Ormskirk Medical Practice

Quality Report

18 Derby Street,
Ormskirk,
Lancashire
L39 2BY
Tel: 01695588805
Website: www.ormskirkmedicalpractice.nhs.uk

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

Ratings

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

Summary of findings

Contents

Overall summary

We carried out an announced comprehensive inspection at Ormskirk Medical Practice (known previously as Leyland House Surgery). Overall the practice is rated as requires improvement.

Specifically, we found the practice to require improvement for providing safe, effective, and well led services. However it was rated as good for providing a caring and responsive service.

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

- Most staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and managed, with the exception of those relating to recruitment checks.
- Data showed patient outcomes were below average for the locality and the practice was taking action to address this, although this was not formalised into an action plan.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice proactively sought feedback from patients and complaints were investigated and responded to appropriately.
- Urgent appointments were usually available on the day they were requested. However patients said that trying to get through on the telephone to the practice was challenging.
- The practice had a number of policies and procedures to govern activity. Many of these had been recently reviewed and updated but several still required updating.
- There was lack of clarity about the leadership of the practice and the staff did not know what the vision and strategy was for the practice.

However there are areas where the provider must make improvements:

- Ensure recruitment processes are up to date and include all necessary employment checks for all staff.

Summary of findings

- Ensure induction training for all staff is comprehensive and prepares each staff member to undertake their role and responsibilities safely and effectively.
- Ensure there is a clear management and organisational structure that includes a lead for clinical governance and ensure formal governance arrangements are in place, to assist in monitoring and addressing gaps in performance.

In addition the provider should:

- Develop a practice vision and strategy that is shared with all staff, to ensure there is a collective understanding of what the practice wants to achieve and how each team member can contribute to the vision.
- Ensure GPs have appropriate updated training to allow them to effectively use the electronic patient record system.
- Ensure a system to monitor stocks and expiry dates of medicines for use in emergencies that are held in GP's bags is implemented so that medicines are available and are replaced in a timely manner.
- Improve the administration and organisation of both paper and electronic records, such as policies, procedures and risk assessment so that all staff can access these quickly
- Ensure information on the practice website is up to date and includes details of how to book online appointments.
- Display fire procedure for patients in waiting rooms, especially in the first floor waiting rooms.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services. Most staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated to appropriate team members to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented effectively to ensure patients were kept safe. For example, significant gaps were noted in the recruitment of new staff.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services. National data showed patient outcomes were below average for the locality and action was being taken to improve this. However, there was no formalised action plan available.Staff induction training needed to be improved as some new staff we spoke with had gaps in their knowledge about the different aspects of the service. Staff had mandatory training and other training appropriate to their roles. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they struggled to get through to the practice on telephone but found it relatively easy to get an appointment once they got through. The practice was in consultation with the CCG Commissioning Support Unit to improve the number of phone lines

Summary of findings

available with a queuing facility. The GP practice offered urgent appointments daily and offered daily telephone consultations. Information about how to complain was available and evidence showed that the practice responded quickly to issues raised.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led. Staff said they felt supported by management and could approach any member of the team with concerns. However, the staff we spoke with were not clear about the vision, future strategy and leadership at the practice. There were no clear systems of governance in place; for example, formalised plans to improve outcomes for patients were not in place. The practice proactively sought feedback from patients and had an active virtual patient reference group (PRG). Staff had received 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

Requires improvement

There were aspects of the practice that were rated as requires improvement and these related to all population groups. However, the actions taken by the practice in supporting older people were good. The practice had higher number of patients than the national average who were over 65 years of age. They provided care and treatment to several patients living in residential care homes and supported living services. All patients over 75 year had a named GP and those patients assessed as being at risk of an unplanned admission to hospital had a care plan in place, which was reviewed regularly. The practice nurse also visited older people at home to undertake over 75 health checks and offer flu vaccinations. The practice held monthly palliative care meetings with the palliative care nurse and district nursing team.

People with long term conditions

Requires improvement

There were aspects of the practice that were rated as requires improvement and these related to all population groups. However, the practice nursing staff were proactive and had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the practice worked with relevant health care professionals to deliver a multidisciplinary package of care. Patients told us they were satisfied with the care and support they received.

Families, children and young people

Requires improvement

There were aspects of the practice that were rated as requires improvement and these related to all population groups. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours. Staff knew how to recognise signs of abuse in children and were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Summary of findings

Working age people (including those recently retired and students)

Requires improvement

There were aspects of the practice that were rated as requires improvement and these related to all population groups.The practice did not offer extended opening hours but told us they tried to accommodate patients who had difficulty attending within normal hours. Telephone consultations were also available with a GP. Patient feedback on CQC comment cards indicated that this was a valued service. Online appointment and prescription ordering was available, although the practice website contained little information on how to book appointments.

People whose circumstances may make them vulnerable

Requires improvement

There were aspects of the practice that were rated as requires improvement and these related to all population groups.The practice held a register of patients living with a learning disability and just over 75% had received a health check within the last 12 months. 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 normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Requires improvement

There were aspects of the practice that were rated as requires improvement and these related to all population groups. Data indicated that some patient mental health /dementia reviews were below the average for the locality. We heard that this was due to a number of reasons including, patient's none attendance for their planned review, increase in patient numbers with dementia and incorrect or missing coding on the electronic patient record. Some staff had recently received in house training in dementia awareness.

Summary of findings

What people who use the service say

During our visit, we spoke with nine patients. They all spoke positively about the GPs and nurses working at the practice and all but one patient was complimentary about the reception team. All nine patients told us it was difficult getting through to the surgery on the telephone to make an appointment, although all said once they got through they usually got an appointment to see a GP quickly.

We received 25 completed CQC comment cards. Five responses referred to difficulty getting through to the practice on the telephone. All 25 comment cards were complimentary about the service they received from reception, nursing staff and GPs.

The practice had a 'virtual' patient representation group (PRG). This meant members of the practice population who had agreed to be part of the group were contacted by email to seek their views and opinions about different aspects of the service. We were told that the PRG had about 50 members although only 15 regularly responded to the practice. We spoke with two members of the PRG by telephone. They confirmed they were consulted about different aspects of the service. Most recently, they had been consulted about their knowledge of how appointments could be booked at the practice.

The practice had also carried out its own patient survey and posted the results of this on their website. Among other questions, the practice asked how easy it was to book an appointment at the practice. 28% of those that responded said it was an easy experience and 44% stated it was not an easy experience, mainly because there was no queuing facility on the telephone line.

The results of the National GP Patient Survey published in January 2015 demonstrated the practice performed well, when compared with the average results for the local Clinical Commissioning Group (CCG). 96% of respondents stated the last GP they saw or spoke to was good at treating them with care and concern; 91% of respondents said the last GP they saw or spoke to was good at involving them in decisions about their care and 94% of respondents stated the last GP they saw or spoke to was good at explaining tests and treatments.

The survey also identified where the practice were performing less well in comparison with the CCG. 66% of respondents said they found it easy to get through to the surgery by phone compared to the CCG average of 72% and 69% of respondents were satisfied with the surgery's opening hours, compared with 75% CCG average.

Areas for improvement

Action the service MUST take to improve

- Ensure recruitment processes are up to date and include all necessary employment checks for all staff.
- Ensure induction training for all staff is comprehensive and prepares each staff member to undertake their role and responsibilities safely and effectively.
- Ensure there is a clear management and organisational structure that includes a lead for clinical governance and ensure formal governance arrangements are in place, to assist in monitoring and addressing gaps in performance.

Action the service SHOULD take to improve

- Develop a practice vision and strategy that is shared with all staff, to ensure there is a collective understanding of what the practice wants to achieve and how each team member can contribute to the vision.
- Ensure GPs have appropriate updated training to allow them to effectively use the electronic patient record system.
- Ensure a system to monitor stocks and expiry dates of medicines for use in emergencies that are held in GP's bags is implemented so that medicines are available and are replaced in a timely manner.

Summary of findings

- Improve the administration and organisation of both paper and electronic records, such as policies, procedures and risk assessment so that all staff can access these quickly
- Ensure information on the practice website is up to date and includes details of how to book online appointments.
- Display fire procedure for patients in waiting rooms, especially in the first floor waiting rooms.

Ormskirk Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP, a specialist in Practice Management and an Expert by Experience (ExE). Experts by Experience are people who have experience of using or caring for someone who uses health and/or social care services.

Background to Ormskirk Medical Practice

Ormskirk Medical Practice is situated in the centre of Ormskirk town. It is part of the NHS West Lancashire Clinical Commissioning Group (CCG.) Services are provided under a general medical service (GMS) contract with NHS England. There are 8,333 registered patients. The practice population includes a higher number (26.1%) of people over the age of 65, and a lower number (12.9%) of people under the age of 18, in comparison with the national average of 16.7% and 14.8% respectively. The practice also has a higher percentage of patients who have caring responsibilities (26.8%) than both the national England average (18.4%) and the CCG average (20.2%).

Information published by Public Health England, rates the level of deprivation within the practice population group as eight on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest.

The practice opens from 8.30am to 6pm Monday to Fridays. It does not offer extended opening hours but does provide seasonal Flu vaccination clinics on Saturdays at certain times of the year. Patients requiring a GP outside of normal working hours are advised to contact an external out of hour's service provider Out Of Hours West Lancashire C.I.C (OWLs)

The practice has four GP partners, two female and two male. There is also one female and one male salaried GP, one female locum GP, two female practice nurses, one health care assistant, a practice manager, an office manager, a medicine management coordinator and reception and administration staff.

On-line services include appointment booking and ordering repeat prescriptions.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and to look at the overall quality of the service 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 (QOF) framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

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

Is it safe?

Detailed findings

Is it effective?

Is it caring?

Is it responsive to people's needs?

Is it well-led?

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

Older people

People with long-term conditions

Families, children and young people

Working age people (including those recently retired and students)

People living in vulnerable circumstances

People experiencing poor mental health (including people with dementia)

Before visiting the practice, we reviewed information we held and asked other organisations and key stakeholders to share what they knew about the practice. We also reviewed policies, procedures and other information the practice manager provided before the inspection. We carried out an announced inspection on 6 May 2015.

We spoke with a range of staff including four GPs, two practice nurses, the medicines co-ordinator, the office manager, reception staff and the practice manager. We sought views from patients and representatives of the patient reference group, looked at comment cards, and reviewed survey information.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. This included investigating reported incidents, checking national patient safety alerts and sharing comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. However, we observed one member of the reception team respond to an issue raised by a patient but did not realise that the issue should have been reported as an incident. Increasing staff awareness of what issues should be reported as incidents will ensure improvements in the quality of the service provided are identified and responded too quickly. Reports and data from NHS England indicated that the practice had a good track record for maintaining patient safety.

We reviewed safety records and incident reports. The practice manager, clinicians and any other relevant staff investigated and reported on the incidents and events. Documented evidence confirmed that incidents were appropriately reported. Staff we spoke with all said that there was an open and 'no blame' culture at the practice that encouraged them to report adverse events and incidents.

Minutes of meetings recorded in 2015 provided evidence that incidents, events and complaints were discussed. We saw that where it was appropriate actions were taken and protocols adapted to minimise re-occurrence of the incident or complaint. Records were available that showed the practice had reviewed and responded to significant events, incidents and complaints.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of significant events that had occurred during the previous 12 months. The practice had only recently commenced recording minutes of their weekly clinical meetings and those available included significant events. There was evidence that the practice had learned from these and adapted or change procedures as required.

Staff spoken with including practice nurses and the medicine management coordinator provided recent examples where procedures had changed following investigation of a significant event.

We saw evidence to confirm that, as individuals and a team, staff were actively reflecting on their practice and critically looked at what they did to see if any improvements could be made. Significant events, incidents and complaints were investigated and reflected on by the GPs and practice manager and learning disseminated to the whole team where relevant. We looked at some recent significant events from 2014 to 2015, which had been analysed, reported and discussed with relevant staff. We saw that the practice had reported one patient safety incident to the National Reporting and Learning System (NRLS). NHS England introduced NRLS e-form to make reporting incidents easier and quicker at the end of February 2015. NRLS provides the opportunity to ensure that the learning gained from the experience of a patient in one part of the country is used to reduce the risk of something similar occurring elsewhere.

National patient safety alerts were disseminated by the practice manager to relevant staff. Nursing staff we spoke with gave examples of recent alerts/guidance that were relevant to the care they were responsible for. One GP told us of a recent alert, however another GP thought they received these alerts by email and another GP thought they received them as paper copies. GPs were unclear where these were stored for future reference.

Reliable safety systems and processes including safeguarding

Staff had access to contact details for both child protection and adult safeguarding teams. We saw evidence of such information displayed in all clinical, reception and administrative areas. One staff member showed us a policy and procedure, which was out of date. The practice manager confirmed that these were in the process of being updated. All GPs had undertaken level three safeguarding training and one GP was the designated lead for safeguarding. They told us that they were not aware of any children on their practice at risk register and could not recall any 'looked after children' on their patient list. All other staff had received up to date training, at a level suitable to their role. One salaried GP, who had been recently employed at the practice, was not aware who the practice safeguarding lead was.

Requires improvement

Are services safe?

All staff we spoke with were knowledgeable about the types of abuse to look out for and how to raise concerns. Staff told us of two recent cases where referrals had been made to adult safeguarding teams because they had identified concerns about the risks to the patients.

The practice had a current chaperone policy. The practice manager confirmed that only staff who had received training in the role and responsibilities of chaperoning carried out this role. All staff who undertook this role had a criminal records check through the Disclosure and Barring Service (DBS). Patients spoken with told us they were aware of the availability of a chaperone if required.

Medicines management

One practice nurse had responsibility for ensuring medicine including vaccines were stored correctly and had not exceeded their expiry date. We checked medicines stored in the treatment rooms and fridges. We found that they were stored appropriately. There was a current policy and procedures in place for medicines management including cold storage of vaccinations and other drugs requiring this. We saw the checklist that was completed twice daily to ensure the two pharmaceutical fridges remained at a safe temperature. Staff told us of the procedure to follow in the event of a potential failure of the cold chain. A cold chain policy was in place for the safe management of vaccines. (Cold chain refers to the process used to maintain optimal conditions during the transport, storage, and handling of vaccines). All medicines we checked were in date.

GPs reviewed their prescribing practices as and when medication alerts or new guidance was received. Quality and Outcomes Framework (QOF) data showed the practice to be performing below expected for the locality in a number medicine related areas. (QOF is an incentive system for the performance management of GP practices). To improve this, the practice was working closely with the Clinical Commissioning Group (CCG) medicine management team to review and improve the practice's prescribing of medicine in line with current guidance and legislation. The practice employed a medicine coordinator who worked closely with the CCG medicine optimisation team to review prescribing practices. The medicines coordinator was specifically trained for the role they carried out. They audited and monitored prescribing trends, reviewed medication alerts, new guidance, patient hospital prescriptions and undertook with GPs clinical audits of specific medications. Recent clinical audits included the monitoring and reducing the prescribing of benzodiazepines. The prescribing of arthritic medicine disease-modifying anti-rheumatic drugs (DMARDs) was also carried out.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance, as these were tracked through the practice and kept securely.

Medicines for use in medical emergencies were kept securely in the treatment room. We saw evidence that stock levels and expiry dates were checked and recorded on a regular basis. Staff knew where these were held and how to access them. Oxygen and an automated external defibrillator (AED) were kept by the practice for use in an emergency. These were checked regularly. An AED is a portable device that is used to treat cardiac arrest by sending an electric shock to the heart to try to restore a normal rhythm. We were told that medicine to respond to suspected meningitis was on order from the local pharmacy. The practice also had emergency medicine kits for anaphylaxis (a severe, potentially life-threatening allergic reaction that can develop rapidly).

Systems to monitor stocks and expiry dates of medicines for use in emergencies that were held in GP's bags had not been implemented effectively. At the time of our visit, we were told that GP bags did not contain any medicines as these were all on order from the pharmacist.

The practice had recently installed electronic prescribing which meant that patient prescriptions could be sent automatically to the patient's preferred pharmacist or chemist. This reduced the need to use paper prescriptions.

Cleanliness and infection control

We saw the premises were clean and tidy. Comments recorded by patients on CQC comment cards referred to the practice as being clean, welcoming and hygienic. The practice employed their own cleaner. There was a cleaning schedule in place, although evidence that the cleaner followed this was not available. Systems to check and audit the cleanliness of the practice were not in place potentially putting people at risk from an increased risk of infection.

We saw that all areas of the practice were clean and processes were in place to manage the risk of infection. We noted that all consultation and treatment rooms had

adequate hand washing facilities. Instructions about hand hygiene were available, with hand gels in clinical rooms. We found protective equipment such as gloves and aprons were available in the treatment/consulting rooms. Couches were washable and privacy curtains in the treatment rooms were changed in accordance with a planned schedule. Nursing staff we spoke with told us about the cleaning they undertook between patient appointments to reduce the risk of cross infection.

The practice nurse was the lead for infection control and they confirmed that they carried out a recent audit of the practice. Records were available of the infection control audit. Records were also available demonstrating that staff had received training in use of personal protective equipment.

We saw that policies and procedures were up to date, and these were stored on the practice's electronic shared drive. Procedures included the safe storage and disposal of needles and waste products and the management of specimens.

The practice had a risk assessment for the management of Legionella (a bacterium that can grow in contaminated water and can be potentially fatal).

Equipment

Staff we spoke with told us they had sufficient and suitable equipment to enable them to carry out diagnostic examinations, assessments and treatments.

All equipment was tested and maintained regularly and we saw equipment maintenance logs, contracts and other records that confirmed this. Contracts were in place for annual checks of fire extinguishers and portable appliance testing (PAT). We saw that annual calibration and servicing of medical equipment was up to date.

Emergency drugs were stored in a separate cupboard. There was an oxygen cylinder, nebulisers and access to an automated external defibrillator. These were maintained and checked regularly.

Staffing and recruitment

The practice policy for the recruitment of staff was basic and did not set out the standards it followed when recruiting clinical and non-clinical staff. The policy was dated 2011 but had been reviewed in 2015, however reference to Disclosure and Barring Service (DBS) checks some staff are required to have was not included, although DBS checks had been completed.

We looked at a sample of three staff recruitment files to see if the practice's recruitment practices were safe. We saw that the employment files for three newer members of the staff team (a GP, a practice nurse and a receptionist) did not have application forms, interview assessments nor were references obtained for two of the new staff members. The third staff file had one written reference but not a reference from the person's last employer. The three recruitment files did not have all the documentation required by legislation. The practice could not therefore demonstrate that its implementation of the recruitment procedures was safe; or that all reasonable checks had been undertaken to ensure these new employees were fit to work with people who were potentially vulnerable. However, DBS checks had been undertaken for the new staff.

A policy was available that stated that professional qualifications would be checked with the clinician's appropriate registration body. However, written documentation to evidence that checks on professional registration of staff was not available. Although we were told that, this was undertaken.

Staff told us there were enough staff to maintain the smooth running of the practice and there were enough staff on duty to keep patients safe. However when the practice's cleaner was absent then the practice manager carried out cleaning duties. The impact of this during these periods potentially reduced the quality of the service provided. The reception staff team worked well and we heard they supported each other in times of absence and unexpected increased need and demand. The practice manager and GP oversaw the rota for clinicians and we saw they ensured that sufficient staff were on duty to deal with expected demand including home visits and chaperoning.

The practice had lines of accountability for some care and treatment. For example, there were designated leads for safeguarding, complaints and mental health. However, when asked who the clinical governance lead was for the practice we found this had not been specifically identified previously.

Monitoring safety and responding to risk

Requires improvement

Are services safe?

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. All new employees working in the building were given basic induction information for the building, which covered health and safety and fire safety.

There was a health and safety policy available for all staff. Workplace risk assessments had been undertaken and were available on the shared drive for all staff to access.

The practice had recently undertaken a fire risk assessment of the premises and the areas identified by the assessment had been actioned. Records of the weekly fire safety checks were available. Information in the patient waiting areas advising patients what to do in the event of fire was not displayed. This information would assist the safe evacuation of the building in the event of a fire, especially from the two first floor patient waiting areas.

Arrangements to deal with emergencies and major incidents

An appropriate business continuity plan (Continuity and Recovery Plan) and supporting risk assessment was in place and up to date. This comprehensive plan covered business continuity, staffing, records/electronic systems, clinical and environmental events. Key contact numbers were included and paper and electronic copies of the plan were kept in the practice. Staff we spoke with were knowledgeable about the business continuity plan and could describe what to do in the event of a disaster or serious event occurring.

Staff had received training in dealing with medical emergencies including cardiopulmonary resuscitation (CPR). This was updated annually. There was suitable emergency equipment. 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 asthma and we were told medicine to treat suspected meningitis was on order from the pharmacy. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. However, we were told that GP bags did not contain any medicines as these were all on order from the pharmacist.

Weekly fire alarm tests were carried out and equipment maintained by a contracted company.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Once patients were registered with the practice, the practice nurse carried out a full health check if the initial information from the registering patient indicated they had a long term health condition. The information covered in a routine health check was comprehensive and included information about the patient's individual lifestyle as well as their medical conditions. Patients told us they were satisfied with the quality of care and treatment they received both from GPs and nursing staff.

All the clinicians we spoke with were familiar with, and using current best practice guidance. The staff we spoke with and evidence we reviewed, confirmed that care and treatment delivered was aimed at ensuring each patient was given support to achieve the best health outcomes for them. Each clinician confirmed that they had online access to NICE (National Institute for Health and Care Excellence) guidance.

The practice patient population of people over the age of 65 was of 26.1 %. This was approximately 10% higher than the national average for GP practices in England. The practice also provided care to patients living in 14 residential care homes and other supported living accommodation schemes. We heard the patients' health care needs included dementia and high dependency care. Evidence showed that the GPs undertook a high number of home visits each week.

The practice took part in the avoiding unplanned admissions to hospital scheme. All their registered patients living in residential care homes within their catchment area had had their healthcare needs reviewed and assessed by a GP and a care plan recorded. The care plans were reviewed as a minimum every three months so that any changes in the patients' health or social care needs were recorded and planned for. One of the GP leads responsible for the unplanned admissions scheme showed us how the care plan information was accessed from the electronic patient database. However, other GPs at the practice were unable to locate these on the database. Electronic markers or flags on the patient record to indicate they had a care plan were not evident. This potentially put patients at risk at not receiving an appropriate response from the GPs. Copies of the care plan were not provided to the patient in order to show communication and inclusion in care and treatment decisions.

GPs and nursing staff held weekly clinical meetings where the clinical needs of patients and the services provided by the practice were reviewed. Nursing staff said that GPs were accessible when they needed advice or support.

Management, monitoring and improving outcomes for people

The practice routinely collected information about patients' care and treatment. It used the voluntary Quality and Outcomes Framework (QOF) to assess its performance and undertook regular clinical audits. Records indicated that the QOF points achieved by the practice for the last four years ending April 2014 was below both the CCG average and England average. For the year 2013-2014, the practice scored 71.3%. The CCG average was 93.8% and the England average was 94% for the same time period. We discussed this with the practice manager and some of the GPs. The QOF data identified certain areas where the practice scores were below the expectations. GPs told us there were a number of reasons for this including: high numbers of patients over the age of 75; increasing patient list size, many of the new patients had high dependency health care needs and lived in residential care homes; around inputting data (read codes) on the patient data base, the absence of GPs and individual GP practices. There was no formal written plan available detailing how the practice was going to improve its QOF performance. However, GPs told us of the action being taken to address the shortfalls in performance. For example, one GP had attended training for the treatment and management of a heart condition (atrial fibrillation); a learning event had been held regarding management of infections such as Clostridium Difficile and action was being taken to ensure patients with diabetes also had their feet checked. We were told the practice had improved its performance for 2014-2015.

The practice had a system in place for completing clinical audit cycles. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. We saw audits of cytology smears that showed that the practice had a lower score on inadequate smears when compared to the other locations, which used the

Requires improvement

Are services effective?

(for example, treatment is effective)

Manchester Cytology centre to analyse these. Therefore, patients did not need to return for a repeat procedure. Other clinical audits included the management of gout and clinical audits linked to medicines management including the use of benzodiazepines.

The practice implemented the gold standards framework for end of life care. They had a palliative care register and held regular multidisciplinary meetings to discuss the care and support needs of patients and their families. Minutes of these meetings were not recorded, but we were told the decisions made regarding patient's individual care were recorded directly into the patient's electronic record. Special information notes were used to inform out of hours services of any particular needs of patients who were nearing the end of their lives.

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. The practice population included a number of patients who had dementia and a number of staff had recently attended training on dementia care.

Almost all patients we spoke with were complimentary about all the staff. Staff we observed were competent, comfortable and knowledgeable about the role they undertook.

Induction training records for new staff consisted of a basic list of tasks. The sample of these we viewed were not signed or dated by the new staff member or by the staff member's mentor. Evidence that new staff received support or had checks on their competency to undertake tasks was not available. Interviews with newer staff identified gaps in their knowledge for example awareness of the safeguarding lead, effective navigation of the electronic patient record and recognition of when an issue required reporting as an incident.

The practice partnership had recently increased to four partners, two salaried GPs had been employed and one regular locum GP worked at the practice. We were told that there was no formal partnership agreement in place. This meant the practice was potentially vulnerable as any partner could leave at will. The British Medical Association (BMA) state in their 2014 guidance on partnerships that, 'a partnership at will' is an unstable business relationship, as any partner can dissolve the partnership on notice. In addition, we were told that there was no insurance in place to cover the cost of replacing the unexpected absence of a GP with a locum GP. The lack of both these business support tools potentially reduced the stability and resilience of the practice to cope effectively if a GP partner left or a GP was absent without notice.

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

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example one newer salaried GP confirmed that they received permission and support to attend additional training for joint injections. The practice nurse confirmed they had applied to undertake a Clinical Supervision course.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage patients with complex needs. It received blood test results, X-ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services both electronically and by post. The staff we spoke with understood their responsibilities in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. They said they felt the system in place worked well. Examples provided by staff and records of significant event analysis provided evidence that the practice changed their procedures when gaps in performance were identified.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients, patients on the risk register hospital admissions and discharges and attendance at A&E. District nurses and a palliative care nurse attended these meetings regularly.

Information sharing

Requires improvement

Are services effective?

(for example, treatment is effective)

The practice used electronic systems to communicate with other providers. We were told they shared information with out of hour's services regarding patients with special needs. However, one newer GP at the practice told us they had never shared any information about a patient with Out of Hours GP services. This potentially reduced the continuity and effectiveness of care and treatment to patients who used the Out of Hours services.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. Staff were trained on the system; however, some GPs we spoke with were unable to locate care plan information within the electronic record suggesting additional training in the use of the software programme was required. The software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

All clinical staff we spoke with demonstrated an awareness of the Mental Capacity Act 2005 (MCA) and their duties in respect of this. However, they had not had training specifically in relation to the MCA. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff we spoke with demonstrated an understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Staff had access to an updated consent policy, which reflected current guidance. We saw evidence that patients' consent to vaccinations was obtained and recorded in the electronic patient records.

Patients we spoke with and comment cards received confirmed that they were involved in decisions about their treatment and care, and consent was always sought before examinations or procedures were undertaken.

Health promotion and prevention

The practice supported patients to manage their health and well-being. The practice offered national screening programmes, vaccination programmes, children's immunisations, 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. This included smoking cessation, management of type 2 diabetes and travel advice. Practice nurse treatment rooms also had advice leaflets available.

New patients registering with the practice completed a health questionnaire. This provided the practice with important information about their medical history, current health concerns and lifestyle choices. This ensured the patients' individual needs were assessed and access to support and treatment was available as soon as possible.

All patients over the age of 75 had a named GP and the practice offered NHS Health Checks to all its patients aged over 40. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. We saw evidence that the practice was on target to meet its vaccinations targets for children and plans were in place to ensure all patients with long term conditions received their flu vaccination.

The practice identified patients who needed on-going support with their health. The practice kept up to date disease registers for patients with long term conditions such as diabetes, asthma and chronic heart disease, which were used to arrange annual health reviews. Patients with Chronic Obstructive Pulmonary Disease (COPD) were given rescue packs to use if they needed emergency treatment. (A rescue pack usually contains a supply of standby medications, such as steroids and antibiotics, which the patients can start taking if their COPD worsens whilst waiting to see their GP). Written information, leaflets and DVDs were available for patients to supplement training provided by the practice for the effective use of the rescue packs. The practice also kept registers of vulnerable patients such as those with mental health needs and learning disabilities and used these to plan annual health checks.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The results of the National GP Patient Survey published in January 2015 demonstrated the practice performed well. 96% of respondents stated the last GP they saw or spoke to was good at treating them with care and concern, 96% of respondents said the last GP they saw or spoke to was good at listening to them and 98% said they had confidence and trust in the last nurse they saw or spoke to. Further 100% of respondents stated they had confidence and trust in the last GP they saw or spoke to.

We received 25 completed CQC comment cards. Five responses referred to their difficulty getting through to the practice on the telephone. All 25 comment cards were complimentary about the service they received from reception, nursing staff and GPs. We spoke with nine patients. They all spoke positively about the GPs and nurses working at the practice and all but one patient was complimentary about the reception team. All nine patients told us it was difficult getting through to the surgery on the telephone to make an appointment, although all said that once they got through to reception they usually got an appointment to see a GP quickly.

The practice had also carried out its own patient survey and posted the results of this on their website. Among other questions, the practice asked how easy it was to book an appointment at the practice. 28% of those that responded said it was an easy experience and 44% stated it was not an easy experience, mainly because there was no queuing facility on the telephone line. The practice manager confirmed that they were working with the CCG Commissioning Support Unit to increase the number of telephone lines available and to add a queuing facility.

Staff we spoke with were aware of the importance of providing patients with privacy and of the importance of confidentiality. Consultations took place in rooms with an appropriate couch for examinations and screens to maintain privacy and dignity. We observed staff were discreet and respectful to patients. Patients we spoke with told us they were always treated with dignity and respect. Patients acknowledged that the reception area did not afford much privacy to discuss their concerns but said this was not an issue.

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

Care planning and involvement in decisions about care and treatment

Patients we spoke with confirmed they felt involved in decisions about their care and treatment. Patients told us diagnosis and treatment options were clearly explained and they did not feel rushed in their appointment. Comments from patients included that they felt listened to and treated with respect, and options were always discussed.

The National GP Patient Survey published in January 2015 identified 96% of respondents said the last GP they saw or spoke to was good at listening to them; 94% of respondents said the last GP they saw or spoke to was good at explaining tests and treatments and 91% of respondents said the last GP they saw or spoke to was good at involving them in decisions about their care

GPs confirmed that all patients over 75 years had a named GP. An electronic coding system maintained registers of patients with particular conditions or vulnerabilities, for example, diabetes, mental health issues and learning disabilities.

Staff told us that they had access to language line if needed and used an internet search engine translation service to help communicate with people who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

The practice had some health promotion and prevention advice leaflets available in the waiting rooms and the practice nurse provided health specific information and guidance. Detailed information was also available on the practice's website and practice leaflet. Their website also contained a sections with advice for patients about family health, long term conditions and minor illnesses.

The practice nurses held a variety of clinics for long term conditions such diabetes, asthma, general health checks and a weekly baby clinic. The health care assistant carried out phlebotomy (blood tests) and blood pressure monitoring.

Good

Are services caring?

One patient we spoke with told us of the positive support they received whilst coping with bereavement. Although we did not see any information or bereavement packs.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice monitored the service it provided and benched marked it against other practices within the Clinical Commissioning Group (CCG). Patients told us both in person and through our comment cards that they received a good service that was responsive to their health needs. The practice actively sort feedback from patients through their own patient questionnaire, feedback from the Friends and Family test and through consultation with their patient reference group (PRG). The practice was aware that a major concern for patients was getting through on the telephone to make an appointment. The practice manager explained that the previous telephone systems which was an 0844 number was removed in February 2014 and replaced with one telephone line by the CCG. This telephone line has no queuing facility. At this inspection, the practice manager confirmed that she was consulting with the CCG Commissioning Support Unit to change the telephone system to three lines each with its own queuing facility.

The practice held information and registers about the prevalence of specific diseases within their patient population and patient demographics. This information was reflected in the services provided, for example screening programmes, vaccination programmes, specific services and reviews for elderly patients, those patients with long term conditions and mental health conditions.

The practice cared for a number of adult patients who lived in local residential care or nursing homes. Clinical staff undertook regular visits to these patients to review, care plans and medicines; they also reviewed new patients as required. Patients with dementia, learning disabilities and enduring mental health conditions were reviewed annually. They were encouraged to bring carers with them to these reviews. The practice had implemented the 'named GP' for patients over 75 to support continuity of care. The practice was proactive in contacting patients who failed to attend vaccination and screening programmes.

Tackling inequity and promoting equality

The practice had disabled ramped access from the rear of the building and a disabled toilet on the ground floor. There is one small waiting room, one consultation room and one treatment room on the ground floor. Two waiting rooms, six consultation rooms and a treatment room were available on the first floor. These were accessed by a flight of stairs. We were told that patients with mobility problems were provided with ground floor GP and nurse appointments. An induction hearing loop was available for people with hearing impairment. The practice acknowledged that the premises were no longer ideal to meet the needs of the growing patient population.

The staff we spoke with demonstrated a good understanding of how to meet the specific needs of patients with different religious or cultural backgrounds. Most of the staff had had training in equality and diversity.

Access to the service

The practice opening hours were between 8.30 am and 6 pm Monday to Friday. The practice did not offer extended opening hours. The practice offered same day urgent appointments and routine appointments could be booked up to one week in advance and two week in advance with the practice nurse. The practice provided a GP telephone triage surgery in the mornings. Patients commented that they thought this was a good service. The practice closed for half a day each month for staff training and the out of hours service took over any calls during that time. The National GP Patient Survey results showed that 92% of respondents stated that the last appointment they got at the practice was convenient.

Information was available to patients about appointments on the practice website. A recent patient survey undertaken by the practice identified that many patients were not aware of the on-line appointment booking system. The practice website required updating to include information regarding booking appointments online. The website did have information on how patients could obtain urgent medical assistance when the practice was closed.

Clinical staff told us that longer appointments times were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to patients living in care homes, older patients and those vulnerable housebound patients, many of these patients benefiting from being part of the avoiding unplanned admissions to hospital scheme. Patients with long term conditions did not have to attend condition

Good

Are services responsive to people's needs?

(for example, to feedback?)

specific clinics they could make appointments at times convenient for them. This increased the flexibility for patients who may have difficulties attending at specific times of the day perhaps due to carer availability.

Patients told us they were generally satisfied with the appointments system once they got through to the surgery on the telephone. They confirmed that they could see a doctor on the same day if they needed to. Many of the patients we spoke with had rang that day for an appointment. At the time of our visit, we observed patients waiting a long time to see the GP. We were told that there had been medical emergency and this had resulted in a delay in patients being seen in a timely manner. However, nobody had informed the patients why their appointments had been delayed.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice.

We looked at the records of the nine complaints received by the practice between 2014 and 2015. We saw the practice responded to complaints proactively investigating the concern, responding appropriately to the complainant, identifying improvements in service quality, sharing learning and adapting practice. Staff spoken with verified that they were consulted and made aware of changes in procedures because of complaint investigations.

Information for patients on how to make a complaint was displayed in the waiting room and on their website.

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

The practice provided us with a copy of their Statement of Purpose which listed its aims and objectives. However when we spoke with staff in different roles they told us they were not aware of the vision, values, strategy or aims and objectives for the practice.

We heard that reception and administrative staff had recently had their first staff meeting. Staff told us that the reception team would like to be more involved in the development of the practice and felt communication between the different staff groups could be improved.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity. These were in the process of being reviewed and updated. Paper copies were available to staff but the updated copies were being added to the practices shared drive. We found the organisation of the policies on the shared drive was not easy to navigate and staff spent some time trying to find the policies we asked to look at.

Staff told us they were unclear on the leadership structure within the practice. Most staff knew who the leads were for safeguarding, infection control and complaints but there was no designated lead for clinical governance at the practice. The lack of a partnership agreement and contingency planning in the event of an unexpected absence of a GP potentially reduced the practice's resilience to manage effectively the service it provided.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice in 2013-2014 showed it was performing 20% below national standards. The GPs we spoke with told us about how they were addressing the shortfalls in the QOF data but no specific recorded action plan to address and monitor progress for each identified area had been developed.

Staff recruitment records we viewed did not have all the required information to make sure safe recruitment decisions were made. Systems to monitor stocks and expiry dates of medicines for use in emergencies that were held in GP's bags had not been implemented effectively and staff induction training records did not detail the content of the training, or when or who provided it.

Clinical audits were undertaken and the practice had arrangements in place for identifying and managing risks. Risk assessments and general work place risk management plans were in place.

Leadership, openness and transparency

The staff we spoke told us they were clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns. Staff were aware of specific leads for aspects of the service provided; however they were unclear on the overall leadership within the practice.

We heard that staff meetings had only recently commenced at the practice. Staff told us that felt communication could be improved between all staff teams at the practice.

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

We reviewed complaints and found they were well managed. The practice investigated and responded to them in a timely manner. The outcome from complaints were discussed with individual staff members and shared at clinical meetings as required.

The practice had a 'virtual' patient representation group (PRG). We spoke with two members of the PRG by telephone. They confirmed they were consulted about different aspects of the service. Most recently, they had been consulted about their knowledge of how appointments could be booked at the practice. They told us that the practice planned to have face to face meetings in the future.

The practice also carried out its own annual patient survey and posted the results of this on their website. They also encouraged patients to complete the Friends and Family test questionnaire.

There was a whistleblowing policy in place. Staff told us they had no concerns about reporting any issues internally.

Management lead through learning and improvement

GPs were all involved in revalidation, appraisal schemes and continuing professional development. We saw that staff were up to date with annual appraisals, which included looking at their performance and development needs. Staff told us appraisals were useful and provided an opportunity to share their views and opinions about the practice.

Are services well-led?

Requires improvement

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

The practice had an induction programme for new staff, although the records of this needed developing further. In addition, when speaking with newer staff it was clear that there were gaps in their knowledge for example awareness of the safeguarding lead, how to find information on the patient electronic database and recognition of incidents that require reporting.

Staff told us they felt supported to undertake a wide range of training relevant to their role and responsibilities. Records of staff training and copies of training certificates were available. The practice had training and development half days each month.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The registered provider must ensure recruitment procedures are established and all information specified in Schedule 3 is available in respect of staff employed to ensure staff are safely and effectively recruited and employed.** **Regulation 19 (1), (2), (3) Schedule 3**

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The registered provider must ensure that all new staff receive appropriate induction training and support which is supervised to ensure they are able to carry out the duties they are employed to perform.** **Regulation 18(2)(a)**

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered provider must establish effective systems and processes to regularly identify assess and monitor the quality of the service provided so that risk to the health, safety and welfare of service users are mitigated.** **Regulation 17(1)(2)(a)(b)**