

Tame Valley Medical Centre

Quality Report

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

Summary of findings

Contents

Summary of this inspection

| | Page |
|---|------|
| Overall summary | 3 |
| The five questions we ask and what we found | 4 |
| What people who use the service say | 6 |
| Areas for improvement | 6 |

Detailed findings from this inspection

| | |
|--|---|
| Our inspection team | 7 |
| Background to Tame Valley Medical Centre | 7 |
| Why we carried out this inspection | 7 |
| How we carried out this inspection | 7 |
| Findings by main service | 9 |

Summary of findings

Overall summary

Tame Valley Medical Centre provided primary medical services in the centre of Ashton Under Lyne Monday to Friday. The practice was open between 08:00 and 18:00, with extended opening on Mondays until 19:30pm and early opening on Tuesdays at 07:00. The practice also provided home visits for people who were not well enough to attend the centre. Tame Valley Medical Centre are registered to provide the following regulated activities: Diagnostic and screening procedures, Family planning, Maternity and midwifery services, Surgical procedures and Treatment of disease, disorder or injury.

The majority of patients we spoke with during our inspection were happy with the care and treatment that they received.

We saw the service was provided in a clean and hygienic environment and there were systems in place to ensure the safety of patients. However systems to ensure vulnerable adults were protected from harm were inconsistent and cleaning practices were not in line with policy. The practice assured us they would address this immediately.

We found overall medicines management was safe, with the practice making appropriate checks on medicines.

Patients received a caring service and told us that they were involved in discussions about the health care they received and we saw patients being treated with sensitivity and respect by reception staff.

We found the service was effective in meeting the wide ranging needs of patients. They used best practice guidance and worked effectively with other health and social care professionals, as well as out of hour's services to provide joined up care for patients. The service was responsive to the needs of the patients attending the practice. All staff had access to equipment, guidance, protocols and pathways to make clinical decisions and provide safe effective care for patients.

The new manager had a clear action plan in place of policies, procedures and tasks which needed to be completed to bring the practice up to date. Staff described the service as well led and staff at all levels felt supported. Information was routinely shared with staff via email and through formal and informal meetings.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Overall the practice was safe. They had a range of measures in place to protect children from harm. All staff we spoke with were able to tell us how they would respond if they believed a patient or member of the public were at risk, however the adult safeguarding policy was not up to date and there was no training for staff in relation to protecting adults from abuse. The practice had systems in place to investigate and learn from significant incidents. Safe recruitment processes were in place for staff, which included criminal record checks and checks to ensure staff were registered with their professional bodies and safe to practice.

Are services effective?

The practice was effective. Care and treatment was being delivered in line with current published best practice. Patients' needs were being met, with patients involved in decision making. We were told comprehensive assessments of care and treatment were in place and support provided to enable people to self-manage their condition. The practice carried out audits to monitor patient experience, quality and to ensure treatment was being delivered in line with best practice.

Are services caring?

The practice was caring. Patients we spoke with described being treated with respect and dignity and felt involved in decisions about their health care. All staff we spoke with understood the principles of gaining consent including issues relating to capacity. Staff we spoke with were able to explaining to us how they involved patients in the decision making process, about their care and treatment. Staff told us where necessary they would book longer consultations to ensure people had the time to make an informed decision.

Are services responsive to people's needs?

The service was responsive. The practice had an understanding of their patient population, and responded to meet people's needs. The service asked for patient feedback on an annual basis. We saw evidence of changes that had taken place as a result of input from patients. We saw there was a complaints procedure in place and we reviewed complaints made to the practice over the past twelve months. They were fully investigated with actions and outcomes documented and learning shared.

Summary of findings

Are services well-led?

The practice was well led. Staff described a service which was supportive and open to learning, providing staff with training and professional development opportunities. Systems had been established by the new practice manager to identify, assess and manage risks related to the service provided through a series of internal checks and audits.

Summary of findings

What people who use the service say

During our inspection we spoke with 10 patients including three members of the patient participation group and reviewed four comment cards which patients had completed leading up to the inspection.

The majority of comments were positive about the care and treatment people received. Patients told us they were treated with dignity and respect and involved in making decisions about their treatment options.

A small number of patients reported difficulty in making timely routine appointments with a GP, however they reported where emergency appointments were required these were accommodated on the same day.

Feedback included individual praise of staff for their care and kindness and going the extra mile. We reviewed the results of the patient survey carried out in 2013/14 and found that patients responded as follows :- 97% said receptionists were helpful, 85% said it was easy or fairly easy to speak to a doctor or nurse at the practice, 95% were generally happy with the opening times and 95% said they would recommend the surgery.

Areas for improvement

Action the service COULD take to improve

Adult safeguarding: Policies and protocols which help to protect vulnerable adults from abuse were not up to date and training for staff had not been carried out.

Infection control: No risk assessments were in place linked to infection control and Control of Substances Hazardous to Health (COSHH). Not all staff had completed infection control training.

Tame Valley Medical CentreTame Valley Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

A **CQC Inspector** and a **GP**. The team included a practice manager.

Background to Tame Valley Medical Centre

Tame Valley Medical Centre provides primary medical services in the centre of Ashton Under Lyne from Monday to Friday. The practice is open between 08:00 and 18:00, with extended opening on Mondays until 19:30pm and early opening on Tuesdays from 07:00. The practice also provides home visits for people who were not well enough to attend the centre.

The practice has four GP partners and one salaried GP. It is a teaching practice and had two GP registrars at the time of the inspection. The practice also has two practice nurses and two healthcare assistant. The practice is supported by a practice manager, administrators and receptionists.

Tame Valley Medical Centre is an accredited GP Training Practice by the North Western Deanery of Postgraduate Medical Education.

Tame Valley Medical Centre is situated within the geographical area of NHS Tameside and Glossop Clinical Commissioning Group (CCG). The CCG is responsible for

commissioning health services for the 240,300 people registered with their 42 member GP practices. The CCG has three local priorities: improving GP disease risk registers, dementia and smoking quitters, which it hopes will contribute to reducing health inequalities and improving health outcomes.

Tame Valley Medical Centre is responsible for providing care to 6767 patients, of whom 20% are from minority ethnic groups.

When the practice was closed patients were directed to Go to Doc out of hours service.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information about practice. We asked the practice to give us information in advance of the site visit and asked other organisations to share their information about the service.

Detailed findings

We carried out an announced visit on the 21st May 2014. The inspection team spent seven hours at the Practice. We observed how patients were being cared for and talked with carers and/or family members and reviewed information provided on the day by the practice. We spoke with ten patients including three members of the patient participation group and a range of staff, including receptionists, the office manager, the practice manager, GP's, a practice Nurse, health care assistants and a trainee GP.

We reviewed four Care Quality Commission comment cards where patients and members of the public had shared their views and experiences of the service.

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

Are services safe?

Summary of findings

Overall the practice was safe. They had a range of measures in place to protect children from harm. All staff we spoke with were able to tell us how they would respond if they believed a patient or member of the public were at risk, however the adult safeguarding policy was not up to date and there was no training for staff in relation to protecting adults from abuse. The practice had systems in place to investigate and learn from significant incidents. Safe recruitment processes were in place for staff, which included criminal record checks and checks to ensure staff were registered with their professional bodies and safe to practice.

Our findings

Safe patient care

We found that the practice had systems in place to monitor patient safety. Information from the quality and outcomes framework (QOF), which is a national performance measurement tool, showed that in 2012-2013 the Practice had a good track record of appropriately identifying and reporting incidents.

A system to report, investigate and act on incidents of patient safety was in place, this included identifying potential risk and near misses.

We saw staff had access to multiple sources of information to enable them to maintain patient safety and keep up to date with best practice. The practice had systems in place to respond to safety alerts.

The practice investigated complaints, carried out audits and responded to patient feedback in order to maintain safe patient care.

Learning from incidents

The practice had in place arrangements for reporting significant incidents that occurred at the practice. We saw from the practice significant events log and speaking with staff, they had carried out detailed investigations and provided detailed records of outcomes and actions taken in light of the significant events. Monthly meetings took place between relevant staff to discuss findings and plan action to be taken in light of significant events. Staff told us learning from incidents was shared via weekly meetings or sooner where required.

Safeguarding

All staff we spoke with were able to tell us how they would respond if they believed a patient or member of the public were at risk. Staff explained to us where they had concerns they would seek guidance from the safeguarding lead or seek support from a colleague as soon as possible.

We saw the practice had in place a detailed child protection policy and procedure. We saw procedures and flow charts were in place for staff to follow should they have concerns about a child. Where concerns already existed about a child, alerts were placed on patient records. These alerts were nationally recognised, so would transfer with a child's records to another GP or health

Are services safe?

provider where appropriate. We spoke with the GP who had responsibility for safeguarding; they had a clear understanding of their role and attended local safeguarding lead meetings.

We discussed with the safeguarding lead the limited information available for staff, and training for staff in relation to adult safeguarding. The adult safeguarding policy, which had been updated in May 2014 directed staff to the practice manager, should they have any concerns and not the safeguarding lead. We noted the practice manager had received no safeguarding training. The safeguarding lead noted the discrepancy between children's and adults' procedures and acknowledged, that although they were confident any member of staff would appropriately raise concerns, lack of clarity in policy and procedure could lead to confusion among staff. They told us they would review the policy and staff training as a matter of urgency and ensure all staff where appropriate received training relating to the protection of vulnerable adults.

Monitoring safety and responding to risk

The practice had developed clear lines of accountability for all aspects of care and treatment. The GPs, nurses and health care assistants had been allocated lead roles to make sure best practice guidance was followed in connection with infection control, safeguarding and training. Speaking with GP's and reviewing minutes of meetings we noted safety was being monitored and discussed routinely. Appropriate action was taken to respond to and minimise risks associated with patient care and premises. We saw evidence that all clinical staff received regular cardiopulmonary resuscitation (CPR) training and training associated with the treatment of anaphylactic shock.

Medicines management

The practice held medicines on site for use in an emergency or for administration during consultations such as administration of vaccinations. Medicines administered by the nursing and health care assistants at the practice were given under a patient group directive (PGD) and patient specific directions (PSD), directives agreed by doctors and pharmacists which allows nurses to supply and/or administer prescription-only medicines. This had also been agreed with the local Clinical Commissioning Group.

We saw emergency medications were checked weekly to ensure they were in date and safe to use. We checked a sample of medicines and found these were in date, stored safely and where required, were refrigerated.

During our inspection we noted the emergency drugs cupboard was not locked, and could be accessed by a member of the public. The practice manager told us this would be addressed immediately to ensure the cupboard was locked at all times.

Cleanliness and infection control

The practice was found to be clean and tidy. The toilet facilities had posters promoting good hand hygiene displayed.

We looked in three consulting rooms and the treatment room, which was also used for minor surgery. The flooring in the treatment room had coved skirting and all the rooms had hand wash facilities and work surfaces which were free of damage, enabling them to be cleaned thoroughly.

We saw rooms were well stocked with gloves, aprons and alcohol gel, and hand washing guidance displayed by the sinks.

Speaking with staff they demonstrated a clear understanding of their role in maintaining a clean and safe environment.

The practice manager new in post, was in the process of updating policies and procedures associated with cleanliness and infection control and provided us with an action plan with dates when this would be completed. This would ensure the practice were fully compliant with infection control, best practice guidance and legal requirements. We were provided with a copy of the infection control policy which had been updated in May 2014, and clearly set out people's roles and responsibilities. Additional to the infection control policy, we saw policies which related to the Decontamination of Re-usable instruments, single use instruments, hand hygiene and clinical waste.

There were appropriate systems in place for the decontamination of re-usable equipment. A member of staff went through the checks with us that they carried out in the central decontamination room. We noted that all the checks had been signed and dated. We saw that clean equipment was packaged and dated. A cleaning protocol was in place for the decontamination room.

Are services safe?

Where single use instruments were used we noted stock rotation and saw equipment was in date and stored appropriately. We saw fridge temperatures were monitored throughout the day to ensure medicines and vaccinations were stored safely and at the correct temperature in line with manufacturer guidelines.

At the time of our inspection no risk assessments were in place linked to infection control or Control of Substances Hazardous to Health (COSHH) and only four members of staff had recently completed infection control training. This included the infection control lead and practice manager. We saw no evidence that cleaning staff had received any infection control training. We raised this with the practice manager who was aware of the training requirements and the need to complete risk assessments and these were highlighted on their action plan.

A new cleaning plan had been introduced the week prior to our inspection which gave detailed guidance to the cleaning staff of daily and weekly tasks to be completed. These were to be recorded and returned to the practice manager on a weekly basis. We noted a colour coding scheme had been introduced in line with good practice guidelines to ensure cleaning materials and equipment were not used across all areas. This was to prevent the spread of infection. Despite the introduction of colour coding we saw this was not being implemented. We highlighted this to the practice manager and they assured us they would rectify the situation straight away. The practice manager told us as part of the new policy system, spot checks were to be introduced to monitor the quality of cleaning across the practice.

Staffing and recruitment

There were formal processes in place for the recruitment of staff to check their suitability and character for employment. We looked at the recruitment and personnel records for six staff. We saw recruitment checks had been undertaken for the majority of staff. This included a check of the person's skills and experience through their application form, personal references, identification, criminal record and general health. Where we identified

gaps such as references; these were for staff who had been employed with the practice for a number of years, however all staff recruited in the last 18 months had all the appropriate checks carried out.

Where relevant, the practice also made checks that members of staff were registered with their professional body and on the GP performer's list. This helped to evidence that staff met the requirements of their professional bodies and had the right to practice.

We were satisfied that criminal record checks had been carried out appropriately for all clinical staff to ensure patients were protected from the risk of unsuitable staff. For all other staff, risk assessments were in place and checks were carried out where required.

Dealing with Emergencies

There were plans in place to deal with emergencies that might interrupt the smooth running of the service. Within the business continuity plan there was clear guidance, with staff roles and responsibilities being clearly defined. We noted that alternative premises had been identified so that if the practice was unable to open for any reason, patients would still receive a service.

We saw fire safety checks were carried out and full fire drills were scheduled every six months. This ensured that in the event of an emergency staff were able to evacuate the building safely.

Equipment

The practice manager had a plan in place to ensure all equipment was effectively maintained in line with manufacture guidance and calibrated where required. We saw maintenance contracts were in place for all equipment. The new practice manager told us they were developing an annual maintenance and calibration schedule to ensure all checks were carried out in a timely manner and to prevent any gaps.

We spoke with three GPs including a registrar (GP in training), the practice nurse and a health care assistant. They all told us they had access to the necessary equipment and were skilled in its use.

Checks were carried out on portable electrical equipment in line with legal requirements.

Are services effective?

(for example, treatment is effective)

Summary of findings

The practice was effective. Care and treatment was being delivered in line with current published best practice. Patients' needs were being met, with patients involved in decision making. We were told comprehensive assessments of care and treatment were in place and support provided to enable people to self-manage their condition. The practice carried out audits to monitor patient experience, quality and to ensure treatment was being delivered in line with best practice.

Our findings

Promoting best practice

We saw information available to staff, minutes of meetings and by speaking with staff, that care and treatment was delivered in line with recognised best practice standards and guidelines. We saw staff had access to a range of professional journals and resources within a small library. Staff told us they received updates relating to best practice or safety alerts they needed to be aware of via pop up alerts within the computer system and emails.

The GP's we spoke with discussed with us using best practice guidelines to treat and review patients with long term health conditions such as diabetes, chronic obstructive pulmonary disease (COPD) and asthma. Speaking with the GP lead for palliative care, they told us additional to their role at Tame Valley Medical Centre they also worked for a hospice, which proved invaluable in sharing learning and good practice. The practice held weekly multi professional meetings in line with the gold standard framework for palliative care, to ensure shared care was in place for patients at the end of life. The gold standard framework is a national framework to ensure patients are provided with quality appropriate care for people nearing the end of life.

Prior to the inspection, we received data which highlighted the practice may not be in line with national targets such as recording patients smoking status and carrying out physical health checks for people with severe mental illness. Speaking with the GP's they told us during 2013 they had a shortage of nursing staff and were aware of the impact this had had on reviewing all patients effectively. This had been resolved with new nursing staff in post and plans were in place to make sure that all patients received the appropriate checks and reviews in line with best practice. This included the introduction of additional clinics for patients with long term health conditions.

Management, monitoring and improving outcomes for people

Speaking with clinical staff, we were told comprehensive assessments of care and treatment were in place and support provided to enable people to self-manage their condition. A range of patient information leaflets were

Are services effective?

(for example, treatment is effective)

available for staff to give out to patients which helped them understand conditions and treatments. One patient told us: “you never leave a consultation without information to read.”

We were told pop up alerts were in place within patients’ records which alerted staff to patients who required reviews, or routine checks/treatment such as flu vaccinations or smear tests.

Care plans were in place for patients with long term health conditions. We were told care plans for patients, specifically for complex mental health issues were in place and they were introducing care plans for patients with complicated co-morbidities (two or more physical and or psychological illness).

The practice carried out clinical audits to monitor patient experience and quality and to ensure treatment was being delivered in line with best practice. We were provided with a range of audits the GP’s had carried out over the past year. These included an audit of the appointment system, childhood immunisation, minor operations and co-ordinated care. We saw from the clinical audits that outcomes and actions were recorded and any changes which resulted from the audits were shared with staff through meetings and email correspondence.

Staffing

Speaking with staff and reviewing training records we saw all staff including locum GP’s were appropriately qualified and competent to carry out their roles safely and effectively in line with best practice.

There was an induction programme in place and mandatory training for staff which included basic life support, child protection, confidentiality and health and safety.

The practice had a system for supervision and appraisal in place for all staff, and revalidation of doctors; however the staff appraisals were out of date, due to a gap between practice managers. The new practice manager told us they had met with all staff informally and a timetable was in place for staff appraisals during 2014. All staff we spoke with told us they were happy with the support they received from the practice. The GP registrar confirmed they received supervision and a daily de-briefing session where required.

Staff told us they were able to access training and received updates on a regular basis, with time protected to undertake learning. Additional to mandatory training we saw staff had access to training as part of their professional development with GPs and nurses attending training on a monthly basis in which updates on key issues was provided. We were told reception staff were in the process of completing a customer care qualification, and one member of staff told us they had been supported to become a phlebotomist, with internal training and support.

Working with other services

We found that GP’s, nurses and health care assistants at the practice worked closely as a team, and with other providers including district nurses, and Macmillan nurse. External professionals were also invited to clinical meetings to ensure information was shared effectively. Patients could also be referred to community services such as smoking cessation and weight management.

We saw a protocol for shared care was in place and the practice worked to the gold standards framework for end of life care, with multi-agency meetings scheduled monthly. This showed us that patient care was co-ordinated.

Details of out-of-hours consultations that patients had attended were shared with the practice by the out of hours provider each morning. These were reviewed and where follow up action was required this was allocated to the GP on duty. The practice had a shared secure IT system with the out of hours provider which allowed them to share information relating to any complex patients or patients receiving end of life care. The system allowed both to create or alter an electronic record for a patient, to ensure records were kept up to date.

Health, promotion and prevention

New patients looking to register with the practice were provided with a registration pack which included a health background questionnaire and a new registration form. New patients were provided with an appointment with a member of the nursing team for a health check.

The practice website provided new patients where English was their second language, with translated factsheets on the role of GP’s and right to access NHS services. The practice website had a wide range of health promotion information and links to local and national organisations which patients could access. Written information was available for patients in the waiting area, including

Are services effective?

(for example, treatment is effective)

information they could take away on a range of health related issues, local services and health promotion. There was also a wide range of information for patients who were carers, with local support services identified.

We were provided with details of how staff actively promoted healthy lifestyles during consultations. The clinical system had built in prompts for the clinicians to alert them when consulting with patients who smoked or

had weight management needs. The clinician would then advise and signpost the patient to the best course of action. Options included in-house smoking cessation, weight management nurse or the community clinics. Staff told us where patients expressed concerns over their mental health they were able to signpost patients to local organisations for additional support.

Are services caring?

Summary of findings

The practice was caring. Patients we spoke with described being treated with respect and dignity and felt involved in decisions about their health care. All staff we spoke with understood the principles of gaining consent including issues relating to capacity. Staff we spoke with were able to explaining to us how they involved patients in the decision making process, about their care and treatment. Staff told us where necessary they would book longer consultations to ensure people had the time to make an informed decision.

Our findings

Respect, dignity, compassion and empathy

During our inspection we observed staff to be kind, caring and compassionate towards patients. We saw reception staff taking time with patients and trying where possible to meet people's needs.

We spoke with 10 patients and reviewed four comment cards received the week leading up to our inspection. All were positive about the care and treatment they had received from staff. Comments from patients we spoke with included: "Care is brilliant. My son has seen one of the doctors and they really involved him in his treatment options and we would always go home with a reading sheet." "I usually try to see the same GP; they really put you at ease, takes time to explain and doesn't rush you. They know my Husband has a health problem and although I sometimes have to wait two weeks to see a specific GP, they always try to see my husband as soon as possible." Another patient told us: "Excellent very, very good, they go over and above what you would expect. I have been in a couple of time with emergencies, I was seen straight away, and they called the hospital and got me in straight away."

We observed staff speaking with patients, with respect. We spent time with reception staff and observed courteous and respectful face to face communication and telephone conversations. Staff told us when patients arriving at reception wanted to speak in private; they would speak with them in one of the consultation rooms.

We found all rooms were lockable and there were appropriate screens in place in all but one room to maintain patients' dignity and privacy whilst they were undergoing examination or treatment. One small consultation room used by health care assistants had small glass panels in the door from which you could see consultations taking place from the corridor. We highlighted this to the practice manager who assured us they would cover the glass to maintain privacy in the future. We were also told that air conditioning systems had been ordered as they had identified the consulting room became very hot. This would create a comfortable environment for patients and staff to work in the future.

We saw patients had access to a chaperone service when they underwent an examination. Information was displayed in the waiting area informing patients of the

Are services caring?

service and how to request a chaperone during an examination. Staff acting as chaperones had received training. When we spoke with staff who acted as a chaperone they told us they remained behind the screen, which meant they were not able to properly observe the procedure so as to be a reliable witness about what happened.

Staff were able to clearly explain to us how they would reassure patients who were undergoing examinations, and described the use of modesty sheets to maintain patient's dignity.

Involvement in decisions and consent

The practice had a confidentiality statement, which was displayed for patients and available to view on the website. A clear policy was also available linked to confidentiality for patients under 18 years of age. A consent policy was in place which set out clearly how consent should be obtained and recorded. The policy clearly stated a patient should understand a proposed treatment, immunisation or investigation before they were able to consent.

The policy included information about the patient's right to withdraw consent and made reference to Gillick competency when assessing whether young people under sixteen were mature enough to make decisions without parental consent for their care. Gillick competency allow professionals to demonstrate they have checked the persons understanding of the proposed treatment and consequences of agreeing or disagreeing with the treatment. We were shown the template within patients records which staff were required to complete to ensure young patients had been assessed for capacity to consent. We were shown forms for which consent other than implied consent would be recorded. This consent form, once signed would be scanned into patients' notes.

Clear policies and procedures were in place for staff to ensure appropriate action was taken where people did not have the capacity to consent. The policy was in line with the Mental Capacity Act 2005. The policy gave guidance for staff if patients with capacity wished to make an advanced directive. These enabled adults with capacity to make provision for a time when they might lose capacity. This could include an advance decision of refusal of life-sustaining treatment.

A mental capacity assessment guidance and checklist was available for staff to support them in making assessments and outlined the need to keep clear records where decisions were made in the best interest of patients who did not have capacity to make decisions. This showed us that staff were following the principles of the Mental Capacity Act and making detailed records of decisions to ensure patients or relatives were involved in the decision making process.

All staff we spoke with understood the principles of gaining consent including issues relating to capacity. Staff told us where they had concerns about a patients capacity, they would initially carry out a short memory test, and where required refer patients to a memory clinic for further investigations. One GP told us of a close working relationship with a psychiatrist who specialised in the assessment and treatment of elderly people, where they could refer complex patients.

Staff explained how they involved patients in the decision making process, about their care and treatment. Staff told us where necessary they would book longer consultations to make sure people had the time to come to an informed decision. The patients we spoke with confirmed that they had been involved in decisions about their care and treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The service was responsive. The practice had an understanding of their patient population, and responded to meet people's needs. The service asked for patient feedback on an annual basis. We saw evidence of changes that had taken place as a result of input from patients. We saw there was a complaints procedure in place and we reviewed complaints made to the practice over the past twelve months. They were fully investigated with actions and outcomes documented and learning shared.

Our findings

Responding to and meeting people's needs

The practice had an understanding of their patient population, and responded to meet people's needs.

The practice population in the main were white British, with only 20% from minority ethnic groups. The practice ensured that for patients where English was their second language they had easy access to an interpretation service via telephone. They were also able to offer an interpretation service in-house as one member of staff was a trained interpreter, able to speak Punjabi and Urdu. The practice had in place information in different languages, accessed via the website. These interpretation services ensured patients were able to make informed decisions about care and treatment.

The practice were proactive in making reasonable adjustments to meet people's needs. Staff and patients we spoke with provided a range of examples of how this worked, such as accommodating home visits, providing extended appointments where necessary and arranging appointments at times convenient to patient's needs. We noted the practice had appointments available early morning from 07:00 am and late evening appointment until 19:30 allowing patients to arrange appointments to meet their needs and commitments.

The practice provided care and treatment to children with severe disabilities living in a local residential home, routinely seeing the children in the home environment. The practice also provided care to two nursing homes in the community and worked closely registering people as temporary patients who were living in a local hostel. This enabled the practice to provide care and treatment to a range of vulnerable patients in a timely manner, working in partnership with other local services. One GP told us they would also register patients who were homeless as temporary patients to ensure they had access to services when required.

We saw where patients required referrals to another service these took place in a timely manner. The majority of patients told us they were happy with the referrals made. One patient told us: "referral to other services is good, for instance I had been having dizzy spells, when I saw the GP, they got me to the hospital the following day, and they are pretty on the ball." Another patient told us: "I had been

Are services responsive to people's needs?

(for example, to feedback?)

referred for treatment, and the staff phoned once the referral had been made and managed to get me an earlier appointment and I was treated within six weeks instead of 18.”

A repeat prescription service was available to patients; however patients were unable to request repeat prescriptions over the phone and were required to request repeat prescriptions online, this was to avoid error. Acute requests were taken over the phone as these were dealt with by a doctor. Patients we spoke with expressed concerns over not being able to request prescriptions over the phone; however the majority of patients were happy with the system and told us of staff going the extra mile where they required a new prescription.

Access to the service

The practice was accessible for people with mobility difficulties. The consulting rooms were all on one level, the rooms in the main were large with easy access for patients. There was also a toilet for disabled patients and baby changing facilities. We noted a hearing loop was in use for people with hearing problems. Patients had a choice to see either male or female GP's.

The practice was responding to patient feedback in relation to accessing appointments, and were in the process of auditing the appointment system. Initial findings from the audit have shown the need to increase the number of appointments available and increasing patient awareness of telephone consultations.

A number of patients raised concerns with us regarding the length of time they sometimes had to wait for a non-emergency appointment with a GP, especially a named GP of choice, which could be up to two weeks. Reception staff expressed to us a number of patients became unhappy over the phone or at reception because no appointments were available, but did not often follow this up with formal complaints. One patient told us they had had to use out of hours services when they could not get an appointment.

We saw reception staff working hard to provide patients with the earliest possible appointment and accommodate people's preference of GP. Where alternatives were available these were offered to patients to ensure they were seen.

Patients also expressed concerns over the waiting time once they arrived at the practice. We noted on the day of

the inspection people were waiting up to 25 minutes to see a member of staff. Reception staff told us this was not unusual. A notice was displayed on the TV system in the waiting area explaining why patients sometimes had to wait and referred patients back to reception if they were waiting upwards of twenty minutes. Staff did not however inform patients as they arrived for an appointment of the estimated wait time. We discussed this with staff, who reassured us they would introduce a means of informing patients as they arrived of an estimated wait time, in response to patients' feedback.

Not all patients expressed concerns over the appointment system or waiting times and told us of positive experiences. They told us they were accommodated with appointments within a couple of days, or seen straight away for emergencies. Patients were also offered telephone consultations which were popular with patients we spoke with as an alternative to having to travel to the practice. One patient told us: "Appointments are very good, usually accommodate me straight away or within a couple of days, and when I arrive I don't have to wait longer than 10 minutes." The practice were aware of patients concerns and had conducted an audit into the appointment system, and were exploring ways to increase the number of appointments available to patients.

Same day emergency appointments were available for patients, patients were triaged by reception staff and where appointments were necessary patients were seen by the GP on duty that day. If all appointments were full for the day, the patient's details were taken and advice sought from the GP on duty.

Home visits were available for patients each day. The GP on duty would call patients prior to visits and where necessary a home visit would be arranged. This ensured patients who were housebound had access to a range of services provided by the practice in a timely manner.

The practice had a clear, accurate and up-to-date practice leaflet containing information about services provided. There was also a clear and accurate website, which provided a wide range of information on services with links to local and national organisations which provide support. Information was clearly available for patients on how to access the out-of-hours service.

Are services responsive to people's needs?

(for example, to feedback?)

Concerns and complaints

We saw there was a complaints procedure in place. We reviewed complaints made to the practice over the past twelve months and found they were fully investigated with actions and outcomes documented and learning shared with staff through team meetings.

Complaints leaflets were available to patients and displayed on notice boards. The information was also available on the practice website. Patients we spoke with told us they would know how to make a complaint if they felt the need to do so.

The practice had a robust system in place to investigate concerns, with meetings held monthly to discuss issues arising from complaints and incidents. We reviewed the log of serious incidents and concerns recorded over the past twelve months and found these were fully investigated with actions and outcomes documented and learning cascaded to staff.

Are services well-led?

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

Summary of findings

The practice was well led. Staff described a service which was supportive and open to learning, providing staff with training and professional development opportunities. Systems had been established by the new practice manager to identify, assess and manage risks related to the service provided through a series of internal checks and audits.

Our findings

Leadership and culture

The practice had a newly appointed practice manager, in post since February 2014. Prior to the new practice manager starting, we were told there was a gap in management which had resulted in some audits and checks not taking place, and some staff not having access to annual appraisals. The lead GP's were aware of the gaps in provision and national targets not being met in patient care. Since the new practice manager started a clear action plan was in place to address gaps and ensure systems and quality checks were in place.

Speaking with staff, they all described to us an open and supportive environment to work. Staff told us they would have no hesitation to speak to senior staff if anything was troubling them as they knew they would be supported, and where appropriate, action would be taken.

The practice was a training practice. For patients this meant they may be seen by a Doctor twelve months post qualification, who had decided to pursue a career in General Practice. Speaking with one GP in their third year of training they told us they felt well supported within the practice and were able to review any issues or concerns with the training GP at the end of clinics.

The practice had clearly set out leadership and governance roles among the GP partners, with GP's each taking a lead role in different areas for example training, safeguarding and staffing.

The practice had a mission statement in place which was visible in the practice for staff and patients to see. The statement was also visible on the practice website. Observing staff and speaking with staff and patients we found the practice clearly demonstrated a commitment to compassion, dignity, respect and equality.

We were provided with details of a peer review process which was in place between the GP's in the practice. This was a system where GP's checked each other's patient records for accuracy and appropriate treatment and referrals. Monthly clinical meetings were held in which GP's discussed difficult and complex cases to identify the best outcome for the patient. One GP told us of an open culture among colleagues in which they talked daily and sought each other's advice.

Are services well-led?

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

Governance arrangements

We found the practice was in the process of updating and introducing new systems to assess and monitor quality following the appointment of the new practice manager. Staff had access to a range of policies and procedures which had recently been updated or were in the process of being reviewed by the practice manager and GP's. We looked at several of the policies and saw where these had been updated they were comprehensive and reflected up to date guidance and legislation. The policies and procedures were available to staff on line.

Systems to monitor and improve quality and improvement

The practice participated in the quality and outcomes framework system (QOF). This was used to monitor the quality of services in the practice. From national data provided leading up to the inspection we were aware the practice had not met a small number of targets set out in the QOF in 2013. Speaking with one of the GP partners they told us the key reason for not meeting all the targets was due to a shortage in nursing staff which had had a significant impact. New nursing staff had been appointed and an action plan was in place which included additional clinics. This provided patients with access to reviews of care in a timely manner in the future, and they were confident targets would be achieved during 2014. We were also told of detailed analysis taking place as to why as a practice they had a higher number of patients with dementia admitted to hospital compared to a national average. They identified one nursing home where instead of seeking visits from a GP for residents, they were directly referring patients inappropriately to hospital.

GP's were actively involved with the Clinical Commissioning Group and had representatives on the Local medical council.

The practice manager provided us with details of the maintenance and equipment checks which had been carried out in the past twelve months. These guaranteed equipment was safe to use and maintained in line with manufacture guidelines. The practice manager told us they had introduced a maintenance and calibration matrix to check that equipment was routinely maintained at all times.

Patient experience and involvement

Feedback was sought from patients through an annual survey. We saw the results from the survey carried out in

2013. The results were available for patients to see on the practice website. Feedback from the 2013 survey was overall positive. We saw action had been taken to address issues which had been raised from the survey, for example, when asked 'how easy is it to get through to someone at the Practice on the telephone?' 85% of patients said it was very or fairly easy. We were told this was an improvement on the previous year. The practice manager told us they were now fully staffed in the reception team, which had led to more receptionists being available to answer calls. This was an area the practice continued to review and look at ways to improve.

Patients were able to provide feedback on-going through an online survey, but facilities to do this were not available within the practice apart from the formal complaints process. We saw that there was a robust complaints procedure in place, with leaflets and details available for patients in the waiting area and on the website.

The practice had an established patient participation group (PPG) for patients with six people actively involved. We spoke to three representatives of the PPG, who provided us with examples of changes the practice had made in light of their involvement. This included a statement on the waiting room TV system informing patients about waiting times. A notice board had also been developed in the reception area with information for carers.

The PPG met every two to three months, and following the appointment of the new practice manager they had regular email communication between meetings. Comments from the PPG included: "Our PPG is brilliant, they (the practice) do listen and do try to put things right, the new practice manager seems very active." "We held an immunisation day with practice staff and spent time in the waiting areas chatting with patients, gathering feedback and supporting people."

Staff engagement and involvement

All staff we spoke with told us they felt supported and involved in the development of the practice, speaking highly of the new practice manager.

Following the appointment of a new practice manager a timetable of annual appraisals was in place. The practice manager told us they had met with staff informally in the first instance and had timetabled appraisals for all staff to bring appraisals up to date.

Are services well-led?

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

Weekly meetings were held by the clinical staff and GP's but full staff meetings and meetings with administration staff were not regular. This was something the new practice manager planned to improve with a proposal for monthly staff meetings, the first of which was arranged for May 2014.

Learning and improvement

We saw evidence of learning taking place from audits, significant events and complaints, all of which were routine agenda items for the weekly clinical meetings.

The practice had a clinical audit system in place to continually improve the service and deliver the best possible outcomes for patients. We saw audits to monitor patient experience and quality and to ensure treatment was being delivered in line with best practice. We were provided with a range of audits the GP's had carried out over the past year. These included an audit of the appointment system, childhood immunisation, minor operations and co-ordinated care. We saw from the clinical audits outcomes and actions were recorded and any changes which resulted from the audits were shared with staff during weekly clinical meetings and email correspondence.

From the summary of significant events we were provided with and speaking with staff we saw learning had taken place and improvements were made. One example given

was where a back log of incomplete clinical correspondence was identified by the new practice manager. Alterations to the system were made which allowed the practice manager to monitor correspondence on a daily basis and ensured it was sent out in a timely manner.

We were told that all staff were provided with regular 'mandatory' e-training and training specific to their roles. They also had access to a range of training opportunities based upon their personal and professional development needs, with the nurse and health care assistants having access to regular updates from the hospital.

We looked at the training records for both clinical and non-clinical staff. The records showed that staff were provided with a range of training which the practice identified as mandatory. This included training in areas such as confidentiality; basic life support, infection control and children's safeguarding training, however adult safeguarding training was inconsistent for staff.

Identification and management of risk

We saw that health and safety risk assessments had not been completed recently. The new practice manager was aware of the need to complete risk assessments and had an action plan in place. Risk assessments which had been completed included fire safety.