Willowbrook Medical Centre - JG Astles

Quality Report

195 Thurncourt Road
Leicester
LE5 2NL
Tel:0116 243 2727
Website:www.willowbrookmedicalcentre.co.uk

Date of inspection visit: 9 July 2014
Date of publication: 10/10/2014

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.

Contents

Summary of findings

Overall summary

Willowbrook Medical Centre is located in a suburban area on the eastern outskirts of the City of Leicester. On the day of our inspection the practice population consisted of 10,050 patients from a mix of social classes and ethnic groups.

The practice has another surgery located at Springfield Road Health Centre that was not included as part of this inspection.

We carried out an announced inspection on 9 July 2014.

During the inspection we spoke with patients and carers that used the surgery and met with members of the Patient Participation Group.

Patients we spoke with told us that they were treated with respect and their dignity was maintained.

We found the practice was effective and responsive in meeting patients' needs and was well led by an enthusiastic and innovative management team.

We found that the practice was responsive to the needs of older people, people with long term conditions, mothers, babies, children and young people, the working age population, people in vulnerable circumstances and people experiencing poor mental health.

We identified that the practice must improve in assessing and monitoring the quality of service provision. This concerned ensuring that incoming correspondence that may contain important or urgent medical information was dealt with in a timely manner so as to minimise the risk to patients.

We identified deficiencies in the recruitment process for staff and training for staff in the area of mental capacity.

The practice had undertaken some outstanding work in developing a care package for patients with long term conditions that was being adopted by other practices.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

We found that in most areas the practice was safe but that improvements should be made to recruitment procedures to ensure that staff were of good character and competent to carry out their roles and meet the needs of patients.

The practice was pro-active in identifying and responding to safety risks. Incidents were reviewed and action identified where the service could improve safety.

Staff had received training and were knowledgeable in how to identify and respond to concerns of potential abuse in vulnerable adults and children.

Emergency medical equipment and drugs were available and staff were trained to deal with medical emergencies.

There were processes in place to ensure patients and staff were protected from the risks of infection and inappropriate storage of medications.

Are services effective?

We found the practice was effective in meeting patients' needs but must improve in dealing with correspondence that may have contained important medical information about patients in a timely manner to negate the risk of patients not receiving the appropriate care and treatment.

The practice referred to and used national best practice in providing care and treatment.

There was evidence of effective clinical audits to review and improve the care and treatment of patients.

Some patients with complex needs were discussed with external healthcare professionals to ensure they had adequate and consistent support from different services.

Patients were supported to live healthy lives and manage their health and wellbeing independently.

Are services caring?

The practice was caring.

Patients were treated with respect, dignity and courtesy by staff. Their privacy and confidentiality was respected.

Summary of findings

Patients told us the practice was welcoming, family friendly and met their needs.

Staff provided choice and involved patients in decisions about their care and treatment.

The practice had systems in place to support people during bereavement.

Are services responsive to people's needs?

The practice was responsive to patients' needs.

We found patients were asked for their views about the practice and action was taken as a direct result of their feedback.

The practice had set up an active and involved Patient Participation Group (PPG) which was independent of the staff from the surgery. The PPG is a group of patients who have volunteered to represent patient's' views and concerns and are seen as an effective way for patients and GP surgeries to work together to improve services and to promote health and improved quality of care.

We found the appointments system met patients' needs and they commented very positively about how flexible it was.

There was a thorough process for dealing with and responding to complaints from patients.

Are services well-led?

The service was well led.

The Partners had a clear purpose and desire to achieve the best possible outcomes for patients, which was reflected in the attitudes of the staff that we spoke with.

The practice had an open culture which encouraged staff and patient feedback. We found feedback provided by staff and patients was acted on.

There were meetings for all staff to communicate with each other.

The practice identified, responded to and managed risks to safety and quality effectively.

Staff were supported and able to undertake a wide range of training appropriate to their role.

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

We found that the practice was responsive to the needs of older patients. Every patient who was over 75 had a named GP and patients had been contacted to inform them of the name of their GP. They were also informed that they may see any GP they chose, not just the one allocated to them.

There was evidence of multi-agency working with other healthcare providers to identify older patients who might be in need of additional support.

Patients told us all their healthcare needs were met.

Care homes that had residents who were on the patient list at Willowbrook had a nominated GP to help ensure continuity of care, and to reduce the incidence of admission to hospital.

People with long-term conditions

Arrangements for regularly reviewing patients with long term medical conditions were in place.

The practice was responsive to the needs of patients with long term conditions for example diabetes and chronic obstructive pulmonary disease.

Patients told us that they felt they received integrated care.

Mothers, babies, children and young people

The practice worked flexibly around the needs of this population group.

Appointments for antenatal and postnatal check-ups were available.

Mothers told us that referrals to paediatric services at local hospitals were done without delay.

The Health Visitor attended monthly meetings at the practice to share information on families and children they were working with and to make the practice aware of children who might be 'at risk'.

The working-age population and those recently retired

The practice had implemented extended opening times to allow people to access appointments early and late in the day, who might otherwise have found difficulty due to them working during traditional surgery hours.

Summary of findings

There was a range of information available in the practice and on the practice website to working patients or those who had recently retired. The website provided information about self-management of minor illness for working age patients to avoid the need for them to attend the practice if this were not needed.	
People in vulnerable circumstances who may have poor access to primary care Staff were provided with safeguarding training and were aware of how to identify and take action to address any concerns they had regarding potential abuse of vulnerable patients. The practice provided a range of translation services for patients who did not speak English.	
People experiencing poor mental health Patients were referred to the appropriate mental healthcare professionals quickly. There were weekly meetings to consider patients' health care needs which were attended by community psychiatric nurses.	

Summary of findings

What people who use the service say

We spoke with 15 patients who had attended the surgery for a consultation with a GP or nurse during our inspection. All expressed positive views about the practice and commented upon the way GPs and nurses explained clearly their health issues, treatment choices and the caring and respectful attitude of staff. Patients stated their confidentiality was respected and they felt listened to.

We reviewed 20 completed comments cards that had been left at the surgery by the CQC to enable patients to record their views on the practice. The comments were exclusively positive and were particularly complimentary about the caring and respectful attitude of staff, quality of treatment and the ease of getting appointments.

We met with five members of the patient participation group (PPG). The PPG is a group of patients who have volunteered to represent patient's' views and concerns and are seen as an effective way for patients and GP surgeries to work together to improve services and to promote health and improved quality of care.

The group told us there were high levels of patient satisfaction at the practice, there was easy access to appointments and the doctors were well respected and patients had confidence in them. They told us patients were highly satisfied with staff and with the environment and layout of the surgery.

Areas for improvement

Action the service MUST take to improve

We found the practice to be in breach of the regulation that related to assessing and monitoring the quality of service provision. The practice must take action to ensure that incoming patient and clinical mail, both postal and by facsimile, is scrutinised to ensure that patients are not put at risk of inappropriate care and treatment.

Action the service SHOULD take to improve

The practice should take action to ensure that recruitment procedures for clinical and non-clinical staff are followed as per best practice to help ensure that patients are protected from the risks associated with unsuitable staff being employed.

The practice should ensure that all staff receive training in mental capacity as a lack of training and awareness in this area may pose a potential risk of patients not receiving the most appropriate care and treatment.

Willowbrook Medical Centre - JG Astles

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP and the team included an additional CQC inspector, a GP practice manager and an Expert by Experience.

An Expert by Experience is a person who has experience of using this type of service and helps to capture the views and experiences of patients and carers.

Background to Willowbrook Medical Centre - JG Astles

Willowbrook Medical Centre is located in a suburban area on the north eastern outskirts of the City of Leicester and covers the areas of Humberstone, Clarendon Park, Knighton, Thurnby Lodge, Evington, Bushy and Thurnby.

It is located within the area covered by Leicester City Clinical Commissioning Group (CCG).

It is registered with the Care Quality Commission to provide the regulated activities of; the treatment of disease, disorder and injury; diagnostic and screening procedures; family planning; maternity and midwifery services and surgical procedures.

The practice patient population scores slightly higher than the England average in terms of income deprivation affecting older people and children but is lower than the average for all the other practices within its CCG area.

The practice is staffed by four partners and four salaried GPs, two GP Registrars, a nurse practitioner, three practice nurses and a phlebotomist. They are supported by a practice manager, administration and reception staff.

The surgery was open from 7.30am to 6pm Monday to Friday.

The practice has opted out of the requirement to provide GP consultations when the surgery is closed. The out-of-hours service is provided by The Leicester, Leicestershire and Rutland Out- of -Hours Service.

The surgery is purpose built, spacious, and is of single storey construction, providing good access to patients and carers. Level car parking is available and some bays close to the entrance doors are designated for the use of patients with restricted mobility.

Why we carried out this inspection

We inspected this out-of-hours service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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

- 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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problems

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service. We also looked at information we had asked the practice to send to us and looked at information held in the public domain, such as NHS Choices. We viewed the practice website.

We carried out an announced visit on 9 July 2014. During our visit we spoke with a range of staff including GPs, nurses, healthcare assistants and reception and administration staff. We spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

We met and spoke with the patient participation group and looked at surveys they had completed at the practice to gauge the patient experience.

Are services safe?

Our findings

Safe Patient Care

Patients told us they felt safe when using the service. We found that the premises were safe and accessible for patients.

Effective systems were in place to report and record significant events, safety incidents, concerns and near misses. Discussions with staff and records showed that incidents and concerns were discussed at the clinical and team meetings. Staff were aware of their responsibility to promote safety and to report incidents, and received feedback as to what action had been taken.

We saw that effective systems were in place to ensure that relevant staff were informed of patient safety alerts, to protect patients and the staff team against risks to their safety and to ensure patients received safe care.

The practice used divers sources of information available to them to review the safety of patient care.

Staff told us, and minutes of meetings showed us, that several sources of information were reviewed to assess how safe patient care was. This included the review of results of audits, feedback from patients, carers and other professionals.

Learning from Incidents

We looked at the significant events log for the practice to review how incidents were reported and investigated. We saw that events, which had the potential to impact on patient safety, were investigated by the practice and discussed at staff meetings. Action was taken to address any risks identified from investigation of events. We saw meeting minutes which indicated that staff periodically discussed significant events at meetings to ensure that any learning from events was communicated properly and reflected the day to day working of the practice. The practice had processes for ensuring that any incidents which could affect patient safety were acted on and any learning required by staff was communicated to reduce the risk of similar incidents reoccurring.

Safeguarding

Staff were aware of their responsibilities in keeping patients safe from harm and reporting any suspicion of abuse.

We saw the practice had a clear policy in place aimed at protecting children and vulnerable adults. Staff had been provided with clear direction on reporting incidents of safeguarding. All of the staff we spoke with were aware of how to report incidents and events which could put patient safety at risk and were able to name the GP who was the safeguarding lead. Some staff told us they would initially refer any concerns to the practice manger as they were always around. This enabled staff to be proactive in identifying, reporting and taking action to reduce the risk to patient safety. We spoke with five members of the staff team who were able to describe different types of abuse as well as the possible signs and symptoms. They were aware of where to find the contact details for the local authority safeguarding team and told us they had received safeguarding training. Training had been delivered by Leicestershire Police, Leicestershire City Council and a specialist nurse from a domestic violence team.

Monitoring Safety & Responding to Risk

The practice was effectively monitoring risks to patients and staff. We saw that the practice had a health and safety policy and protocol that had recently been reviewed and updated. In line with the policy we saw that environmental risk assessments had been conducted that had looked at the potential risks to staff, patients and contractors visiting the premises.

We looked at the accidents book that was used by the practice to record accidents in the workplace and saw that those that had occurred had been appropriately recorded and where necessary investigated to help reduce the chance of any re-occurrence.

Emergency medicines and equipment were stored on site. We saw records of staff training in dealing with medical emergencies which showed this was undertaken annually.

Medicines Management

Medicines were managed safely by staff to ensure their effective and safe use. We saw that the medicines management policy was based on recognised national guidance and best practice.

We found all medical equipment and drugs were within expiry dates. Emergency medicines were within the manufacturers recommended expiry dates. Fridges were monitored to ensure they remained within the correct temperature ranges for the drugs stored in them.

Are services safe?

Cleanliness & Infection Control

We found the practice was visibly clean from the reception area through to the clinical areas. Patients were cared for in a clean and hygienic environment. We saw regular cleaning and checks took place.

Clinical rooms were free from dust and dirt on all surfaces and chairs in clinical rooms were easily cleaned. There was a hygiene and infection control audit tool used to monitor hygiene and infection control. We saw the infection control policy and saw it was available to staff.

Staff were aware of their responsibilities regarding hygiene and infection control, and there was formal training to help ensure staff followed relevant guidance.

Staffing & Recruitment

Patients were cared for by an experienced and skilled team that consisted of four partners and four salaried GPs, two GP Registrars, a nurse practitioner, three practice nurses and a phlebotomist. They were supported by a practice manager, administration and reception staff.

We looked at the staff records for three GPs. There was evidence of Criminal Record Bureau checks and employment histories. We saw evidence of the GPs' inclusion on the medical performers list and of the appropriate professional indemnity cover.

The practice manager explained GP references had been taken verbally and were not recorded and there was no record of who the referees had been or what had been discussed.

We saw that in one file there was evidence that the person had been subject to a criminal investigation for a matter that may have made the person unsuitable to work with vulnerable patients in a healthcare setting. The practice manager told us the subject had been discussed at the employee's interview and the applicant had satisfied the interviewers. There was no record of the interview, the conversation that had taken place or any assessment of the risk. We were told that references had been sought by telephone but again no details had been recorded.

The staff files we looked at for other members of staff did not contain any written references. The practice manager told us that these references had been taken up verbally but there was no record of that having been done.

Dealing with Emergencies

We saw the practice had a business continuity plan to be used for events such as bad weather or loss of utilities which could potentially impact on the safe running of the service. This was available for staff to refer to if required. An arrangement was place with another surgery to cover patient needs in the event that the practice was forced to cease operating. Patient and other records were backed up remotely to help ensure patient records were not lost due to information technology failure.

Equipment

We saw equipment was in good working order. Maintenance records were available for safety equipment such as fire extinguishers and the fire alarm system. Records showed that all equipment was checked at least quarterly or more frequently if required and each piece of equipment had its own reference number to allow for easy identification.

We saw that the testing of portable electrical equipment was planned for day following our inspection and the practice manger sent us confirmation that it had been completed.

External contractors were used for the maintenance of the premises. We saw evidence of electrical wiring checks and a recent risk assessment for the Legionella in the surgery's water supply.

Are services effective?

(for example, treatment is effective)

Our findings

Promoting Best Practice

Patients received care according to national guidelines. We found that the practice was proactive in working to best practice, for example guidance issued by The National Institute for Health and Care Excellence (NICE) We saw that the practice co-ordinated the care of diabetic patients across GPs and nurses according to NICE guidance and by the use of patient group directives.

The practice was able to demonstrate that it used recognised policies and procedures to ensure the safety of its patients, for example the medicines management policy was based on recognised best practice and its implementation was evidenced from clinical records.

We found that the practice had achieved above the national average in Quality and Outcomes Framework (QOF) audits. This meant that patients were offered care and treatment in accordance with nationally recognised standards.

GPs described how they discussed with the patient which consultant to refer them to based on the patients' needs and individual preferences.

Management, monitoring and improving outcomes for people

Auditing processes were in place to ensure that the practice worked within nationally recognised good practice guidelines. For example we saw evidence of completed audit cycles having been undertaken in respect of prescribing errors and the review of admission data. The learning from the audits had been used to adjust and amend their process and practice. The changes had been reviewed to assess their effectiveness.

We found that the practice was not dealing with correspondence that may have contained important medical information about patients in a timely manner and that this posed a risk of patients not receiving the appropriate care and treatment. We saw that incoming patient and clinical mail, both postal and by facsimile, had not been dealt with since 24 June 2014, resulting in a back-log of approximately 600 items. This was because the member of staff responsible for dealing with it was on annual leave. Whist we were told that items that were marked as 'Urgent' would have been identified and referred to a clinician, there was no process in place to ensure that all the mail was scrutinised on the day of receipt to ensure that it did not contain any urgent or immediate clinical issues. Some mail may not have been marked by the sender as 'Urgent' and this put patients at risk of inappropriate care and treatment as their health needs may not have been identified in a timely manner.

We saw that the practice had innovated through the work of two of its GPs a comprehensive scheme of advanced care planning for patients with long term conditions and in palliative care. Called 'Right Decision' it involved the patient and where appropriate, their carers and relatives in making advanced decisions about their future care. The care plan was shared across all other relevant services and organisations that the patient may have contact with, for example social services, the ambulance trust and the GP out-of-hours provider. We saw that the scheme had been adopted across the geographical area covered by the clinical commissioning group.

Evidence showed that adoption of this scheme had resulted in an increase of patients dying in the place of their choice from 30% to 86%.

Staffing

Staff we spoke with and records we saw showed that staff received annual appraisal which provided them with the opportunity to reflect their own performance and highlight any areas where they could improve. It also gave the opportunity to request additional training appropriate to their role. Appraisal was carried out either by a GP or the practice manager, dependent upon whether the staff member was clinical or administrative.

Working with other services

Evidence showed the practice was effective in the timely referral for more specialised assessment and care. There was clear co-ordination of care for patients across organisation boundaries with such services as the out-of-hour service and social services.

The practice undertook regular, active involvement in the planned joint working pathways and activity analysis with the clinical commissioning group, aimed at improving joint working between healthcare providers and as a result, outcomes for patients.

Health Promotion & Prevention

We saw among the leaflets and posters displayed in the waiting room, there were some with information about health promotion. Staff we spoke with told us that health

Are services effective?

(for example, treatment is effective)

promotion advice was given routinely when patients were seen. Staff told us that when patients registered with the practice a full new patient assessment was undertaken. This helped ensure that patients received advice and treatment to promote good health.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We observed patients being treated with respect when they were speaking to the practice receptionist and were requested to wait at a distance from the reception desk, whilst the person in front was being seen. This was to help ensure that conversations were more difficult to overhear and helped to maintain patient confidentiality. Background noise in the form of a television also helped to reduce the chances of being overheard.

We heard staff talking with patients on the telephone. Staff were polite and took time to fully explain to patients their options.

We saw that the receptionist did not have a telephone on the reception area. This ensured that patients received uninterrupted face to face attention from the receptionist as they were not distracted by a telephone.

An audio induction loop system or hearing loop was fitted to the reception area as an aid to people who were hearing impaired.

We saw there were notices regarding the availability of chaperones during consultations displayed throughout the surgery.

The practice had counsellors who were able to give advice to bereaved families and were able to signpost them to other agencies for support. We were provided with a copy of the Community Bereavement Book that gave comprehensive advice to families on a wide range of subjects resulting from a person's death.

Involvement in decisions and consent

We saw the practice had access to a number of resources to help in treating patients whose first language was not English. We found that the GP and some other members of staff could speak other languages, in particular Indian and Pakistan languages and dialects. This enabled effective communication with the sizeable Asian patient group. The practice had established links with the Ujala Centre that provided translation and interpreter services in a wide range of languages as well as providing services for people who were hearing impaired. The practice re-arranged appointments to allow for interpreters from the centre to accompany patients.

While practice information in the patient waiting room was in English, it did indicate that the information was available in other languages.

Where patients had opted for family members to interpret on their behalf they were asked to complete consent forms which were stored on the patient's records. This enabled clinicians to be confident that they could share personal and medical information with a third party.

We spoke with a nurse regarding the capacity of patients to make decisions about their care and treatment. They spoke knowledgably about how they assessed the patient's capacity to give consent and what other information they might consider. The nurse also explained the use of the Gillick competency when dealing with patients under the age of 16, mainly when they sought contraception advice. (Gillick competence is used to decide whether a child of 16 or under is able to consent to his or her own medical treatment, without the need for parental permission or knowledge).

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We saw that the practice operated an Extended Integrated Health Care Project, which was also known as Unique Care. This consisted of weekly meetings between GPs, district nurses, community matron, community psychiatric nurses and the local authority's health and social care co-ordinators. This information sharing meeting enabled professionals to discuss patient care and identify patients who might need some additional support from the practice and allowed them to arrange a GP consultation either at home or at the surgery.

There was also evidence that the practice worked with the Immediate Care Response Service that provided assistance to people in their own homes whilst an assessment was undertaken as to their long term care and support needs.

The practice had opted out of the requirement to provide GP consultations when the surgery was closed. The out-of-hours service was provided by The Leicester, Leicestershire and Rutland Out of Hours Service.

Patient records were available to the out-of-hours service through the IT system and they received copies of the practice's 'Right Decision' care planning for patients who had made advanced decisions regarding their care and treatment during palliative care.

Access to the service

GP recruitment had resulted in there having been a steady decrease in the ratio of patients to GPs at the practice since 2010, resulting in there being 1,445 patients per GP at the date of the inspection. This enabled there to be more hours available for patient consultations. A nurse practitioner carried out telephone triage between 8.30am and 2.30pm to assist the GPs. This scheme was due to start on 21 July 2014 and was to be trialled for two months. One GP also performed telephone triage to identify those patients that required face to face consultations or those who could have their healthcare needs met through telephone advice.

Patients could access appointments either in person, by telephone or using the 'on line' booking system. Half of the appointments available were pre-booked the remainder booked on the day. Pre-booked appointments could be made with a GP up to four weeks in advance.

The number of appointments not attended by patients were monitored on a weekly basis. The number of people who did not attend appointments (DNA) for the four weeks 11 June to 9 July 2014 amounted to 197, which the practice considered to be low and within acceptable limits. Repeated failure to attend appointments resulted in the patient being contacted by letter and then by the practice manager to discuss the issues. The practice manager told us this process was sufficient to encourage people to attend their appointments and there had never been a need to remove a patient from the list.

Concerns & Complaints

We saw there was a robust complaints procedure in place, with leaflets and details available for patients in the waiting area and on the website. We looked at the complaints that had been received and saw that they had been dealt with in line with the practice policy and within the timescales prescribed.

Concerns had been raised about the efficacy of the telephone system and the long delays in getting through to the surgery. As a result of the concerns and complaints the telephone system had been changed five weeks prior to our inspection and that had resulted in much shorter waiting times. Feedback from patients we spoke with and the patient participation group confirmed this to be the case.

Are services well-led?

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

Our findings

Leadership & Culture

Staff that we talked with all displayed a desire to improve the patient experience and shared values that put the patient at the heart of what they did.

Staff told us they worked in an open and supportive environment. They said they would have no hesitation in speaking to senior staff if anything was troubling them as they knew they would be supported and where appropriate, action taken. We saw the practice had a Whistleblowing policy and staff we spoke with were aware of who they could report to internally. They were also aware of the external organisations they could refer to.

Governance Arrangements

We found the practice had systems to assess and monitor quality. Staff had access to a range of policies and procedures and we saw that they were comprehensive and covered a range of issues such as medicines management, complaints, safeguarding and business continuity.

Staff were provided with the opportunity to undertake a range of training appropriate to their role. This included such areas as sexual and reproductive healthcare, infection control, managing significant events and chaperone training. We also saw that basic life support and safeguarding children and vulnerable adults was deemed as 'mandatory' training and completed by all staff.

We talked with a member of staff who had expressed an interest at their annual appraisal in gaining more experience in supervision and management. The practice had agreed and identified suitable training courses with a view to them taking over the management at the other location run by the practice.

Systems to monitor and improve quality & improvement

The practice manager had clear management systems in place to monitor the quality of the service provided and met weekly with the partners to monitor quality and discuss emerging issues. Systems were established to identify, assess and manage risks related to the service provided through a series of internal checks and audits, these included risk profiles, infection control, call answering and maintenance.

The practice participated in the quality and outcomes framework system (QOF). This was used to monitor the quality of services in the practice. There were systems in place to monitor services and record performance against the quality and outcomes framework.

Patient Experience & Involvement

Feedback was sought from patients through an annual survey. Feedback from the survey was positive overall. The results were available for patients to see on the practice website. We saw action had been taken to address issues which had been raised from the survey.

The practice had a well-established patient participation group (PPG) that had representatives from minority ethnic groups. The group had sought the view of patients and many had expressed their concerns regarding the length of time it took for staff to answer the telephone, even outside of the traditionally busy times. The PPG had conducted their own survey of patients and the results were available to view on the practice website. This had resulted in the PPG being able to provide evidence to support changes to the practice telephone system.

Staff engagement & Involvement

We saw that regular meetings were held for all staff at the practice that enabled staff, both clinical and administrative to express their views about the way the practice was run and how it was performing in meeting patients' needs. We viewed the minutes of the meetings and saw they had addressed a wide range of subject matters relating to patient care, welfare and safety.

Learning & Improvement

Staff received regular training updates and protected time for training days was given throughout the year.

We saw that staff received an annual documented appraisal and ongoing informal supervision, which was not recorded. Staff we spoke with felt they received the support they needed.

Identification & Management of Risk

We found that risk assessments were in place and some areas of risk such as significant or adverse events were discussed at team meetings. We saw that contingency plans for dealing with emergencies were in place and we saw that the plans had been reviewed recently. We saw that health and safety risk assessments were in place. They

Are services well-led?

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

clearly stated the nature of the risk and what measures had been put in place to minimise the risk in the future. Where further action to minimise risk had been identified we saw that this had been actioned.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Our findings

We found that the practice had allocated every patient over 75 years a named doctor, but were also informed that they did not have to see their named doctor if they preferred not to.

The practice operated an Extended Integrated Health Care Project, which was also known as Unique Care. This consisted of weekly meetings between GPs, district nurses, community matron, community psychiatric nurses and the local authority's health and social care co-ordinators. This information sharing meeting enabled professionals to discuss patient care and identify patients who might need some additional support from the practice and allowed them to arrange a GP consultation either at home or at the surgery.

There was also evidence that the practice worked with the Immediate Care Response Service that provided assistance to people in their own homes whilst an assessment was undertaken as to their long term care and support needs.

Care homes that had residents who were on the patient list at Willowbrook had a nominated GP to help ensure continuity of care, and to reduce the incidence of admission to hospital for those patients.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Our findings

We found that regular appointments to review their health needs were scheduled for patients with long term conditions. The frequency of reviews was dependent on the severity of the condition. At these appointments patients had their general health assessed as well as any symptoms specific to their long term condition. They also had their medication reviewed.

We found that the practice held weekly multidisciplinary meetings. These were attended by at least one of the GPs and a range of other professionals attended according to the changing needs of the patients.

The practice website held a wide range of information for patients with long term conditions such as coronary heart disease, asthma, cancer and stroke. The site gave details of clinics and services and sign-posting to other resources and charities.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

We spoke with four patients who were also mothers whose children were patients at the practice. They told us that the care and treatment they received was exemplary and they had no concerns.

They told us that they felt listened to by the clinicians and that the GP always explained things clearly. One mother told how the GP had explained to her eight year old in terms they could easily understand.

We were told that referrals to paediatric services were completed without delay, on the same day in one case.

We saw that the health visitors attended monthly meetings at the practice to discuss families and their children and provided the opportunity for the practice to be made aware of children who might be 'at risk'.

Clear information and guidance to expectant mothers and mothers with children was detailed on the practice website and included such things as childhood immunisation advice.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Our findings

The practice had implemented extended opening times to allow people to access appointments early and late in the day, who might otherwise have difficulty due to them working during traditional surgery hours.

There was a range of information available to working patients or those who had recently retired in the practice and on the practice website. The website provided information and links to other resources about the self-management of minor illness for working age patients to help avoid the need for them to attend the practice for care and treatment.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Our findings

The practice had a safeguarding policy that helped to protect patients in vulnerable circumstances, for example patients with a learning disability from avoidable harm. All staff that we spoke with were conversant with it and their roles and responsibilities in reporting any areas of concern.

A wide range of resources were available to enable patients whose first language was not English to access GP services.

The practice operated an Extended Integrated Health Care Project, which was also known as Unique Care. This consisted of weekly meetings between GPs, district nurses, community matron, community psychiatric nurses and the local authority's health and social care co-ordinators. This information sharing meeting enabled professionals to discuss patient care and identify patients who might need some additional support from the practice and allowed them to arrange a GP consultation either at home or at the surgery.

Home visits and telephone consultations were available for people who could not get to the surgery. There was appropriate access for people with restricted mobility.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Our findings

We found evidence that Willowbrook Medical Centre made appropriate and timely referrals to specialised health care providers for people with long-standing mental health issues.

The practice operated an Extended Integrated Health Care Project, which was also known as Unique Care. This consisted of weekly meetings between GPs, district nurses, community matron, community psychiatric nurses and the local authority's health and social care co-ordinators. This information sharing meeting enabled professionals to discuss patient care and identify patients who might need some additional support from the practice and allowed them to arrange a GP consultation either at home or at the surgery.

Clear information and guidance was detailed on the practice website and included such things as advice about how to seek help for patients with Alzheimer's Disease and other mental health issues. There was clear sign-posting to other agencies, healthcare providers and charities.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **Regulation 10 (1) (b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision.** **Patients who use services were not protected against the risks of inappropriate care or unsafe care and treatment by means of the effective operation of systems designed to enable the registered person to identify, assess and manage risks relating to the health, welfare and safety of patients from the carrying out of the regulated activities.**