

Tonge Fold 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

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Requires improvement



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

Tonge Fold Health Centre was inspected on the 22 December 2014. We rated the practice overall as requires improvement.

Specifically, we found the practice to be good for providing effective, caring and responsive services. It required improvement for providing services for all the population groups that we assess. It required improvement for providing safe and well-led services.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed learning was not always communicated to all staff.
- Risks to patients were not always assessed and well managed, for example those relating to recruitment checks.

- People's needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

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

The areas where the provider MUST make improvements are:

Summary of findings

- There was a failure to adopt in full the recruitment checks that legislation requires.
- The leadership lacked strategic aim and direction and effective communication was not always evident. Quality assurance and the monitoring and review of risk was not always effective.
- Review the security arrangements for the fridges used to store medicines.
- Additional guidance/training for chaperones.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

The areas where the provider should make improvements are:

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 requires improvement for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned but not always communicated widely to support improvement. Information about safety was recorded, monitored, however not always reviewed and addressed, for example a review of patients in atrial fibrillation had not been completed as Nationally advised. Risks to patients were not always assessed and well managed for example appropriate recruitment checks on new staff were not completed. There were enough trained staff to keep people safe.

Requires improvement



Are services effective?

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence (NICE) guidance was referenced however its use was inconsistent. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included the promotion of good health. Staff had received training appropriate to their roles and further training needs were identified and planned. The practice had an effective appraisal system in place for all staff. Multidisciplinary working was evidenced.

Good



Are services caring?

The practice is rated as good for providing caring services. Data showed patients rated the practice higher than others for several aspects of care. Patients said 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 saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Good



Are services responsive to people's needs?

The practice is 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, GPs and nurses and continuity of care, with urgent appointments available the same day. The

Good



Summary of findings

practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised.

Are services well-led?

The practice is rated as requires improvement for well-led. The practice did not have a clear vision, staff were aware of their responsibilities but not how they contributed to an overall goal. There was a leadership structure and most staff felt supported by management but at times were unclear of whom to go to with issues. The practice had a number of policies and procedures to govern activity, however some of these were overdue a review or being written. Review meetings relating to serious events were held annually, however learning was not always shared with all staff. The practice proactively sought feedback from patients and had an active patient participation group (PPG). All staff had received inductions and regular performance reviews, not all staff attended practice meetings.

Requires improvement



Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as requires improvement 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 the older people in its population 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 enhanced needs. Improvements around staff recruitment checks and assessing services were required.

Requires improvement



People with long term conditions

The practice is rated as requires improvement for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed longer appointments and home visits were available. All these patients had been identified by the GP and there were structured annual reviews to check their health and medication needs were being met. For those people with the most complex needs the GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. Improvements around staff recruitment checks and assessing services were required.

Requires improvement



Families, children and young people

The practice is rated as requires improvement for the population group of 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. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We were provided with good examples of joint working with health visitors and district nurses. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health. Improvements around staff recruitment checks and assessing services were required.

Requires improvement



Summary of findings

Working age people (including those recently retired and students)

The practice is rated as requires improvement for the population group of the 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 offered to ensure these were accessible, flexible and offer continuity of care. The practice was proactive in offering a full range of health promotion and screening which reflected the needs for this age group. Improvements around staff recruitment checks and assessing services were required.

Requires improvement



People whose circumstances may make them vulnerable

The practice is rated as requires improvement for the population group of people whose circumstances may make them vulnerable. The practice had carried out annual health checks for people with learning disabilities and a system was in place to follow up those who did not attend. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. 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. There were no barriers to people in vulnerable circumstances registering with the practice and accessing the services provided. Improvements around staff recruitment checks and assessing services were required.

Requires improvement



People experiencing poor mental health (including people with dementia)

The practice is rated as requires improvement for the population group of people experiencing poor mental health including people with dementia. A system was in place to ensure people experiencing poor mental health had received an annual physical health check. The practice regularly worked with the local mental health team and other mental health professionals in the case management of people experiencing poor mental health including those with dementia. The practice had a system in place to refer patients for counselling. A number of local groups were available to offer support for people with poor mental health. Staff were proactive in promoting these. Improvements around staff recruitment checks and assessing services were required.

Requires improvement



Summary of findings

What people who use the service say

We received 49 completed CQC comment cards and spoke with 11 patients at the time of our inspection visit. We spoke with older people, mothers with babies, vulnerable people and people of working age.

Patients we spoke with and who completed Care Quality Commission (CQC) comment cards were positive about the care and treatment provided by the GPs and nurses and the assistance provided by other members of the practice team. They told us that they were treated with dignity and respect and that the care provided by the GPs was of the highest standard. There was a newly formed patient participation group (PPG). This group was a way for patients and the practice to listen to each other and work together to improve services, promote health and improve the quality of care. Requests for volunteers were advertised through the practice newsletter and on posters displayed in the waiting area.

We also looked at the results of the 2014 GP patient survey. This is an independent survey run by Ipsos MORI on behalf of NHS England. The survey results showed the practice performed above average in many areas which included;

91% of respondents found the receptionists at the practice helpful

84% of respondents said the last appointment they got was convenient

88% of respondents said the last GP they saw or spoke to was good at listening to them

84% of respondents described their overall experience of this surgery as good

Areas for improvement

Action the service **MUST** take to improve

- There was a failure to adopt in full the recruitment checks that legislation requires.
- The leadership lacked strategic aim and direction and some staff were not communicated with effectively. Quality assurance and the monitoring and review of risk was not always effective.

Action the service **SHOULD** take to improve

- Review the security arrangements for the fridge used to store medicines.
- Additional guidance/training for chaperones.

Tonge Fold Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team consisted of a CQC Lead Inspector and a specialist advisor (a GP). Our inspection team also included an Expert by Experience who is a person who uses services them self and wants to help CQC to find out more about people's experience of the care they receive.

Background to Tonge Fold Health Centre

Tonge Fold Health Centre is located in the village of Tonge Fold on the outskirts of Bolton. At the time of this inspection we were informed 5,905 patients were registered with the practice. The practice operates from a large single story building which used to be used by some additional community services which moved out several years ago.

The practice consists of five GPs (two male and three female). These GPs are providing general medical services to registered patients at the practice under a personal medical services (PMS) contract. The GPs are supported in providing clinical services by three practice nurses (female) and a health care assistant. Clinical staff are supported by the Practice Manager, a deputy and their team who are responsible for the general administration and organisation of systems within the practice.

The practice is open Monday, Tuesday and Friday 8.00am to 6.30pm, with an additional hour on Wednesday and Thursday mornings (7.00am); the practice closes at lunchtime on a Wednesday.

Out of hours service is provided by Bolton out of hours service. Telephone (01204) 390390.

Why we carried out this inspection

We inspected this service as part of our new 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.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework (QOF) 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:

Detailed findings

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 22

December 2014. During our visit we spoke with the GPs, nursing staff, the Practice Manager, their deputy and reception staff. We also spoke with patients who used the service and three members of the patient participation group (PPG).

We saw how staff interacted with patients and managed patient information when patients telephoned or called in at the service. We saw how patients accessed the service and the accessibility of the facilities for patients with a disability. We reviewed a variety of documents used by the practice to run the service.

Are services safe?

Our findings

Safe track record

The practice had a system for managing safety alerts from external agencies. For example those from the medicines and healthcare products regulatory agency (MHRA). These were received electronically by the Practice Manager and emailed to the clinical staff for their information. The alerts were given to one of the GPs to deal with. Where appropriate, research was completed to check if any patients could have been adversely affected and measures were put in place as required. We noted that records of alerts were not kept and consequently could not be audited or reviewed. There appeared to be no system in place for who best to allocate each alert to in terms of their knowledge and skill base. We talked to the Practice Manager and one of the GPs about how these could be better managed, they told us that they would review the system.

Before visiting the practice we reviewed a range of information we hold about the practice and asked other organisations such as NHS England and the Clinical Commissioning Group (CCG) to share what they knew. No concerns were raised about the safe track record of the practice. Information from the quality and outcomes framework (QOF), which is a national performance measurement tool, showed that in 2012-2013 the provider was appropriately identifying and reporting significant events. The Practice Manager told us they completed incident reports and carried out significant event analysis. We looked at minutes of practice meetings for 2014 and were unable to confirm that these issues were discussed and any learning was put into practice. The Practice Manager told us that the events were discussed on an ad hoc basis, but not necessarily documented. An annual documented significant event review was scheduled for January 2015.

Learning and improvement from safety incidents

Significant events that we reviewed showed the date the event was discussed; a description of the event, what had gone well, what could have been done differently, a full reflection of the event and what changes had been carried out. If it was deemed necessary, events and lessons learned were shared with multi-professional agencies outside the practice, for example Bolton CCG. We did note that some events were not always identified as significant and some

learning could have been missed. For example the practice computer system had failed for a period of time creating some difficulties and although this was a region wide failure it had not been identified as a significant event and as a consequence no future learning had been shared.

There was evidence that appropriate learning had taken place, such as changes to office procedures for handling referrals. We saw from the records that investigations included discussions with relevant staff. Staff members said they were encouraged to report incidents. Any member of staff could report an incident and said they would do this to the practice manager or senior GP.

Reliable safety systems and processes including safeguarding

Safeguarding policies and procedures for children and vulnerable adults had been implemented at the practice. One of the GPs and one of the nurses took the lead role for safeguarding. Their role included providing support to their practice colleagues for safeguarding matters and speaking with external safeguarding agencies, such as the local social services, CCG safeguarding teams and other health and social care professionals as required.

Staff training records demonstrated that clinical and non-clinical staff had been provided with regular safeguarding training in respect of vulnerable children and adults. In line with good practice enhanced (level 3) safeguarding training for children had been completed by the GP safeguarding lead and their deputy. Staff we spoke with were able to describe how they could keep patients safe by recognising signs of potential abuse and reporting it promptly. Staff were aware of the need to raise issues about staff within the practice through a whistleblowing procedure but were unable to confirm the contact details of the agency they would speak to. The Practice Manager was unable to locate the whistleblowing policy at the time of our inspection they said that this would be located and displayed in prominent places for staff.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on paper or the practice computer system, which collated all communications about the patient, including scanned copies of communications from hospitals.

GPs were appropriately using the required codes on their electronic case management system to ensure risks to

Are services safe?

children and young people who were on child protection plans were clearly flagged and reviewed. Vulnerable children were discussed at weekly practice meetings and any actions required agreed.

Nurses and reception staff, on the occasions that a nurse was not available, were used to chaperone patients who requested this service and information about this service was available in the waiting area. Staff had been trained by one of the nurses in the intricacies of chaperoning. When we spoke to reception staff they told us that they were confident in performing a role as a chaperone but would not necessarily know whether an examination was clinically appropriate or not. Reception staff they told us that they were confident in performing a role as a chaperone and told us that the clinicians would always explain in full to the patient and chaperone what they were doing and why. They told us it was their practice to stand outside the privacy curtain when examinations were taking place. We discussed this with the Practice Manager and they told us that further guidance around where to stand during a chaperoned examination would be provided.

Medicines management

Systems were in place for the management, secure storage and prescription of medicines within the practice. Prescribing of medicines was monitored closely and prescribing for long term conditions was reviewed regularly by the GPs. A procedure was being introduced to enable patients to request and obtain their repeat prescriptions either online as currently that service was only available in person, fax or email. We noted that the box for patients to leave their repeat prescription requests was secure as it was in a public area. A system was in place to prevent patients re ordering repeat prescriptions before an appropriate period of time had elapsed. Any medication errors were treated as significant events. We spoke to the Practice Manager about uncollected prescriptions and were told it was not practice policy to investigate these; however they were going to review this policy.

We looked at the processes and procedures for storing medicines. This included vaccines that were required to be stored within a particular temperature range. We found appropriate action had been taken to achieve this and a daily check and record was made to ensure the appropriate temperature range was maintained. We noted that the fridge used for storing vaccines were not hard wired, and the power socket for the fridge was sited so that

they could be inadvertently switched off. We noted that on two occasions that we inspected the fridge during the day it was unlocked and in an area where the public had access. We spoke to the Practice Manager and one of the GPs about this and they told us that they planned to have the fridge hard wired and would review its security. Staff we spoke to were clear on how to maintain the cold chain so that drugs remained at an appropriate temperature.

We saw that a documented system was in place to regularly check the medicines contained in the doctor's bags taken when visiting patients at home. This was to ensure the required medicines were present and within their expiry date.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. Expired and unwanted medicines were disposed of in line with waste regulations.

Cleanliness and infection control

We observed all areas of the practice to be clean. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. Patient toilets were observed to be clean and had supplies of hot water, soap, paper towels and hand sanitizer. Aprons, gloves and other personal protective equipment (PPE) for staff were available in all treatment areas. Sharps bins were appropriately located, labelled, closed and stored after use. Disposable curtains were used in consulting and treatment rooms, which were labelled with disposal dates.

We saw that an audit relating to infection control had been completed by the Practice Manager in 2012; this was done to ensure actions taken to prevent the spread of potential infections were maintained. We noted that no audits on infection control had taken place since. The Practice Manager showed us a new infection control policy which they were completing which included a more thorough auditing process.

We saw that practice staff were provided with equipment (for example disposable gloves and aprons) to protect them from exposure to potential infections whilst examining or providing treatment to patients. These items were seen to be readily accessible to staff in the relevant consulting/treatment rooms. We talked to reception staff about handling samples provided by patients, they had a sound knowledge of how to deal with these although no documented protocol was in place. We noted that the

Are services safe?

treatment room was some distance from the consulting rooms and we were told that this had proved inconvenient for clinicians and patients. This had led to some minor procedures taking place in consulting rooms which were not entirely suitable for that purpose. For example to flooring in consulting rooms was carpet tiles. One of the GPs showed us a schedule of work that was being undertaken to update the consulting rooms to higher specification and make them suitable for carrying out these minor procedures.

We looked at medical equipment that was stored in readiness for use and found that it was all within the manufacturers' recommended use by date. We did note that one of the store rooms containing items such as syringes was insecure and patients could access this. The Practice Manager told us that this issue would be addressed.

Equipment

There were contracts in place for annual checks of fire extinguishers, portable appliance testing (PAT) and calibration of equipment such as spirometers to measure lung capacity. Documentation evidenced that equipment was regularly inspected to ensure it remained effective. Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. All the equipment we examined had been checked and calibrated within the manufacturer's guidelines.

Staffing and recruitment

The practice had a recruitment policy in place and had recognised that it required updating. We were shown a new policy which better reflected the national requirements on recruitment; this policy had yet to be implemented. We looked at two staff files and saw that in one file for a receptionist, some of the employment checks that were required to be carried out had not been completed, for example a declaration that person is medically fit to undertake their role and photographic proof of identity. A file relating to the recent recruitment of a new GP lacked employment references, proof of identity and other checks required. We spoke to the GP who had been involved in their recruitment and they told us that these checks had been completed but copies had not been kept, they accepted this was not acceptable even though the recruited GP was known personally to the team. The GPs had disclosure and barring service (DBS) checks

undertaken by the NHS England as part of their appraisal and revalidation process. Revalidation is whereby licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice. The nurses also had DBS checks completed, however the reception staff did not have such checks undertaken. The Practice Manager showed us documented rationale why such checks may not be required

The practice had sufficient staff to enable the personal medical service needs of patients to be met. The staff team were well established and most had worked at the practice for many years. The staff were also multi skilled which enabled them to cover each other in the event of planned and unplanned absence. The staff we spoke to told us of the improvements made by the current Practice Manager, they told us this had improved the overall effectiveness of the practice and more use of information technology was being encouraged.

Monitoring safety and responding to risk

There were systems in place to identify and report risks within the practice. These included regular assessments and checks of clinical practice, medications, equipment and cleaning. We saw evidence that these checks were being carried out weekly, monthly and annually where applicable. There was an incident and accident book and staff knew where this was located. Staff reported that they would always speak to the Practice Manager if an accident occurred and ensure that it was recorded. The practice had a health and safety policy, which staff had read and signed to say that they had understood its contents. This and all other practice policies were available to all staff at any time via the computer systems.

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, emergency medicines and an automated defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment. Staff we spoke with were able to describe what action they would take in the event of a medical emergency situation. Fire safety training had been undertaken and the Practice Manager was the identified fire Marshall on the day of our inspection.

Are services safe?

A written contingency plan was in place to manage any event that resulted in the practice being unable to safely provide the usual services. The plan was available for all staff. Each member of staff we spoke with was aware of the

policy relating to emergency procedures. This demonstrated there was an effective approach to anticipating potential safety risks, including disruption to staffing or facilities at the practice.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients we spoke with said they received care appropriate to their needs. They told us they were involved in decisions about their care as much as possible and were helped to come to decisions about the treatment they required. New patient health checks were carried out by the practice nurses. Cardiovascular and other regular health checks and screenings were on-going in line with national guidance. The practice had a documented system for reviewing patients with specific conditions. The Practice Manager showed us how each group of patients were easily identified electronically for review by the coding on their patients notes. Conditions for review included mental illness and the elderly. Patients with multiple conditions were allocated longer appointments and more regular reviews in order to review their more complex needs. We saw that the practice ensured that checks on patients' blood and weight were completed before the reviews to ensure the GP had as much information available as possible.

There was no clear mechanism in place for the consideration of current best practice. Instead each GP considered any changes in guidance themselves and formed their own opinion of how to engage with it. We asked one of the GPs to demonstrate the suggested clinical options available in the computer system. They had difficulty locating these and told us they didn't regularly use them. We asked specifically if an audit had been done following on from the publication of National Institute for Health and Care Excellence (NICE) guidance for patients in atrial fibrillation in June 2014. We were informed that there had not been any audit for this. It therefore is possible that the practice may have some patients on their list who are not on the recommended oral anticoagulation for this condition.

Multi-disciplinary meetings were held regularly to discuss individual patient cases making sure that all treatment options were covered. GPs at the practice had different areas of responsibility for example one GP attended the monthly CCG meetings and fed back information to their colleagues.

Management, monitoring and improving outcomes for people

Information about the outcomes of patients care and treatment was collected and recorded electronically in individual patient records. This included information about their assessment, diagnosis, treatment and referral to other services. If information was deemed to be particularly significant, it was flagged to appear on the patient's home screen so it was immediately visible to the viewer. This included information such as whether a person was a carer or a vulnerable person.

The practice completed clinical audit cycles. These are quality improvement processes that seek to improve patient care and outcomes through the systematic review of patient care and the implementation of change. We saw examples of these at the practice including audits relating to medications optimisation and cost effectiveness. There appeared to be no strategic organisation of these clinical audits and GPs completed them as they saw fit and generally as part of their annual appraisal process.

We saw no evidence of formal peer review within the practice and we discussed this with the Practice Manager and one of the GPs. We noted that because the GPs at the practice did not maintain their own patient list, this meant that informal peer review was taking place on a daily basis as each GP would review each other's treatment and care decisions.

The GPs and nurses had developed areas of expertise and took the lead in a range of clinical and non-clinical areas such as joint injections, contraception and safeguarding patients. They provided advice and support to colleagues in respect of their individual area.

Feedback from patients we spoke with, or who provided written comments, was complimentary and positive about the quality of the care and treatment provided by the staff team at the practice. We spoke with three members of the PPG who told us how they felt they were valued and listened to by the practice.

Effective staffing

Staff we spoke to at the practice were very complimentary and happy about the training opportunities available to them. Staff undertook mandatory training to ensure they were competent in the role they were employed to undertake. In addition to this they were encouraged to develop within that role and progress to other roles within

Are services effective?

(for example, treatment is effective)

the practice. Most staff were multi-skilled and able to carry out the role of their colleagues at short notice if required. The Practice Manager expressed some concern that she was sometimes perceived as a senior receptionist and was keen to have a more strategic role in moving the practice forward, particularly given her IT skills.

Most staff were long serving but there was an induction process for any new staff which covered the practice safety, introduction to policies and procedures and confidentiality. We saw that the Practice Manager maintained a clear planner documenting staff commitments and how absences would be covered. They told us that this gave them a clear view of staffing requirements and enabled them to grant things like annual leave based on the projected staffing levels.

The GPs were supported to obtain the evidence and information required for their professional revalidation. This was where doctors demonstrated to their regulatory body, the general medical council (GMC), that they were up to date and fit to practice. The GPs we spoke to told us they undertook regular clinical appraisals. The practice nurses confirmed that they were also supported to attend updates to training that enabled them to maintain and enhance their professional skills.

All patients we spoke with were complimentary about the staff and we observed that staff appeared competent, comfortable and knowledgeable about the role they undertook.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. For example multi-disciplinary 'Gold Standards' meetings for end of life care patients had involved district nurses, GPs and Macmillan nurses. GPs and nurses within the practice worked closely together.

The service used special patient notes, care plans and do not attempt resuscitation requests, which were updated and reviewed to ensure out of hours providers had accurate information available to them.

Information from out of hour's services was received via the practice computer system to the appropriate GP who checked them and arranged follow up treatment or appointments where required.

The practice kept disease registers for patients with long term conditions such as asthma and chronic heart disease which were used to arrange annual, or as required, health reviews. They also provided annual reviews to check the health of patients with learning disabilities and mental illness.

Blood results, investigations and information from out of hour's providers were generally received electronically and disseminated straight to the relevant doctor or nurse. Where necessary a procedure for scanning documents such as discharge letters was in place. The GP seeing these documents and results was responsible for the action required. The GP recorded their actions around results and discharge on the computer system, such as ringing a patient to discuss an abnormal blood result, or arranged to see the patient as clinically necessary.

Referrals were made within appropriate timescales, and the practice used the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

Information sharing

GPs met regularly with the practice nurses and the Practice Manager. The GPs and Practice Manager attended CCG meetings and disseminated what they had learned in practice meetings. This kept all staff up to date with current information around enhanced services, requirements in the community and local families or children at risk. Patients and individual cases were discussed by the practice clinicians and also with other health and social care professionals who were invited to attend meetings. The GPs and the Practice Manager attended local area meetings. Feedback from these meetings was shared with practice staff where appropriate. In addition the Practice Manager regularly attended area Practice Manager meetings to share information about their role and maintain their professional knowledge. We noted that staff meetings did not include all members of staff; we discussed this with one of the GPs who said that this would be reviewed as it was a good method to increase effective communication within the practice.

There was an informative practice website with information for patients including signposting, the PPG and out of hours contacts. We talked with three members of the PPG who confirmed that the practice was very responsive to

Are services effective?

(for example, treatment is effective)

patient feedback. Information leaflets were available within the practice waiting room and notices provided an array of support information. We saw that the results of the patient survey conducted in December 2013 were published on the practice website as was a link to the family and friends test.

Consent to care and treatment

Patients we spoke with told us that they were spoken to appropriately by staff and were involved in making decisions about their care and treatment. They also said that they were provided with enough information to make a choice and gave informed consent to treatment. The practice computer system identified those patients who were registered as carers and any other information relating to consent was scanned onto the system and alerts set up to notify clinicians.

GPs and clinicians had received training in the Mental Capacity Act and we saw evidence that patients were supported in their best interests, with the involvement of other clinicians, families and/or carers where necessary. 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.

The 2014 national GP patient survey indicated 87% of people at the practice said the last GP they saw or spoke to

was good at explaining tests and treatments, 75% said the last GP they saw or spoke to was good at involving them in decision making and 92% had confidence and trust in the last GP they saw or spoke to.

Health promotion and prevention

The practice supported patients to manage their health and well-being. The practice offered national screening programmes, vaccination programmes, long term condition reviews and provided health promotion information to patients. They provided information to patients via their website and in leaflets in the waiting area about the services available.

The practice offered all new patients a consultation to assess their past medical history, care needs and assessment of risk. Advice was given on smoking cessation, alcohol consumption and weight management. Flu vaccination clinics were carried out each year, and travel vaccines were available.

The practice held clinics to identify potential issues, for example a health trainer who offered advice to promote healthy living to different groups of people. This trainer also completed work around the national initiative for people aged between 40 and 75 aimed at improving people's health and well-being from middle age.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Staff we spoke with were clear on their responsibilities to treat people according to their wishes and diversity. We saw that staff had received training in confidentiality, bullying and harassment, data protection and information governance. We also noted that there were practice policies to cover all these areas.

We spoke to 11 patients in person and received feedback from 49 via completed CQC comments cards. Information we received from patients reflected that practice staff were professional, friendly and treated them with dignity and respect. Patients spoke highly of the practice, the reception staff, nurses and the GPs.

Patients informed us that their privacy and dignity was always respected and maintained particularly during physical or intimate examinations. All patient appointments were conducted in the privacy of an individual consultation or treatment room. There were privacy curtains for use during physical and intimate examinations and a chaperone service was offered.

We looked at the results of the 2014 GP patient survey. This is an independent survey run on behalf of NHS England. The survey results reflected that 88% of respondents said the last GP they saw or spoke to at the practice was good at treating them with care and concern. 77% of respondents said the last nurse they saw or spoke to was good at listening to them. These percentages were higher than the average for practices in the area.

Care planning and involvement in decisions about care and treatment

Patients we spoke to during the inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and confirmed patients felt listened to and involved in their care.

The templates used on the computer system for people with long term conditions supported staff in helping to

involve people in their care, and nursing staff were able to provide examples of where they had discussed care planning and supported patients to make choices about their treatment. The surgery offered longer appointments to those with more complex conditions to allow the patient extra time to discuss their care and treatment.

People said the GPs explained treatment and results in a way they could understand, and they felt able to ask questions, and felt sufficiently involved in making decisions about their care. Staff told us that translation services were available for patients who did not have English as a first language.

The 2014 GP patient survey reported that 75% of respondents said the last GP they saw or spoke to at the practice was good at involving them in making decisions about their care. 66% of respondents said the last nurse they saw or spoke to at the practice was good at involving them in making decisions about their care.

Patient/carer support to cope emotionally with care and treatment

Patients said they were given good emotional support by the doctors, and were supported to access support services to help them manage their treatment and care. Comment cards filled in by patients said doctors and nurses provided a caring empathetic service, and some highlighted when they had been given additional care and support following bereavement.

The practice was signposting patients and/or families to local bereavement counselling services when necessary, and also contacted patients either by telephone or home visit following bereavement to ensure they were supported. We saw that there was a system for notifying staff about recent patient deaths and a list was posted in the staff room so that everyone at the practice was aware of any recent deaths. Staff told us that this was helpful when speaking to relatives and others who knew the person who had died.

Notices in the patient waiting room also signposted people to a number of support groups and organisations. The practice's computer system alerted staff if a patient was also identified as being a carer so they could opportunistically assess whether the person needed extra support.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The GPs we spoke to were able to demonstrate that they considered the particular needs of patients who were vulnerable such as people with long term health conditions, dementia, learning disabilities and older people. Clear and well organised systems were in place to ensure these vulnerable patient groups were able to access medical screening services such as annual health checks, monitoring long term illnesses, smoking cessation, weight management, immunisation programmes or cervical screening.

The practice completed a patient satisfaction survey in December 2013, published the results on their website and promoted the family and friends test to measure what people thought about the service. The practice team had planned and implemented a service that was responsive to the needs of the local patient population. The practice actively engaged with commissioners of services, local authorities, other providers, patients and those close to them to support the provision of coordinated and integrated pathways of care that met patient's needs. The practice had explored and was involved in a variety of ways to continually improve the way they responded to people's needs. These included regular locality meetings, buddy group meetings with a nearby practice, primary health care team meetings and meetings with district nurses. The practice provided enhanced services including unplanned admissions to hospital, dementia reviews and alcohol monitoring.

We saw that the practice had been proactive in seeking and responding to patients. Examples we saw were a new front door having been fitted and the provision of hand washing gel in the waiting room both following suggestions from patients.

Tonge Fold Health Centre had a reception area, a patient waiting area, several treatment/consultation rooms and other rooms for training and administration purposes. The treatment rooms were designated for carrying out minor surgical procedures. The building was easily accessible to patients including those using wheelchairs. One of the GPs told us that they were looking for ways to best utilise the extra unused space that they had.

Tackling inequity and promoting equality

Staff told us that there was little diversity of ethnicity within their patient population. However they were knowledgeable about language issues and told us about the language line available for people who did not use English as their first language. They also described awareness of culture and ethnicity and understood how to be respectful of patients' views and wishes. One patient we spoke to on the day of the inspection did not use English as their first language and said that they sometimes found it difficult to understand some of the things that they were told by clinical staff. They said they tended to bring a friend or family member with them when they could.

The practice had taken steps to remove barriers to accessing the services of the practice. The practice team had taken into account the differing needs of people by planning and providing a care and treatment service that was individualised and responsive to individual need and circumstances. This included having systems in place to ensure patients with complex needs were enabled to access appropriate care and treatment such as patients with a learning disability or dementia.

Access to the service

Access to the surgery was good with wide doors to the entrance for wheelchair users. A hearing induction loop was available in several areas of the practice for use by patients with difficulty hearing.

There was a good appointment system where people could receive same day emergency appointments, call backs and home visits by the doctor. We saw that people requiring same day appointments were asked to attend at 11am and despite there being a large number of people; they were all seen relatively quickly. Patients we spoke to told us that they could usually get to see or speak to one of the GPs and they felt that the 11am appointment system worked well and they had not experienced any long waiting times, usually less than 20 minutes. The manner in which the GPs saw patients meant that if any one consultation took a long time, other patients were not adversely affected. One example we witnessed involved a baby having to be admitted to hospital, this meant that one GP was busy for quite some time and the other GPs were able to deal in turn with patients waiting to be seen.

We looked at the results of the 2014 GP survey 91% of respondents found the receptionists at the practice helpful,

Are services responsive to people's needs?

(for example, to feedback?)

84% of respondents said the last appointment they got was convenient and 80% were able to get an appointment to see or speak to someone the last time they tried. These averages were higher than for other practices in the area.

The opening hours and surgery times at the practice were prominently displayed in the reception area and on the practice website. The practice was open every weekday 8.30am to 6.30pm except for Wednesdays when they closed at lunchtime. Extended hours were operated on Wednesdays and Thursdays from 7.00am to provide service for patients who could not generally attend during office hours. There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed.

The practice operated a referral system to secondary care (hospitals). This was a choose and book system where the GPs used a variety of means to prompt reception staff to create an appropriate appointment based on patient choice. We were told that some GPs used email, some a Dictaphone message and some hand wrote instructions, this caused difficulty for administration staff in establishing a single effective system. We spoke to one of the GPs about this and they told us that they had recognised the need to streamline a number of the individual processes currently used by each GP.

The practice ensured that a summary of the most important information was also provided in any transfer of patients, this included any repeat medicines, recent blood pressure information and any significant alerts.

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 practice.

The practice carried out a patient survey in December 2013. An action plan was then drawn up and discussed with the PPG to look at the results. The practice was able to demonstrate where they had made changes in response to feedback. Results of the patient survey were advertised on the website, and in reception for patients to see. Information on how to make a complaint was available in the practice leaflet and on a poster with the reception area.

We looked at complaints from the previous year, and could see that these had been responded to with a full explanation and action points for learning detailed. We spoke to reception staff who told us they would refer serious complaints to the Practice Manager, however if they felt they could deal with effectively they would do so. They said details of minor complaints would be recorded on patient notes. We discussed this with the Practice Manager and they accepted that this would make review and audit of minor complaints difficult to complete.

We saw that compliments were also received regularly. We looked at thank you cards and letters of appreciation praising the staff and the care and treatment received.

Are services well-led?

Requires improvement 

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

Our findings

Vision and strategy

Discussions and evidence we reviewed did not demonstrate the management team had a clear vision and purpose. The GPs we spoke with demonstrated an understanding of their area of responsibility and they took an active role in ensuring that a high level of service was provided on a daily basis. All the staff we spoke with said they felt they were valued however administration and reception staff were not included in regular practice meetings. Two of the GPs had been at the practice for many years and we were told that they sometimes found difficulty in embracing new technology and ways of working. For example the practice IT system and the use of management information. We spoke with three members of staff and they all had some difficulty in describing the practice vision and values. They knew what their responsibilities were in relation to providing a high standard of care. We looked at the minutes of the practice meetings during 2014 and saw no evidence of discussion around the vision and values.

The practice newsletter, website and PPG demonstrated that the practice was interested in the views of their patients and carers and these views were fed into the practice so that they could consider how the service could be improved. The staff told us they were dedicated to providing the best possible service to their patients.

GPs and the Practice Manager attended locality and Clinical Commissioning Group (CCG) meetings to identify needs within the community and tailored their services accordingly. They worked with local safeguarding, domestic violence and other organisations to make sure they were aware of the requirements within their patient population.

Governance Arrangements

We saw that the practice had a documented statement of purpose which included their aims and purposes, some of which stipulated: 'Tonge Fold Health Centre prides itself on being a family friendly orientated Practice. The Practice strives to deliver a high quality service within a safe health care environment. The GP's Practice Nurses and Admin Staff aim to provide a caring, professional and efficient service to all our patients, carers and visitors to the Practice.'

The practice used the Quality and Outcomes Framework (QOF) to measure their performance, the Practice Manager told us they kept a regular check on their QOF figures to ensure they were performing well within their CCG. The QOF data for this practice showed it was performing around the average for the area.

The practice did not have robust arrangements for identifying, recording and managing risks. The Practice Manager said they did not maintain a risk log which could address a wide range of potential issues, such as the environment and infection prevention. We saw no evidence that the risks were regularly discussed at team meetings.

The practice had no strategy in place for completing clinical audit cycles. These were quality improvement processes that sought to improve patient care and outcomes through the systematic review of patient care and the implementation of change. Clinical audits were instigated by GPs usually as part of their ongoing appraisal responsibilities. We looked at several clinical audits around different medicines; they were well documented and demonstrated a full audit cycle.

Leadership, openness and transparency

There was no clear leadership structure. We spoke with three members of staff and they were all clear about their own roles and responsibilities, but less so about who was leading the practice in terms of its direction and focus. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns. Most of the team had worked together for many years and until recently there was a very low turnover of staff. They told us that the current Practice Manager had been effective in beginning to introduce some new IT systems and processes. Staff told us that all the GPs were professional and effective, however each worked differently and this made it difficult to standardise processes. We were told that one GP leads the practice whilst another was responsible for facilitating change by negotiation. Staff told us that it was a family friendly practice and as long as patients are happy then the GPs are.

We saw staff undertook annual appraisals. We discussed the potential for documented supervision meetings between appraisals as a method of evidencing staff support. The Practice Manager told us that in addition to the open door policy and strong informal communications between staff and management, this would be introduced.

Are services well-led?

Requires improvement 

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

The Practice Manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example an induction policy in place to support staff when they first began working there. Staff we spoke with told us these policies were available if they needed to refer to them on the practice computers.

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

Patients spoken with reported that they felt comfortable providing concerns, compliments or complaints and some had done so. Information received was acted upon and we saw evidence that changes were made to working practice where ever possible.

The practice had an active patient participation group (PPG) which had recently been formed. We spoke to three members of the PPG who said that it worked effectively and was an excellent way of patients influencing the way the practice was run. Patient survey reports and action plans were published on the practice website for the practice population to read. The practice was able to demonstrate through action plans where they had made changes in response to feedback from the patient group and patient surveys, such as advertising online booking facilities more.

Staff reported they could feedback through talking with the practice manager, however they were not asked to contribute to staff meetings.

Management lead through learning and improvement

We saw a clear understanding of the need to ensure that staff had access to learning and improvement opportunities. Newly employed staff had a period of induction and mandatory training was role relevant. E-Learning was carried out where face to face training was not required. A core set of training was provided for all staff and this was monitored on an annual basis. The Practice Manager showed us a training plan which gave them overview of which staff required training and in what subject matter.

The nurses and GPs kept their continuing personal development up to date and attended other courses pertinent to their roles and responsibilities within the practice such as safeguarding vulnerable patients and current immunisation advice . This ensured that patients received treatment which was most current.

The practice had completed reviews of significant events and other incidents but there was no evidence that they had always shared the outcomes of these with staff particularly during meetings. Where appropriate significant events had been notified to the CCG in order that learning on a wider area base could be achieved.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers</p> <p>People who use services were not protected against the risks associated with ineffective recruitment procedures and not carrying out relevant checks when employing staff. The provider must take action to ensure that people who use the service are protected by operating effective recruitment and selection procedures that includes relevant checks being carried out (and evidenced) when staff are employed.</p> <p>Contrary to Regulation 21(a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010</p>

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers</p> <p>The registered person must protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to—</p> <p>(a) regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity against the requirements set out in this Part of these Regulations; and</p> <p>(b) identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity.</p> <p>Contrary to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010</p>