patients who completed the comments cards we used during the inspection also reported the same issues. We spoke with the practice team about this. They were aware of these concerns and had taken a number of recent steps to try and improve patient access, the new triage telephone system being one of these.

The practice was situated on the ground floor of a public building which also had other community services within it. This made accessing both GP and local community services easier for the patient. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

The practice had a small population of non-English speaking patients and if required could access interpreter services locally to assist with translation for patients.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the service. Staff were knowledgeable regarding the complaints process. We saw posters advising patients how patients could make a complaint. We looked at a number of complaints that had been made. We considered that the practice response to complaints was appropriate but timely responses in line with their policy had not always been met. Patients were also not signposted to what steps they could take if they were dissatisfied with the outcome of the practice investigation.

The practice reviewed complaints on a quarterly basis to detect themes or trends. We looked at the report for the last year and found that patient access to appointments was a reoccurring theme along with problems associated with prescribing repeat prescriptions. We did not see individual action plans in place for each of the complaints but we saw how the practice had made improvements and

Good

Are services responsive to people's needs?

(for example, to feedback?)

had learnt lessons from the issues raised by patients. For example new systems had been put into place to reduce the complaints made about repeat prescriptions not being ready when patients attend the practice to collect these.

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 good patient care and staff were engaged with this. There was a clear leadership structure and staff felt supported by management. We spoke with a number of staff during our visit, who knew and understood the vision and values of the practice and knew what their responsibilities were in relation to these. There was positive discussion about their involvement with developing the practice vision and values and for providing the best possible outcomes for patients attending the practice.

Governance arrangements

We saw transparent and open governance arrangements. We found practice staff were clear about their roles and they understood what they were accountable for. Formal arrangements were in place to identify report and monitor patient and staff safety risks. We saw risk assessment and risk management processes and procedures and staff were aware of these. We saw records with information showing the skills and fitness of people working at the practice.

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. Policies were up to date however they did not have review dates identified. The practice held fortnightly practice meetings during which time governance and risk management issues were discussed. Risks and patient complaints that had been identified were discussed and actions taken. However the practice did not complete an action plan for each risk and patient complaint. This would identify who might be accountable for ensuring actions were taken in a timely way and how it could be monitored at each meeting to ensure actions were completed.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with, or at times, above average national standards. We saw that QOF data was regularly discussed at practice team meetings and action plans were produced to maintain or improve outcomes.

We found a robust systematic approach to clinical and internal audit and this was used by the practice to monitor the services and treatments they were providing.

Leadership, openness and transparency

We spoke with staff in different roles and they were clear about the lines of accountability and leadership. They spoke of good visible leadership and full access to the senior GP and practice manager. Staff told us they enjoyed working at the practice and they felt valued in their roles. Staff felt supported, motivated and reported being treated fairly and compassionately. They reported an open and 'no-blame' culture where they felt safe to report incidents and mistakes.

The management model in place was supportive of staff. Staff we spoke with said they enjoyed working at the practice, they recognised that bringing together three previous practices had been a challenge but they said they felt supported through the changes. The practice had proactively conducted a recent audit of staff satisfaction and arrangements were in place to review this further. Plans were in place for a team away day to discuss their strategy and priorities for the next year. The practice had a strong team who worked together in the best interest of the patient. All staff were aware of the practice Whistleblowing Policy and they were sufficiently confident to use this should the need arise.

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

Staff reported a culture where their views were listened to and if needed action would be taken. We saw how staff interacted and found there was care and compassion not only between patients and staff but also amongst staff themselves. We were told that regular clinical and non-clinical meetings took place. At these meetings any new changes or developments were discussed giving staff the opportunity to be involved. All incidents, complaints and positive feedback from surveys were discussed.

We found the practice proactively engaged with the general public, patients and staff to gain feedback. An annual patient survey had been carried out and appropriate action plans were in place. The practice had an active Patient Participation Group (PPG) and during our inspection we

Are services well-led?

Good

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

met with eight of their members. They spoke positively about how the practice engaged with them at meetings and how they took account of any recommendations or changes the group asked them to consider.

We saw the practice carried out a comprehensive patient survey between January and February 2014. They worked closely with the Patient Participation group (PPG) and included patient groups they considered might be difficult to reach, for example vulnerable or older patients. They also sought the views of visually impaired patients by telephone. We saw the practice used a 'you said' and 'we did' communication of the results of the survey which gave clear information of the responses and what the improved outcome had been.

Management lead through learning and improvement

Staff had access to a programme of induction and training and development. Mandatory training was undertaken and monitored to ensure staff were equipped with the knowledge and skills needed for their individual roles. Staff were supervised until they were able to work independently but written records of this were not kept.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at a number of staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.

The practice had completed reviews of significant events and other incidents and findings and conclusions were shared with staff via meetings and team away days to ensure the practice improved outcomes for patients.