The Bethesda Medical Centre

Quality Report

Palm Bay Avenue
Cliftonville
Margate
Kent
CT9 3NR
Tel: 01843 209300
Website: www.bethesdamc.co.uk

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Bethesda Medical Centre on the 17 February 2015. Overall the practice is rated as good.

We found the practice to be outstanding for providing effective services and good for providing caring, responsive and well-led services. It was also good for providing services to older people, people with long-term conditions, families, children and young people, working age people (including those recently retired and students) and for people experiencing poor mental health (including people with dementia). It was rated outstanding for people whose circumstances may make them vulnerable. The practice required improvement for providing safe services and the concerns which led to this rating applied to all population groups.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles, with the exception of some areas of training that had not been updated or undertaken, although further training needs had been identified and training planned.
- Recruitment procedures were not always used effectively when employing staff, as not all staff had undergone criminal records checks and the risks had not been assessed in relation to this.
- 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.

Summary of findings

- Patients said they generally found it easy to make an appointment with a named 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 was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw some areas of outstanding practice:

- The practice worked in partnership with two other local practices to initiate a pilot scheme to provide an 'out of hours' on-call service with a paramedic practitioner, to respond, visit and support care home residents, who became unwell. The scheme had been developed to avoid unnecessary visits to the local hospital accident and emergency department. The latest data indicated that over a twelve week period, of the residents seen by the paramedic, 95% had remained at home, rather than being transferred to hospital by ambulance.
- The practice was located in an area of high deprivation and supported a range of patients with complex needs, including disadvantaged families who lived in vulnerable circumstances. A GP from the practice was involved in 'street work' activities with local support groups, including a 'task force' partnership. This involved approaching local families on a 'one-to-one' basis to promote health care services, many of whom had not registered with a GP. The group had received an 'innovation collaboration award' in recognition of their achievements in reaching out to vulnerable people in the local community, particularly those experiencing mental health problems.
- The practice had arranged an 'outreach day' at a local hotel to offer support to people who found it difficult to access GP services, and were sign-posted to other agencies and services who could help support their needs. The practice had registered many patients at the event and there was a particular focus on children who lived in vulnerable circumstances, in promoting childhood immunisations, as well as family planning and follow-up health care provision at the practice.

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

Importantly the provider MUST:

- Review the arrangements for DBS checks for administration staff who undertake chaperone duties.

Also, the provider SHOULD:

- Review the staff training requirements in relation to chaperone duties, the Mental Capacity Act 2005 and infection control.
- Review the processes for assessing the risks associated with legionella.

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. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe. However, there were concerns in respect of the checks that had not been undertaken for staff who carried out chaperone duties.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services. There were systems to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. Data showed that the practice was performing highly in many areas when compared to neighbouring practices in the clinical commissioning group (CCG). The practice was using innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice, for example, in supporting older people and those whose circumstances may make them vulnerable.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that 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 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 clinical commissioning group (CCG) to secure improvements to services where these were identified. For example, in responding to the needs of specific groups of vulnerable people within the community. Patients said they found it easy to make an appointment with a named GP, with urgent appointments available the same day. The practice had good facilities and was well

Summary of findings

equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was discussed and shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear set of aims and objectives and staff were clear about their responsibilities in relation to these, although these had not been formalised into a written strategy. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in 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 the avoidance of unplanned hospital admissions. A partnership initiative with other GP practices in the area provided focused health care support to older people in local care homes that had effectively reduced unplanned hospital attendance for this age group. The practice was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

The practice was caring in the support it offered to older people and there were effective treatments and on-going support for those patients identified with complex conditions, such as dementia and conditions associated with end of life care. All patients over the age of 75 had a named GP who was responsible for their care and treatment. A nurse within the practice visited housebound older patients to undertake annual health checks and GPs had allocated time away from the practice to undertake dementia screening in patient's own homes or the care homes where they lived.

Annual influenza vaccinations were routinely offered to older people to help protect them against the virus and associated illness.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff 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. Patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, GPs worked with relevant health and social care professionals to deliver a multidisciplinary package of care.

Annual influenza vaccinations were routinely offered to patients with long term conditions to help protect them against the virus and associated illness.

Families, children and young people

Good

The practice is rated as good for families, children and young people. Expectant mothers were supported by the midwifery team

Summary of findings

for ante-natal checks. GPs provided full post-natal care and six week baby checks and the practice worked effectively with health visitors and school nurses to provide the care and support required for mothers, babies and children.

Immunisation rates were lower in some of the standard childhood immunisations, and the practice had therefore developed initiatives to promote health care in the community and engage with local families, many of whom lived in vulnerable circumstances and were sometimes reluctant to register with GPs.

Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of 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 offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Outstanding

The practice is rated as outstanding for the care of people whose circumstances may make them vulnerable. The practice regularly worked with multi-disciplinary teams in the care it provided to vulnerable people and offered support and information about how to access various support groups and voluntary organisations.

The practice had a GP who took the lead in working with disadvantaged families and vulnerable people in the community, and who may have found it difficult or were reluctant to access health and social care. The GP worked with a local 'task force' who undertook regular street work to engage with the community on a one-to-one basis, as well as offering drop-in clinics at the practice and outreach sessions in community venues to encourage people to access health care, information and advice. These arrangements particularly focused on those people with drug / alcohol dependence, mental health problems, as well as immigrants to the area, who did not speak English. The task force had received a public health 'innovation collaboration award' for its work with vulnerable people in the community and the practice supported the health care needs of those people identified in this way.

Summary of findings

The practice management team had worked collaboratively with other local practices to identify and bid for funding to develop new ways of supporting the most vulnerable in its patient population group, for example, the development of a walk-in health centre.

Practice staff knew how to recognise signs of abuse in vulnerable adults and children. They 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.

The practice held a register of patients with a learning disability. A community nurse from the specialist learning disability team held clinics at the practice and carried out annual health checks for people with a learning disability.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

The practice offered in-house clinics from the specialist community mental health team, and were able to refer patients directly to the NHS emergency team for crisis intervention and support. Counselling services were also provided at the practice and specific health promotion and information literature was available.

Staff had been made aware of the risks in relation to patients with mental health problems and would alert the named GP or on-call GP where an urgent response was required.

Summary of findings

What people who use the service say

We spoke with 10 patients on the day of our inspection and we received one comment card. The patients we spoke with told us they were satisfied with the care provided by the practice. They said they felt listened to and involved in decisions about their care and treatment and said that referrals to other services for consultations and tests had always been efficient and prompt.

Patients told us they had no concerns about the cleanliness of the practice and that they always felt safe. They were complimentary about the staff, and said they were always caring, helpful and efficient, and that they were treated with respect and dignity.

Patients told us the appointments system worked well and that they were able to get same day appointments if urgent, although some comments were less positive in relation to getting through to the practice on the telephone in the mornings.

Patients we spoke with reported they were aware of how they could access out of hours care when they required it and had also received telephone consultations from the practice GPs.

We looked at one patient comment card that had been completed prior to the inspection, which contained one suggested improvement to the practice.

We reviewed the comments from the 2013/14 national patient survey and the practice had been rated well in most areas, including 92% of respondents who said that the last time they saw or spoke with a GP they were good at treating them with care and concern, compared to the local clinical commissioning group (CCG) average of 82%. Similarly, 89% of respondents said the GP was good at involving them in decisions about their care, compared to the local CCG average of 79%. Areas of less satisfaction had been identified, that were rated lower than the local CCG average. For example, 54% of respondents said that it was easy to get through to the practice on the telephone, compared to the local CCG average of 57%.

Areas for improvement

Action the service MUST take to improve

- Review the arrangements for DBS checks for administration staff who undertake chaperone duties.

Action the service SHOULD take to improve

- Review the staff training requirements in relation to chaperone duties, the Mental Capacity Act 2005 and infection control.
- Review the processes for assessing the risks associated with legionella.

Outstanding practice

- The practice worked in partnership with two other local practices to initiate a pilot scheme to provide an 'out of hours' on-call service with a paramedic practitioner, to respond, visit and support care home residents, who became unwell. The scheme had been developed to avoid unnecessary visits to the local hospital accident and emergency department. The latest data indicated that over a twelve week period, of the residents seen by the paramedic, 95% had remained at home, rather than being transferred to hospital by ambulance.
- The practice was located in an area of high deprivation and supported a range of patients with complex needs, including disadvantaged families who lived in vulnerable circumstances. A GP from the practice was involved in 'street work' activities with local support

groups, including a 'task force' partnership. This involved approaching local families on a 'one-to-one' basis to promote health care services, many of whom had not registered with a GP. The group had received an 'innovation collaboration award' in recognition of their achievements in reaching out to vulnerable people in the local community, particularly those experiencing mental health problems.

- The practice had arranged an 'outreach day' at a local hotel to offer support to people who found it difficult to access GP services, and were sign-posted to other agencies and services who could help support their needs. The practice had registered many patients at the event and there was a particular focus on children who lived in vulnerable circumstances, in promoting childhood immunisations, as well as family planning and follow-up health care provision at the practice.

The Bethesda Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to The Bethesda Medical Centre

The Bethesda Medical Centre provides medical care Monday to Friday from 8.30am to 6.30pm each week day and operates extended opening hours from 7am on Friday mornings, and until 8pm on Wednesday evenings, as well as 8am to 10am on Saturday mornings. The practice is situated in a coastal town, near Margate in Thanet, Kent and provides a service to approximately 15,400 patients in the locality.

Routine health care and other clinical services are offered at the practice. There are a range of patient population groups that use the practice, including a large number of Eastern European immigrants in the community, many of whom live in vulnerable circumstances and do not speak English. Thanet is also considered to be an area of significant deprivation, with many disadvantaged families, and people experiencing drug / alcohol and mental health problems.

The practice has more patients in the newly retired population age group than the national average. There are also a higher number of older people when compared to the national average. The number of patients in all age groups recognised as suffering deprivation is significantly higher than both the local and national averages.

The practice has five GP partners, one female and four male and has a total of six salaried GPs, two of whom are female. There are four female practice nurses, and three female health care assistants. There are a total of 27 administration, secretarial and reception staff, six housekeeping staff, and a practice manager.

The practice does not provide out of hours services to its patients and there are arrangements with another provider (the 111 service/IC24) to deliver services to patients when the practice is closed. The practice has a general medical services (GMS) contract with NHS England for delivering primary care services to local communities.

Services are delivered from:

The Bethesda Medical Centre

Palm Bay Avenue

Cliftonville

Margate

Kent.

CT9 3NR

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.

This provider had not received a comprehensive inspection before and that was why we included them.

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 17 February 2015. During our visit we spoke with a range of staff, including three GPs, two nurses, five members of the administration team, and spoke with patients who used the service. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents, accidents and national patient safety alerts, as well as 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. For example, staff told us about an incident concerning a patient who fell outside the practice and the procedures they used to report and record the incident.

Records showed that incidents were reported and recorded and had been consistently discussed at meetings over time.

Learning and improvement from safety incidents

The practice had a system for reporting, recording and monitoring significant events and we reviewed some of those that had occurred during the last year. Significant events were discussed at weekly practice meetings and there was evidence that the practice had learned from these and that the findings were shared with relevant staff. All staff, including reception and administrative staff, knew how to raise an issue for consideration at the meetings and said they felt encouraged to do so.

The practice manager was responsible for managing all significant events and we saw the system used to monitor these. We tracked four incidents and saw records were completed in a comprehensive and timely manner and that actions were taken as a result. For example, a review of how changes to patients' medicines were dealt with in the practice.

National patient safety alerts were disseminated by a designated manager to other staff using the practice email system. Records demonstrated that follow-up actions had been taken to address safety issues relevant to the practice, for example, patients were contacted regarding a type of injection that had been identified on a medicine alert.

Reliable safety systems and processes including safeguarding

There were effective systems and processes to manage safety within the practice, including arrangements for safeguarding vulnerable adults and children who used services. The practice had a policy for safeguarding both children and vulnerable adults and this clearly set out the procedures for staff guidance and contact information for referring concerns to external authorities. The policy reflected the requirements of the NHS and social services safeguarding protocols and was available to all staff.

Staff told us that there was a GP within the practice who was the designated lead in overseeing safeguarding matters. GPs, nurses and administrative staff we spoke with were knowledgeable in how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record safeguarding concerns and how to contact the relevant agencies in working hours and out of hours. Staff told us they had received training in safeguarding vulnerable adults and children and records confirmed this. GPs had received the necessary safeguarding training (level three) to fulfil their roles in managing safeguarding issues and concerns within the practice.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so that staff were aware of any relevant issues when patients attended appointments, for example, children subject to child protection plans. GPs liaised regularly with social services to share information in relation to child protection concerns that were identified within the practice. For example, the practice had worked closely with the police and social services in an investigation of organised child abuse within the local area.

The practice had a chaperone policy. A chaperone is a person who accompanies a patient when they have an examination and we saw that the practice policy set out the arrangements for those patients who wished to have a chaperone. The policy set out the roles and responsibilities of staff who undertook chaperone duties. Although staff had not undertaken specific chaperone training, they were aware of the policy and the procedures to follow. Patients were made aware that they could request a chaperone, for example, details were displayed within the practice and in the patient information leaflet. Staff we spoke with confirmed arrangements were made for those patients who requested a chaperone.

Medicines management

Requires improvement

Are services safe?

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure and temperature checks were undertaken on a daily basis.

There were processes to check the stocks of medicines kept at the practice, although these processes did not include checking that medicines were within their expiry date and suitable for use. For example, we saw that records were kept to check the availability of the resuscitation equipment, but there was no record of the expiry dates. Of the medicines checked, we found one injectable medicine and some needles / syringes that were out of date. These were removed immediately by staff, who told us that the checklists would be reviewed with immediate effect to include a record of expiry dates for all medicines and equipment kept in the practice. We were told that the system for checking expiry dates of medicines kept in GP bags would also be reviewed. We subsequently received evidence from the practice that a significant event report in relation to these issues had been raised and discussed with the GPs and all relevant staff. The practice reported that immediate changes had been made to the system for checking medicines and medical equipment and we subsequently received evidence of the revised system and documents that had been put in place.

The nurses used up-to-date Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. The health care assistant administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the prescriber. We saw evidence that nurses and the health care assistant had received appropriate training and been assessed as competent to administer the medicines referred to either under a PGD or in accordance with a PSD from the prescriber. Expired and unwanted medicines were disposed of in line with waste regulations. The practice did not keep controlled drugs.

All prescriptions were reviewed and signed by a GP before they were given to the patient. The practice had a process to maintain the security of blank prescription forms and these were handled in accordance with national guidance. They were tracked through the practice and kept securely at all times.

Cleanliness and infection control

The practice was clean and tidy and patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. The practice had an infection control policy, which included a range of procedures and protocols for staff to follow, for example, hand hygiene, the management of sharps and clinical and hazardous waste management. We spoke with the lead member of staff for infection control. They demonstrated a clear understanding of their role and responsibilities in relation to infection prevention and control. Infection control audits had been undertaken and identified actions were monitored and discussed at practice meetings.

Treatment and consultation rooms contained sufficient supplies of liquid soap, sanitiser gels, anti-microbial scrubs and disposable paper towels for hand washing purposes. Notices about hand washing techniques were displayed for staff guidance and patient information. Domestic and clinical waste products were segregated and clinical waste was stored appropriately and collected by a registered waste disposal company. Sharps containers were appropriately labelled and not over-filled.

The practice had considered and discussed the risks associated with Legionella (a germ found in the environment which can contaminate water systems in buildings). However, a risk assessment had not been completed to determine any further checks that may need to be undertaken on a regular basis. Following the inspection, we received evidence that a date had been confirmed for a specialist contractor to undertake a risk assessment.

Staff we spoke with were knowledgeable about their roles and responsibilities in relation to cleanliness and infection control, although records did not show when infection control training had last been updated by staff. The practice had identified this and planned to update infection control training for all staff.

Equipment

Requires improvement

Are services safe?

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. Portable electrical equipment was routinely tested and we saw evidence of calibration of relevant equipment, for example, weighing scales, spirometers and blood pressure measuring devices

Staffing and recruitment

The practice had policies and other protocols that governed staff recruitment, for example, a recruitment policy that set out the standards it followed when recruiting all staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken. For example, proof of identification, references and checks with the appropriate professional bodies. Criminal record checks through the Disclosure and Barring Service (DBS) had been undertaken for the majority of staff, where the practice had considered this appropriate to their roles. However, not all administration staff had undergone DBS checks and we were told that on occasions, these staff were required to undertake chaperone duties. Staff told us that the chaperone policy would be reviewed with immediate effect and DBS checks would be undertaken for all staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The practice had a staffing protocol that set out the arrangements for the planning and deployment of all staff, to help ensure there were enough staff on duty. This also included the arrangements for members of staff to cover each other's annual leave and staff cover was discussed at practice meetings.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

The practice had a health and safety policy and information was included in the induction plans for new staff and was included in the staff handbook. Routine checks of the building were undertaken, for example, fire safety and premises checks.

The practice kept a central folder to monitor identified risks and these were discussed amongst the staff team and follow-up actions agreed, for example, an infection control action plan.

Staff were able to identify and respond to changing risks to patients including deteriorating health and well-being. For example, those patients at higher risk of unplanned admissions to hospital were identified on the practice computer system and had priority for urgent same day appointments. There were emergency arrangements for those patients identified with poor mental health, for example, alerts to their named GP and emergency referrals to local specialist mental health support.

Arrangements to deal with emergencies and major incidents

The practice had arrangements to manage emergencies. The electronic computer system provided an emergency alert button and staff told us about the procedure they would follow to alert other staff that they required assistance in their consultation / treatment rooms. There was guidance displayed for staff in providing an emergency response for patients who became unwell in the practice.

Records showed that staff had received training in basic life support. Emergency equipment was available including access to medical oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Staff we spoke with knew the location of this equipment and records confirmed that it was checked regularly.

The practice had an emergency and business continuity / recovery plan that included arrangements relating to how patients would continue to be supported during periods of unexpected and / or prolonged disruption to services. For example, interruption to utilities, or unavailability of the premises.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with were familiar with current best practice guidance and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. They used guidance available on their computers and accessed the most up-to-date documents, for example, the latest diabetes diagnostic guidelines. We saw minutes of practice meetings where new guidelines were discussed amongst GPs and nursing staff.

GPs told us they led in specialist clinical areas such as diabetes, anti-coagulation and substance misuse and the practice nurses supported this work, focusing on specific areas of health care in dedicated clinics.

Management, monitoring and improving outcomes for people

The practice kept registers to identify patients with specific conditions / diagnosis, for example, patients with long-term conditions, dementia, asthma, heart disease and diabetes. Registers were kept under review and we saw meeting minutes where information was shared and discussed regarding the health care needs of specific patients and any additional risk factors that may need to be identified on the system. All patients over the age of 75 had a named GP who was responsible for their care and treatment and there were care plans for this age group. The GPs had allocated time away from the practice to undertake dementia screening for older patients in their own homes or in the care homes where they lived and a practice nurse undertook annual health checks for older patients who were housebound.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. We saw Quality and Outcomes Framework (QOF) data that indicated multidisciplinary review meetings were held at least every three months to discuss all patients on the register. QOF is a national performance measurement tool used by GP practices to measure and compare their performance to other practices on a local and national basis.

Data collected for the QOF was reviewed at monthly meetings with the lead nurse and administrative staff responsible for performance monitoring using the QOF indicators. The available QOF data showed that the practice had indicators that were higher than both the national and local averages in many areas, including for patients receiving care and treatment for diabetes. For example, 91% of patients with diabetes had received a foot examination in the last year, compared to 88% nationally. Similarly, 95% of diabetic patients had received influenza vaccinations in the last year, compared to the national average of 93%.

Available data showed that the practice used QOF indicators to monitor its performance in supporting patients with mental health issues. For example, 93% of patients experiencing mental health problems had an agreed care plan documented in their records, compared to 86% nationally. Data also showed that 92% in this patient group had a record of their alcohol consumption documented in the last year, compared to the national average of 88%.

Where the practice performed less well, for example, in some areas of anti-biotic prescribing, the practice was aware and had taken steps to address the issues, including discussions at staff meetings and on-going monitoring of QOF data to improve performance. The practice used a computerised system that allowed all staff to access and review QOF performance indicators.

The practice had a system for completing clinical audits, although there was evidence of only one fully completed audit in the last year. For example, a medicines management audit had been undertaken to review those patients placed on a specific medicine for longer than five days. Following completion of the audit, the medicine had been discontinued for most patients in line with updated guidance. A follow-up audit had revealed that the new guidelines had been effectively implemented, as very few patients remained on the medicine on a regular basis, and where this was the case, individual specialist clinical decisions had been made. Other recent audits had also been undertaken, for example, to review that consent procedures were being followed and as a result, consent procedures had been reviewed. A second audit cycle was planned to review on-going compliance to the procedure.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP and the computer system provided an alert for those patients who required a medicines review.

Effective staffing

The practice staff team included GPs, nurses, managerial and administrative staff. Staff told us they had completed mandatory training, for example, basic life support and we saw records that confirmed this, although some mandatory training had not been updated, including infection control and chaperone training. We saw that GPs and nurses had completed specialist clinical training appropriate to their role. For example, diabetes, asthma, family planning and updates in childhood immunisations had been undertaken, although a clinical cytology update was overdue for one of the nurses.

We were told by staff that they received annual appraisals where training needs were discussed and additional learning identified, and we saw records that confirmed this. All the staff we spoke with felt they received the on-going support, training and development they required to enable them to perform their roles effectively. There was a process for GP appraisal and revalidation and we saw that dates were confirmed for annual appraisal and completion of revalidation for each GP within the practice. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the GMC).

Staff we spoke with confirmed that the practice was proactive in providing training, for example, e-learning on the practice computer system was available and undertaken on a regular basis. The practice closed for training one afternoon each month, to provide in-house opportunities for staff learning and development.

Working with colleagues and other services

The practice had well established processes for multidisciplinary working with other health care professionals and partner agencies. Multidisciplinary meetings took place on at least a quarterly basis with community nurses and the palliative care team who had specialist knowledge in relation to patients with long-term and complex conditions.

There were meetings and regular discussions with the 'on-site' health visitor and midwifery team who held clinics providing ante-natal care, support for new mothers and babies and undertook full post-natal and six week baby checks.

The practice was located in an area of high deprivation and as such, supported a range of patients with complex needs. This included people who were drug and alcohol dependent, people with poor mental health and a high proportion of disadvantaged families who lived in vulnerable circumstances. As a result, the practice worked regularly with local multi-agency support groups, and in particular, a local 'task force' partnership, which included the police, social services, probation, housing and employment agency support workers, as well as domestic violence and family intervention workers. A GP from the practice took a lead role within the group, who had received an 'innovation collaboration award' in recognition of their achievements in working together for the benefit of vulnerable people within the local community, particularly those with mental health problems. This involved local door-to-door street work in the community, engaging and inviting people and their families to register with the practice and providing information and advice. People were encouraged to attend the practice for health checks, to receive support for drug / alcohol related problems, as well as supporting people back into work wherever possible.

The practice had also worked in partnership with two other local practices to develop a scheme to provide support for older people who lived in local care homes. This involved on-call arrangements with a paramedic practitioner during the evenings, to respond, visit and support care home residents when they became unwell. The scheme had been developed to reduce unnecessary visits to the local hospital accident and emergency department. The latest data indicated that over a twelve week period, 203 residents had been seen by the paramedic, with 95% of residents remaining in their home. The scheme had also provided training to care home staff in basic observations and signs of deteriorating health in older people.

The practice received blood test results, x-ray results, and letters from the local hospital (including discharge summaries), out-of-hours GP services and the 111 service both electronically and by post. The practice had procedures for staff to follow in relation to passing

information on, as well as reading and acting on any issues arising from communications with other care providers on the day that they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system worked well.

Information sharing

Staff told us that there were effective systems to ensure that patient information was shared with other service providers and that recognised protocols were followed. For example, a referral system was used to liaise with the community nurses and other health care professionals, including the 'out of hours' service. The practice made referrals using the 'Choose and Book' system and made 68% of referrals in this way last year. (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).

An electronic patient record system was used by staff to co-ordinate, document and manage patients' care. Staff were fully trained in how to use the system and told us that it worked well. The system enabled scanned paper communications, for example, those from hospital, to be saved in the patients' record for future use or reference.

Consent to care and treatment

The practice had a consent policy that governed the process of patient consent and guided staff. The policy described the various ways patients were able to give their consent to examination, care and treatment as well as how consent should be recorded. For example, forms were used to gain the written consent of patients when undergoing minor surgical procedures.

We spoke with nursing staff and GPs, who demonstrated an awareness of the rights of patients who lacked capacity to make decisions and give consent to treatment. They told us that mental capacity assessments were carried out by the GPs and recorded on individual patient records. Although formal training in the Mental Capacity Act 2005 had not been undertaken, staff were able to demonstrate their awareness and gave examples of how a patient's best interests were taken into account if they did not have capacity to make a decision and required additional support.

The records indicated whether a carer or advocate was available to attend appointments with patients who required additional support. Reception staff were aware of the need to identify patients who might not be able to make decisions for themselves and to bring this to the attention of GPs and nursing staff.

Health promotion and prevention

The practice had a system for informing patients when they needed to come back to the practice for further care or treatment or to check why they had missed an appointment. For example, the computer system was set up to alert staff when patients needed to be called in for routine health checks or screening programmes. Patients we spoke with told us they were contacted by the practice to attend routine checks and follow-up appointments.

We saw a range of information leaflets and posters in the waiting area for patients, informing them about the practice and promoting healthy lifestyles, for example, smoking cessation, exercise and fitness, and weight loss programmes. Information about how to access other health care services was also displayed to help patients access the services they needed, for example, dementia awareness and memory clinics.

The practice offered and promoted a range of health monitoring checks for patients to attend on a regular basis. For example, breast and cervical smear screening and general health checks including weight and blood pressure monitoring. We spoke with nursing staff who conducted various clinics for long-term conditions and they described how they explained the benefits of healthy lifestyle choices to patients with long-term conditions such as diabetes, asthma, epilepsy and coronary heart disease. All new patients who registered with the practice were offered a consultation with one of the nurses to assess their health care needs and to identify any concerns or risk factors that were then referred to the GPs.

The practice had systems to identify patients who required additional support and were pro-active in offering additional services for specific patient groups. For example, vaccination clinics were promoted and held at the practice, including a seasonal influenza vaccination for older people and those with chronic / complex needs. Available data showed that the practice had performed in line with national indicators for patients receiving the influenza vaccination. The practice also provided annual reviews for

Outstanding ☆

Are services effective?

(for example, treatment is effective)

those patients identified with mental health issues. For example, 83% of patients diagnosed with dementia had received a face-to-face review of their care needs in the last year, which was in line with the national average.

The practice hosted a regular learning disability clinic, provided by the community learning disability nurse and promoted / encouraged annual health checks for these patients. The practice also offered a full range of immunisations for children and available data showed that immunisation rates were mainly in line or above the national averages. For example, 96% of eligible children had received the 12 month meningitis immunisation, compared to the national average of 93%.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice in relation to patient satisfaction. Information from the national patient survey undertaken in 2013/14 showed that the practice had been rated above or in line with the national average in most areas. For example, 92% of patients responding to the survey rated the practice GPs as good or very good at treating them with care and concern, compared with 85% nationally. We also reviewed the results from the most recent patient survey undertaken by the patient participation group (PPG), which demonstrated satisfaction with the practice and the services provided, although some issues were identified in relation to getting through on the telephone in the mornings to make appointments.

We spoke with 10 patients on the day of our inspection. All told us they were satisfied with the care provided and that the practice was very caring and understanding of their needs. We observed that reception staff were welcoming to patients, were respectful in their manner and showed a willingness to help and support patients with their requests.

Reception staff had received awareness training in relation to patients with hearing difficulties and learning disabilities, to help them provide appropriate support to patients.

Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consultation and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

The practice had a confidentiality policy, which provided guidance for staff in how to protect patients' confidentiality and personal information. Staff we spoke with were aware of their responsibilities in maintaining patient confidentiality and the policy had been shared with them. The reception area was designed in a way to help maintain confidentiality when staff were speaking on the telephone and a system had been introduced that only allowed one patient at a time to approach the reception desk.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed there had been a positive response from patients to questions about their involvement in planning and making decisions in relation to their care. For example, data from the national patient survey showed that 82% of respondents said GPs were good or very good in involving them in decisions about their care and this was in line with the national average.

When we spoke with patients, they told us they felt involved in decision making and were given the time and information by the practice to make informed decisions about their care and treatment. They said GPs and nurses took the time to listen and explained all the treatment options available to them and that they felt included in their consultations. They felt able to ask questions if they had any and were able to change their mind about treatment options if they wanted to.

Patient/carer support to cope emotionally with care and treatment

We observed that staff were supportive in their manner and approach towards patients. Patients told us that staff gave them the support they needed and that they felt able to discuss any concerns or worries they had.

We saw that patient information leaflets, posters and notices were displayed that provided contact details for specialist groups that offered emotional and confidential support to patients and carers. For example, a counselling and bereavement support group, as well as counselling sessions that were offered at the practice. The practice's electronic system alerted GPs if a patient was also a carer. We saw a range of information available for carers to ensure they understood and were aware of the support available to them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to patient's needs. The staff we spoke with explained that a range of services were available to support and meet the needs of different patient population groups and that there were systems to identify and address patients' needs and refer them to other services and support if required.

The practice engaged with the clinical commissioning group (CCG) and three of the GPs from the practice had links with the CCG and attended meetings on a regular basis. The practice was therefore kept aware of service developments and opportunities to fund projects and initiatives that targeted specific population groups within the locality, for example, disadvantaged families with complex needs.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). We spoke with members of the group and they told us they felt the practice had embraced the principles behind having a PPG. The most recent patient survey conducted by them showed mainly positive results, although some comments had been received about possible improvements. For example, getting through to the practice on the telephone in the mornings to make appointments. As a result, the practice had deployed more reception staff in the mornings to take more calls from patients.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services and were pro-active in reaching out into the community to engage with the local population. The locality included a range of people in vulnerable circumstances who may have had poor access to primary care, and who may also have been reluctant to engage with health care professionals. A GP from the practice took a lead role in relation to inequalities with a local support group. This involved approaching local families to promote health care services to particularly vulnerable groups, many of whom did not speak English. The local population also comprised of many Eastern European families who had not registered with a GP.

The practice had arranged an 'outreach day' at a local hotel to offer support to those finding it difficult to access GP services, where vulnerable people had also been sign-posted to other support agencies and services. For example, social services, mental health specialists, as well as drug and alcohol support groups. The practice had registered new patients during the event and there had been a particular focus on children who lived in vulnerable circumstances, for example, in promoting childhood immunisations, as well as family planning and follow-up health care provision at the practice.

The practice was located in purpose-built premises that met the needs of patients with disabilities. Services were provided on the ground floor and first floor of the building and there was a lift to provide access for those patients who had difficulty in using the stairs. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. The practice had a hearing loop system for patients who had hearing difficulties and interpretation services were available for patients who did not speak English.

Access to the service

Appointments were available from 8.30am to 12.30pm and from 1.30 to 6.30pm each week day and the practice operated extended opening hours from 7am on Friday mornings, and until 8pm on Wednesday evenings and 8am to 10am on Saturday mornings. This provided flexibility for working patients outside of core working hours. Staff we spoke with were knowledgeable about prioritising appointments and worked with the GPs to ensure patients were seen according to the urgency of their health care needs.

Home visits were available on a daily basis for those patients less able to attend the practice. The practice also co-ordinated care with the community nursing team who were based within the practice. Specialist health care services were available at the practice, for example, mental health counselling, substance misuse and learning disability clinics. Urgent referrals could be made to the specialist mental health team and emergency mental health services for crisis support.

Patients could book an appointment by telephone, online or in person. Most of the patients we spoke with said that

Good

Are services responsive to people's needs?

(for example, to feedback?)

the appointments system worked well, although there were some comments in relation to having more pre-bookable appointments. As a result, the practice had reviewed the appointments system and had offered more pre-bookable appointments each day. Patients told us they could have telephone consultations and that the GPs were very good at calling them back if requested. The GPs we spoke with confirmed that same day telephone consultations were offered to all patients and this was managed via the patient record system.

Patients we spoke with and comments we received all expressed confidence that urgent problems or medical emergencies would be dealt with promptly and that staff knew how to prioritise appointments for them. For example, the practice had a system to identify and prioritise patients at risk of unplanned hospital admissions to help ensure they had urgent access to a GP. The staff we spoke with had a clear understanding of the triage system to prioritise how patients received treatment, if they needed an appointment or how the GPs would decide to support them in other ways, for example, a telephone consultation or home visit. Patients told us they could always request longer appointments if they needed them, particularly if they had long-term conditions or complex health care needs.

There were arrangements to ensure patients could access urgent or emergency treatment when the practice was closed. Information about the 'out of hours' service was displayed inside and outside the practice and was also included in the patient information booklet and on the practice website. A telephone message informed patients how to access services if they telephoned the practice when it was closed. Patients we spoke with told us that they knew how to obtain urgent treatment when the practice was closed.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns. The practice had a complaints policy that was in line with NHS guidance for GPs and there was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. The procedure was included in the practice information booklet and on the practice website, and a leaflet was available in the patient waiting / reception area. We looked at two complaints that had been received in the last year and found that these had been satisfactorily handled and dealt with in a timely way and in accordance with the practice policy.

The practice reviewed complaints on an annual basis and produced a summary report for discussion and review at practice meetings. Changes had been made as a result, for example, a change in the administrative procedure for repeat prescriptions and additional training for staff.

Patients we spoke with told us that they had never had cause to complain but knew there was information available about how and who to complain to, should they wish to do so.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had provided a statement of purpose, reflecting its aims in providing high quality medical care, with equal respect for all. Although the practice did not have a written 'vision' statement or a business plan to inform individual or team objectives, when speaking with staff, it was clear that the leadership / management team promoted a collaborative and inclusive approach to achieve its purpose of providing good quality care to all patients.

Governance arrangements

The practice had a clear leadership structure with named members of staff in lead roles. For example, there was a lead GP for safeguarding, equalities, mental health and medicines management. A senior nurse led the nursing team within the practice. We spoke with ten members of staff who were clear about their own roles and responsibilities. They told us they felt valued, well supported and knew who to go to in the practice with any concerns or issues.

The practice had a comprehensive meetings structure that included weekly meetings, monthly governance / business meetings and monthly clinical meetings. Discussions covered key management areas, decision-making, and patient care. For example, safeguarding concerns, significant incidents / events and complaints, medicines management, and staff recruitment. We saw examples of the minutes from these meetings. Monthly meetings were also held in relation to Quality and Outcomes Framework (QOF) data and information was reviewed to enable the practice to monitor on-going performance.

The practice had undertaken some clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, an audit to review the medicines regime for those patients with raised blood pressure. However, follow-up audit cycles had not always been completed to review on-going outcomes for patients.

The practice had a range of policies and procedures to govern activity and these were available to staff on any computer within the practice. We looked at twelve of these and saw that they had been reviewed annually and were up to date.

The practice had strong links with the clinical commissioning group (CCG) for the area, as three of the GPs had involvement with the CCG, one of whom was the CCG chair. We saw minutes that reflected the information that was shared with staff, for example, where funding was available for specific projects and where bids were put forward to fund new initiatives. The practice had worked in partnership with two other local GP practices and had submitted a bid to fund a 'walk-in' health centre for the local area. This was considered beneficial in providing health care services to the local population, many of whom were in vulnerable circumstances and reluctant to engage and register with GP practices on a formal basis.

The practice had arrangements for identifying, recording and managing risks. Records showed that a wide range of potential issues, for example, trip hazards in the staff areas, had been assessed and actions taken to minimise risks. Identified risks had been reviewed and the records updated in a timely way.

Leadership, openness and transparency

We spoke with the practice GPs who told us they advocated and encouraged an open and transparent approach in managing the practice and leading the staff team. Staff we spoke with told us they felt the GPs were approachable, they felt supported and were able to approach the senior staff about any concerns they had. They said there was a good sense of team work within the practice and communication worked well. All staff said they felt their views and opinions were valued. They told us they were positively encouraged to speak openly to all staff members about issues or ways that they could improve the services provided to patients.

The practice had a staff handbook, which contained a range of human resource policies and procedures. We reviewed a number of these, for example, equalities, absence, bullying and harassment policies, which supported staff. Staff we spoke with knew where to find these policies if required.

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

The practice took account of feedback from patients through patient surveys, comments, complaints and questionnaires. The most recent national patient survey had rated the practice less well in relation to patients getting through to the practice on the telephone in the

Are services well-led?

Good

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

mornings to make appointments. Following the results of the survey, the practice had developed an improvement plan that included a change in the staffing arrangements to provide additional cover to answer the telephones as soon as the practice opened in the mornings.

The practice had an active patient participation group (PPG) who supported the practice in seeking views and feedback from patients. The PPG had conducted surveys each year and met regularly with the practice to consider the results, develop action plans and monitor on-going progress. General feedback and comments were very positive about the practice, although some suggestions had been made, and we saw that these had been acted on by the practice. For example, changes had been made in the reception area, including updating the content displayed on the patient information screen and a new queuing system introduced at the reception desk. Results and actions from the surveys were available on the practice website, as well as the PPG meetings and their annual report.

The practice had gathered feedback from staff through discussions, appraisals and generally through staff meetings. All the staff we spoke with told us they had opportunities to comment and suggest ways of making improvements to the services. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. The practice had a whistleblowing policy which was available to all staff electronically on any computer within the practice.

Management lead through learning and improvement

Records showed that GPs and nursing staff were supported to access on-going learning to improve their clinical skills and competencies. For example, attending specialist training for diabetes, childhood immunisation and opportunities to attend external forums and events to help ensure their continued professional development. GPs were provided with 'protected learning time' on a regular basis, supported by the CCG. Staff said they had dedicated time set aside for learning and development, for example, monthly half-day closure of the practice to undertake training and development. One member of the administration staff team told us they regularly attended an external forum for medical secretaries, to share ideas and best practice initiatives. Formal appraisals were undertaken to monitor and review performance, and to identify training requirements.

The practice regularly reviewed significant events and other incidents and shared them with staff to help ensure learning points were recognised and acted on, to improve outcomes for patients. For example, a recent significant event had resulted in a review of the procedure for dealing with blood test results.

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 Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed How the regulation was not being met: The provider did not have established recruitment procedures that operated effectively to ensure that information was available in relation to each person employed for the carrying on of the regulated activities, because the provider had not undertaken Disclosure and Barring Service (DBS) checks for staff who undertook chaperone duties and the risks had not been assessed in relation to this. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 19(3)(a) – Schedule 3