Florence House Medical Practice

Quality Report

Florence House Medical Practice
Higher Openshaw PCC
1344 Ashton Old Road
Manchester
M11 1JG
Tel: 0161 370 0475
Website: www.florencehousesurgery.co.u

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Florence House Medical Practice on 11th June 2015. Overall the practice is rated as good. Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well led services. Services for the population groups were also good.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, reviewed and addressed appropriately.
- Systems to assess and manage patient safety and effectiveness were appropriate with the exception of those to identify and recall patients who did not attend for follow up appointments.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff received adequate support and training appropriate to their roles as well as additional support and training which enabled them to progress in their roles and in their careers.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice had good facilities and was well equipped to treat patients and meet their needs. A discharge co-ordinator/cancer champion and a carer support group was available for patients who could benefit from this service.
- The practice had a high percentage of asylum seekers who received appropriate advice, care and treatment.
- Information about services and how to complain was available and easy to understand.
- Some patients said they found it difficult to make an appointment with a named GP in a timely manner. However they said there was continuity of care, with urgent appointments available the same day.
- The practice proactively sought feedback from staff and patients, which it acted on.

Summary of findings

- There was a newly embedded leadership structure and staff felt very supported by management. There was a family-orientated ethos which was emulated by all the staff.

We saw some areas of outstanding practice including:

- The practice ran a bi-monthly carer support group which brought carers together for support and discussion. Members of the group reported the positive impact on their lives.
- The practice established “Singing for the Brain”; a weekly singing session to help patients with memory problems and dementia. This was run by a singing music therapist offered to patients from other local practices.

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

The provider should:

- Introduce an effective system to identify and recall patients who do not attend for scheduled and follow up appointments such as health checks, repeat blood tests, cervical smears and immunisations.
- Review and introduce an effective system to show that all information required, in line with legislation, is available in respect of each person employed.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. They recorded, reported, shared and monitored events of significance. All staff were aware of their responsibilities in this regard. They were able to provide examples where events had been discussed and changes had been made to working practice so that re-occurrence of the incident was reduced. Staff were trained appropriately in all things to do with safety such as safeguarding, chaperoning, medicines management, infection control and emergency situations. The practice shared information such as national patient safety alerts and took appropriate action when required. Risks to patients were assessed and well managed with the exception of those to identify and recall patients who did not attend for follow up appointments. There were enough appropriately trained staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. The practice shared good examples where positive outcomes had been obtained for patients, data showed patient outcomes were similar to expected for the locality and staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. The system used to recall patients for follow up appointments such as cervical screening or blood tests had broken down and was not effective. Staff at the practice worked with multidisciplinary teams to promote good outcomes for patients. There was a good mix of staff who had received training appropriate to their roles. Appraisals had been completed and a training needs analysis had been developed from those appraisal meetings. The practice had a high percentage of asylum seekers who received appropriate advice, care and treatment.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice highest in respect of confidence and trust in the nurse, enough time with the GP and good explanations about treatment offered and received. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care. Information was available to help patients understand the services they could access,

Summary of findings

and information was made easy to understand, specifically for those who did not speak English. We saw that staff treated patients with kindness and respect, and mostly maintained confidentiality, although this was sometimes difficult at the reception desk.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Some patients said they found it less easy to make an appointment with a named GP but most patients said that there was continuity of care, with urgent appointments available the same day. Longer appointments were available for patients who did not speak English, asylum seekers and others if required. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders was evidenced and shared with the CCG.

Are services well-led?

Good

The practice is rated as good for being well-led. There was a clear, family orientated vision and value which had been passed down over a period of forty five years. All staff spoken with were aware of the vision and their responsibilities in relation to it. There was an evident leadership structure and staff reported that they felt very supported by both their managers and their peers. There was a number of policies and procedures which were easily accessible by all staff and regular meetings were held where all staff had the opportunity to openly share their working practice and learn from each other. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on and there was an active virtual patient reference group (PRG). Newly employed staff received inductions and regular performance reviews and were offered support when needed. All staff were encouraged to openly provide both positive and negative feedback for discussion.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older patients. Every patient over 75 had a named GP. Vulnerable older patients had been identified and individual care plans had been developed to support their relevant care needs. Those care plans were shared with the out of hours provider and discussed in multi-disciplinary team (MDT) meetings with patients' consent. Flu, pneumonia and shingles vaccinations were offered in accordance with national guidance. Named GPs were responsible for relevant care homes and carried out visits when requested. Monthly MDT meetings were held to ensure integrated care for older people with complex care needs. Rapid access and dedicated appointments during lunchtimes and daylight hours (if necessary) were available for elderly patients with complex care needs.

People with long term conditions

Good

The practice was rated as good for the care of patients with long term conditions. Clinical staff had the knowledge skills and competencies to respond to the needs of patients with long term conditions such as asthma, chronic obstructive pulmonary disorder (COPD) and heart disease. Longer appointments were arranged and the GPs and nurses offered home visits for review of housebound patients. All patients with long term conditions were on a recall register and invited in for review appropriate to their condition to ensure their health and medicine needs were met in a structured review. However, the practice recall system had recently broken down and patients were not being routinely called for follow up appointments. There were no diary reminders and there was the possibility that patients who required follow up appointments or repeat blood tests could slip through the net.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up disadvantaged children and those at risk. Accident and Emergency (A&E) and Out of Hours (OOH) reports were followed up to identify if review was necessary. A leaflet was devised to offer advice regarding the appropriate use of A&E and what to do when the practice was closed. Alerts were placed on patient records to offer a same day urgent appointment if requested and required. Child clinics were held on protected days which had proved positive for mums with

Summary of findings

babies and small children. An information pack had been produced for new mums regarding common conditions. Dedicated appointments were available for under 5s and after school appointments for over 5s.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. Dedicated appointments had been made available at 7:30am and 6:30pm for working patients. A self-care room had been introduced and a full range of health promotion, screening and continuity of care has been promoted. On line appointments, ordering of repeat prescriptions and access to records were available for patients with computer access.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances such as those with a learning disability who received regular follow up and annual health checks.

Longer appointments were offered and support was provided through care plans which they were involved in agreeing. These were reviewed annually or more frequently if required. Interpreters were available for all patients who required it, with double appointments when necessary. Condolence letters were sent to patients relatives following bereavement, followed up with a phone call from a GP. Clinical, medical and administration staff provided many examples where vulnerable people had been assisted to achieve positive outcomes.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). They regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia and carried out advance care planning for patients with dementia. The practice had introduced “Singing for the Brain” which had positive benefits for patients with dementia and this was being offered to patients at other practices. Medicine changes were acted upon promptly and daily/weekly prescriptions were in place for patients at risk.

Summary of findings

The patients at the practice had access to the Community Mental Health Team who were based upstairs in the practice premises. Although the service was available to all patients in North Manchester , patients from this practice felt encouraged to attend appointments due to the location which was convenient and familiar to them.

Summary of findings

What people who use the service say

We spoke with 16 patients and reviewed comments from 13 Care Quality Commission (CQC) comments cards which had been completed. Most of the comments reflected praise for the practice, the GPs and the nursing and administration staff. Some patients we spoke to and via the comments cards said that appointments were sometimes difficult to obtain. All comments were positive when asked about privacy, dignity and respect and all included good feedback for the GPs who were said to be thoughtful, thorough and always caring.

Patients knew they could have someone present at their consultation if required and were able to speak in a private area if necessary. They were satisfied with the cleanliness of the environment and the facilities. There were mixed responses on whether it was easy to see the GP they wanted to see and some said they had to wait a long time for an appointment with a specific GP. Two comments stated that appointments were always available for their children whenever they were requested.

We reviewed the practice's annual survey and action plan. Patient concerns related to a lack of appointments outside working hours, opening times, staff training and confidentiality at reception. However there was positive feedback about appointments as well and comments about happy and helpful staff. The practice provided solutions through an action plan and shared that with patients through a newsletter.

We reviewed the results from the latest GP Survey where 107 responses out of 363 were received. This was a 29% completion rate. The practice scored well in the following three subjects although the responses were still less than the local and national average:

96% of respondents had confidence and trust in the last nurse they saw or spoke to

Local (CCG) average: 96% National average: 97%

81% of respondents say the last GP they saw or spoke to was good at giving them enough time

Local (CCG) average: 84% National average: 87%

80% of respondents say the last GP they saw or spoke to was good at explaining tests and treatments

Local (CCG) average: 84% National average: 86%

The practice scored less well on comments relating to appointments and had made changes to address these concerns. We saw a mixture of positive and negative reviews left by patients on the NHS Choices website.

Areas for improvement

Action the service SHOULD take to improve

- Introduce an effective system to identify and recall patients who do not attend for scheduled and follow up appointments such as health checks, repeat blood tests, cervical smears and immunisations.
- Review and introduce an effective system to show that all information required, in line with legislation, is available in respect of each person employed.

Outstanding practice

- The practice ran a bi-monthly carer support group which brought carers together for support and discussion. Members of the group reported the positive impact on their lives.
- The practice established "Singing for the Brain"; a weekly singing session to help patients with memory problems and dementia. This was run by a singing music therapist offered to patients from other local practices.

Florence House Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor and a practice manager specialist adviser as well as an expert by experience. An expert by experience is someone who has used health and social care.

Background to Florence House Medical Practice

Florence House is a long established family practice. Three generations of GPs from the same family have provided medical care to the residents of Higher Openshaw, Manchester, over a period of 80 years. They are based in an area of high deprivation with a growing practice list of 8130 patients offering services to a multi-cultural population with many asylum seekers. There are three male GPs and one female GP. Two new female GPs were recently recruited to serve the growing population. (At the time of inspection they had not started their employment).

Other staff include a full time and part time practice nurse, a part time assistant practitioner and a part time health care assistant. There are staff dedicated to specific roles such as discharge care co-ordinator and cancer champion, clinical coder and prescription manager. There is a practice manager and deputy practice manager along with several other reception and secretarial staff. The practice will also begin training junior doctors in August 2015.

The practice is open to patients from 8am until 6pm Monday and Friday, 7.30am till 5.30pm on Tuesday and 7.30am until 7.30pm on Thursday. On Wednesdays they open at 8.30am and close at 1pm unless for baby clinics which are held until 4pm. The practice have adjusted their appointment system so that working patients can be seen outside of working hours. All consultations are by appointment. When the surgery is closed patients are signposted to the GP out of hours services.

Clinics and services include consultations for long term conditions, contraceptive care, antenatal, postnatal and children's care, immunisations and vaccinations. District nurses, health visitors and midwives are attached to the surgery. The practice also offer travel advice and travel vaccinations and prescriptions can be requested online and obtained at a pharmacy of choice.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information about the 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.

We carried out an announced visit on the 11th June 2015. We reviewed information provided on the day by the practice and observed how patients were being cared for.

We spoke with 16 patients, including six members of the carers' group and interviewed 12 members of staff. The range of staff included GPs, the advanced practitioner, health care assistant, prescriptions clerk, discharge co-ordinator, receptionists and the practice and deputy practice manager.

We reviewed 13 Care Quality Commission comment cards where patients and members of the public had shared their views and experiences of the service. We also looked at the Friends and Family Test and results from the GP National Patient Survey.

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

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

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

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

Good

Are services safe?

Our findings

The Practice had a system in place for reporting, recording and monitoring significant events which they logged in an on-line tool available to all staff. The practice also used a range of other information to identify risks and improve patient safety. These included national patient safety alerts, comments and complaints received from patients, an incident and accident book and feedback from staff throughout the practice. All staff we spoke with, clinical and non-clinical, were aware of their responsibility to raise concerns which they could do through a form on their computer or refer directly to the practice managers. These were collated on the practice system and shared with the Clinical Commissioning Group (CCG). The practice held regular clinical, managerial, governance and training meetings and we saw evidence in minutes of those meetings that events of significance were discussed.

Learning and improvement from safety incidents

We reviewed the log of significant events sent to us before the inspection and again with one of the GPs on the day. These were kept in a shared folder accessible by all staff. The practice were good at recording and reporting events of significance and the log detailed the event, action plan and learning points. There was evidence that the practice had learned from these events and that the findings were shared with relevant staff. We saw evidence of action taken as a result such as changes in working practice, discussions with pharmacy about medicine errors, discussions with suppliers in relation to needle stick injuries and new systems to ensure any re-occurrences were reduced in the future. Where patients had been affected by something that had gone wrong, in line with practice policy, we saw that they were given an apology and informed of the actions taken.

Significant events were a standing item on the practice clinical meeting agenda and the practice also held regular learning and training initiative meetings where they considered different scenarios and what to do when things went wrong. Staff were encouraged to raise concerns in a blame free culture. Events of significance were also shared appropriately with the CCG through their incident reporting system.

Safety alerts and updates such as those from the National Institute for Health and Care Excellence (NICE), The Medicines and Healthcare products Regulatory Agency (MHRA) and the General Medical Council (GMC) were distributed appropriately and monthly pharmacy reports were received by the prescriptions manager. All these were discussed with the relevant members of staff and changes made when required.

Reliable safety systems and processes including safeguarding

There was a system in place to identify and follow up disadvantaged children and who were at risk. Accident and Emergency (A&E) and Out of Hours (OOH) reports were reviewed to identify if follow up at the practice was required. A leaflet was devised to offer advice regarding the appropriate use of A&E and what to do when the practice was closed. There was a safeguarding lead within the practice trained to the appropriate level 3 and all other staff were trained to the appropriate levels. Update training was disseminated in-house at meetings and during teaching sessions. We spoke with staff who understood their responsibilities in this regard. All staff spoken with knew how to recognise signs of abuse in older people, vulnerable adults and children and who to contact if they had any concerns. Up to date safeguarding policies and procedures, with clear details of lines of contact, were accessible and staff knew where to find them when required.

There was an alert system on the patient electronic record to highlight vulnerable patients and the practice had employed a dedicated clinical coder to ensure that this information was recorded appropriately. This included information to make staff aware of any relevant issues when patients attended appointments such as patients with chronic obstructive pulmonary disorder (COPD) who needed to be seen urgently, over use of A&E or serious cases of domestic abuse. There was also an internal messaging system where clinicians could message each other during consultations if they had any concerns and required support.

There was a chaperone policy, which was visible in the waiting room and in consulting rooms. (A chaperone is a person who acts as a safeguard and advocate for a patient and health care professional during a medical examination or procedure). Nursing and reception staff who acted as chaperones, had been appropriately trained, and were able to describe the correct actions when carrying out the duty.

Good

Are services safe?

This included where to stand to be able to observe the examination and what to do if they had any concerns. They also recorded their attendance at the consultation on the patient record.

Medicines management

We saw that medicines were managed appropriately. Local and National prescribing guidelines were followed and there was a dedicated prescriptions manager. The practice followed policy and protocol supplied by the local hospital and the CCG with regards to the prescribing of antibiotic medicines. A practice protocol was followed for repeat prescriptions and meetings took place with two local pharmacies where best practice was discussed. This ensured that patients received the correct medicines for the correct conditions and were not over prescribed. We saw that these meetings were minuted and learning points were addressed with staff. Changes were made when necessary, for example the practice's hospital prescribing policy which was reviewed and updated in response to a prescribing significant event.

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 nurses and health care assistant were given under a patient group direction (PGD), a directive agreed by doctors and pharmacists which allows nurses to supply and/or administer prescription-only medicines. Processes were in place to check medicines were within their expiry date and suitable for use. Regular weekly stock monitoring meant that medicines were not wasted. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. The practice was registered as a designated yellow fever centre and appropriate documentation was securely kept for patients who required vaccination.

We saw that the cold chain was managed appropriately. The cold chain refers to the process used to maintain optimal conditions during the transport, storage and handling of vaccines, beginning at the manufacturer and ending with the administration to the patient. The practice had recorded a significant event when a fridge had been left open and the cold chain had been broken. They had dealt with the matter appropriately, destroyed any vaccines that had been affected and changed working practice so that re-occurrence of the event was not repeated.

Cleanliness and infection control

Clinic and consulting rooms were clean and free from clutter. The practice had a lead for infection control who had recently undertaken the role and had the appropriate training to enable them to provide advice and educate all staff. An infection control policy and supporting procedures were available for staff to refer to. An infection control audit was required as part of the role and was due to be completed.

All staff received induction training about infection control specific to their role. Staff we spoke to were knowledgeable about how to deal with spills in their areas and knew how to access policy and procedure in the event of a needle stick injury. We were given examples where spills had been dealt with quickly and appropriately.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms and staff and patient toilets.

The entire building was managed by NHS Property Services and cleaners were on site whenever there was someone in the building. Regular checks were carried out in line with policy to reduce the risk of infection to staff and patients. We saw cleaning schedules which evidenced that cleaning was maintained and staff told us the cleaners were very supportive. They provided examples where they had been required and had attended quickly and efficiently to manage the issues. Legionella testing was undertaken and a report sent to NHS Property Services who managed the building. The last report was dated December 2014.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment such as weighing scales, spirometers, blood pressure measuring devices and fridge thermometers.

Staffing and recruitment

Good

Are services safe?

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example references, qualifications, and registration with the appropriate professional body. Newly employed staff we spoke to were able to describe the recruitment process and the documentation requested. Disclosure and Barring Service (DBS) checks were in place and medical indemnity insurances were current. Records reviewed showed that all necessary documentation was either up to date or being actioned. However, pre-employment health checks were not completed.

The practice and deputy managers were responsible for human resources issues and the management of staff. They told us about arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Staff were learning the duties of each other's roles so that continuous cover could be provided if a crisis occurred. A need for extra nursing staff had been identified and was being addressed.

Monitoring safety and responding to risk

There were protocols and systems in place to manage safety and respond to risk. Registers were in place identifying patients living in disadvantaged circumstances, looked after children, patients who were vulnerable and carers. Alerts were placed on patient records to identify these patients to all members of staff. A dedicated member of staff with a patient care co-ordination role identified patients who were at risk of unplanned admissions using a recognised electronic risk stratification tool. Audits had been completed to identify and manage pre-diabetes in the high Asian and African population at the practice.

There were emergency processes in place for patients with long term conditions such as those whose health deteriorated rapidly. The practice nurse held clinics for patients experiencing acute episodes and nurses and GPs gave examples of how they responded to patients experiencing crises, including supporting them to access emergency care and treatment.

There was a health and safety (H&S) policy, building continuity plan and dedicated H&S representative. The NHS property services building manager undertook a weekly walk around of the building to check for any maintenance defects and make sure that all fire exits were clear, a security person was on site, the environment was free of hazards, fire extinguishers were up to date and portable electrical appliances were appropriately tested. The defibrillator and oxygen were checked daily to ensure they were working correctly. We saw that the practice had put up notices in the waiting area advising parents to be vigilant around the stairwells and lifts which were easily accessible to young children.

Arrangements to deal with emergencies and major incidents

There were plans in place to deal with emergencies that might interrupt the smooth running of the service. A continuity and recovery plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. In the event of a member of staff being incapacitated through ill health, no formal arrangements existed, except that other members of staff would cover for the absent staff Each staff member held contact details for every other staff member on a credit-card sized contact sheet.

We saw fire safety checks were regular and full fire drills had been carried out. Fire marshals were in place and staff were able to describe what would be done in the event of fire. This ensured that staff could evacuate the building in the event of any emergency. We saw that a fire evacuation chair existed on the upper floor of the building but established that no staff training had been undertaken in its use.

Emergency equipment including a defibrillator and oxygen were easily accessible, and staff had received training in how to use the equipment. Staff told us they had training in dealing with medical emergencies including CPR and provided examples where this had been put into practice. Debriefing sessions had taken place following the incidents.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The practice had grown in size and offered services to a multi-cultural population and many asylum seekers who were new to the country. They followed a defined registration protocol to ensure that patients were given a new patient medical and offered NHS health checks where appropriate. This ensured that any health issues were identified at the first consultation to enable long term management. Language barriers were identified so that a need for interpreters could be noted and longer appointments could be offered if required.

The nurses and GPs led in specialist clinical areas such as diabetes, heart disease and asthma and supported each other in these subjects. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. The practice had acknowledged that the GPs and nurses could work better together to support patients with diabetes and had put systems in place to do this. The practice nurse we spoke with was receiving advanced training in this area.

Rapid access appointments were offered for patients with enhanced needs such as long term, mental health and/or learning disability conditions. Monthly multi-disciplinary meetings (MDT) meetings ensured integrated care for older patients and other patients with complex needs.

Management, monitoring and improving outcomes for people

Patients over the age of 75 had a named GP. The practice identified vulnerable older patients and developed individual care plans to support their relevant care needs. They shared these care plans with the out of hours provider and discussed them in MDT meetings with patient consent. Flu, pneumonia and shingles vaccinations were offered in accordance with national guidance. Named GPs were responsible for relevant care homes and carried out visits when requested. Dedicated appointments for elderly patients and visits during daylight hours were provided when required.

The practice had a system in place for completing clinical audit cycles. An audit folder was maintained in a shared electronic folder and we saw several examples of completed audit cycles An example included the monitoring of diabetes and pre-diabetes. Of the patients recorded as having Hba1c within the pre-diabetic range, only 32% of them had been given the correct information and advice. Changes were made to working practice because of these findings. Results of re-audit showed the changes had been successful. The figures increased from 32% to 68% in just 10 weeks.

The previously well managed recall system had broken down, was no longer effective and required review. Previously the practice had recalled patients for cervical smears, blood tests and follow up appointments by pro-actively sending letters and making telephone calls. Due to heavy workload they were no longer doing this and patients were being reminded about follow up appointments using the notes section on their prescriptions. This meant that patients who were not collecting medicines or receiving repeat prescriptions were not being recalled for appointments which they needed to attend.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff and dedicated staff for clinical coding, care co-ordination and prescription management. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. There was a good skill mix among the GPs which included specialist training in ear, nose and throat conditions (ENT), cardiovascular medicine,

Good

Are services effective?

(for example, treatment is effective)

musculoskeletal and sports medicine and widespread exposure to hospital medicine. One of the salaried GPs had special interests in general medicine and mental health and held a diploma for family planning and sexual health.

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

The practice were up to date with annual appraisals which included personal development plans to identify and implement learning requirements. Training and learning was disseminated through scenario based discussions.

Administration and reception staff were able to cover each other's roles and those we spoke with felt enabled to do this. A more recently recruited member of staff we spoke with confirmed they had received induction, training and continuing support from other members of staff and always felt able to ask for help if and when required.

Working with colleagues and other services

The practice had introduced the role of care co-ordinator who provided a person-to-person contact service for patients who were over 75 years, vulnerable patients of all ages and patients with cancer. They chaired all the multi-disciplinary team meetings which were well attended by health visitors, district nurses, Macmillan nurses, GPs and active case managers. The meetings, which had been increased from quarterly to monthly, were relevant, concise and informative and ensured a failsafe system for two week referrals. We saw minutes from those meetings which evidenced positive outcomes for the patients concerned. All clinicians attended regular safeguarding meetings where they reviewed Accident and Emergency (A&E) and Out of Hours (OOH) reports to identify if follow up at the practice was required.

Information sharing

Staff had an internal messaging system to inform each other of alerts, actions required, or relevant information about patients. This meant that immediate action could be taken when required. For example a nurse in consultation with a patient could receive immediate advice from a GP without leaving the consultation. Letters, hospital discharges and other patient information was scanned into the patient record or downloaded from the local hospital system. Discharge letters were reviewed by the GPs and changes to repeat medication, follow up tests and reviews were arranged as appropriate. All information from the Out of Hours Service was sent electronically through their internal system.

Referrals were managed mostly through the Choose and Book System and secretaries were able to speak to consultants and other hospital staff to chase referrals on behalf of patients and monitor receipt of any urgent information.

One of the GPs attended a local prescribing sub-group and shared information received therefrom to increase knowledge about prescribing within the practice.

Consent to care and treatment

The practice had a policy and protocol which provided explanation about the different types of consent. Staff we spoke to were familiar with the policy and provided appropriate examples where consent was requested and obtained. Clinical staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and a good example of how this knowledge was put into practice was observed during the inspection. Administration staff had received awareness of the Mental Capacity Act through in-house awareness sessions.

Patients we spoke to told us they were treated appropriately by staff, were involved in decisions about their care and treatment and were given explanations. We discussed different scenarios with the nursing staff who were able to demonstrate their understanding of the different types of consent and how they would obtain it during treatment such as providing vaccinations or taking bloods. Alerts on the patient record or through the internal messaging system informed clinicians about registered carers or advocates who may be asked to articulate on a patient's behalf.

We saw that enough information was provided to patients to enable them to make informed choices.

Health promotion and prevention

Good

Are services effective?

(for example, treatment is effective)

A self-care room had been set up to encourage patients to learn more about managing their own health. This was particularly useful for the hard to reach patients. A range of patient leaflets and information were freely available and if any concerns, such as high blood pressure readings, were identified, there were notices to advise the patients what they should do. Clinicians were always available should the need arise.

The practice website contained information about long term conditions, self-care management and signposting to various other support groups.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Staff understood and respected people's personal, cultural, social and religious needs and took them into account when making appointments or discussing treatment. We saw that the practice had a mixture of patients with different beliefs and staff explained how they dealt with these. Male and female clinicians were available and chaperones were offered to protect patients and staff during intimate procedures. We saw that staff took time to interact with people who used services and included those close to them such as family and carers.

We observed that patients were treated with dignity and respect by reception staff who were considerate and helpful. Staff presented a professional attitude and received customer care training which they had completed. Staff had also completed equality and diversity training.

Patients were happy that they had enough privacy and consultations were carried out behind closed doors where conversations could not be overheard.

Care planning and involvement in decisions about care and treatment

Patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice reasonably well in these areas. 80% of patients said that the last GP they saw or spoke to was good at listening to them compared to the CCG average which was 84% and the national average of 87%.84% said the same of the nurse compared with the CCG and national average at 91%

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. The results from the GP survey were less positive. Only 71% said the last GP they saw or spoke to was good at involving them in decisions about their care compared to the CCG average of 79% and the national average of 81% and 73% said the last GP they saw or spoke to was good at treating them with care and concern compared to the CCG average of 83% and national average of 85%. Patient feedback on the comment cards was positive.

Patient/carer support to cope emotionally with care and treatment

The discharge co-ordinator contacted patients when they returned home from a stay in hospital. We spoke to the member of staff who held this role and heard examples about how their input had positively impacted on patient care. For example, if a patient's medicines had been altered during their stay in hospital, the co-ordinator found out immediately and made sure that the patient understood what changes had been made. The co-ordinator contacted the patients as soon as a discharge sheet was received from the hospital and made sure that any follow up care was in place. If a patient required monitoring by the practice their details were passed to the necessary clinician and a follow up appointment was arranged.

The practice was successful in running a carers' coffee morning and support group for the past few years. This had been co-ordinated and chaired by a member of staff who was a carer themselves. The topics and speakers were chosen by the carers themselves. Every Christmas the staff at the surgery brought raffle prizes and everyone who attended the coffee morning was given a raffle ticket and a gift. Feedback from the carers was that the emotional support was very helpful and they would be lost without it. Citizens Advice held a weekly session at the practice which was accessible by the practice patients. The GPs undertook post bereavement reviews of patients' mood and social circumstances and sent cards of condolence.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had a high proportion of patients of African and Asian descent, patients whose first language was not English and a high intake of asylum seekers. Staff had protocols to follow for the registration of patients who did not have a permanent address and knew who to contact to check data where patients were unable to provide it. New patient packs were given to all patients containing information about the practice. In addition a leaflet explaining how the NHS works was translated in each patient's native language during new patient medical consultations. Non-English patients were asked to point at their national flag through which messages were then translated into their native language. Patient needs were reviewed during consultations and if circumstances changed then appropriate treatment was offered.

The practice provided evidence which showed that it was responsive to their practice population's needs and had systems in place to maintain the level of service provided. The needs of the patients were understood and systems were in place to address identified needs in the way services were delivered. The GPs engaged regularly with the Clinical Commissioning Group to discuss local needs and service improvements were prioritised. In response to concerns about appointments the practice had introduced dedicated appointments around mid-morning for children under five years, daily at lunch time for elderly patients and daily at 4.30pm for school children. Working patients could be seen at 7.30am and 6.30pm but currently there were only two slots per week available at these times with the GP and nurse.

Tackling inequity and promoting equality

Patients who did not speak English had access to translation services and information which was available in different languages. We saw staff dealing with language communication difficulties during the inspection and saw they were handled appropriately.

Staff had undertaken training in equality and diversity and we observed during the inspection how this knowledge was put into practice whilst dealing with many different patient cultures. All patients were treated with the same respect, dignity, compassion and empathy. Patients we spoke with, from a variety of backgrounds, reported positively about the way they were spoken to, treated and cared for.

The premises were purpose built to meet the needs of people with disabilities. There was a suitable entrance at the front of the building for wheelchairs and a lift to the second floor. A hearing loop, which is assistive listening technology for individuals with reduced ranges of hearing, was available at reception. The waiting area was large enough to accommodate patients with wheelchairs, mobility scooters and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing and breast feeding facilities.

Access to the service

The practice was open to patients from 8am until 6pm Monday and Friday, 7.30am till 5.30pm on Tuesday and 7.30am until 7.30pm on Thursday. On Wednesdays they opened at 8.30am and closed at 1pm unless for baby clinics which were held until 4pm. The practice had adjusted their appointment system so that working patients could be seen outside of working hours on Thursdays. All consultations were by appointment and when the surgery was closed patients were signposted to the GP out of hours services.

Dedicated appointment slots had been introduced for children under 5, elderly patients, school age children and working patients. Rapid access appointments were offered for patients with enhanced needs such as long term, mental health and/or learning disability conditions.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England. There was a designated person who handled complaints in the practice. We reviewed the log of complaints sent and received feedback from patients who had made complaints to the practice. We saw that these were dealt with appropriately and that the patients were kept informed of action taken until a satisfactory outcome

Good

Are services responsive to people's needs?

(for example, to feedback?)

was reached. The practice had responded to negative comments about appointments by increasing dedicated appointments and creating an information leaflet to explain how the appointment system worked.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a business development plan which detailed their vision and strategy for the next two years. The purpose of the plan was to set out clear objectives and the changes required to achieve those objectives. Staff we spoke with were clear about the practice vision and held the partners, managers, and their peers in high regard. The practice aimed to deliver high quality care and promote good outcomes for patients and staff were encouraged to be a part of the future plan. All the staff understood their areas of responsibility and took an active role in providing a high level of service on a daily basis. The staff we spoke with felt valued and included in how the service should be developed.

The practice demonstrated that they were interested in the views of their patients and they did this through various areas of feedback such as the carers' forum, patient reference group (PRG) feedback forms, patient surveys and other questionnaires. Staff who had been employed for many years were proud of their positions and new staff said there was a helpful, honest, friendly and approachable culture.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at many of these policies and procedures which were up to date and had been shared with staff. Staff we spoke with said they knew where the policies were and how to access them when required and each had their own personal pack to refer to. All staff were provided copies of the policies and procedures on induction and we spoke to a new member of staff who confirmed this.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. Each GP carried out an audit to monitor performance as part of their annual appraisal. The practice was proactive in areas such as their discharge co-ordinator, prescribing (where they had reduced their budget by £100k) and medicines management in patients discharged from hospital. Where patients were discharged from hospital new protocols had been introduced to ensure that they received positive and early interventions.

Leadership, openness and transparency

There was a new leadership structure which was in its infancy. The long-standing lead partner had retired and new leads and seniors had stepped into the roles. Staff we spoke with said they knew who to go to with regard to different issues such as safeguarding, infection control or practice concerns. They reported that the management structure worked well and described all their colleagues as helpful, open and approachable. The practice also held regular governance meetings where performance, quality and risks were discussed.

The practice managers were responsible for human resource issues and were aware of their responsibilities in this regard, such as responding to whistleblowing and employee performance management. There had been one recorded issue and we saw that this had been dealt with appropriately and openly. However, closure had not been reached for all parties concerned as feedback/outcome had not been shared. We discussed this during feedback and the practice acknowledged it. The practice managers were also responsible for ensuring that the nurses' professional registration was checked, hepatitis B status was kept up to date, Disclosure and Barring Service (DBS) checks were in place and medical indemnities were current. Records reviewed showed that all these were either up to date or being actioned.

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

One of the aims of the surgery was to work more closely with patients and enter into discussion about changes that could be made to improve services. There were currently 209 patients in their virtual patient reference group. Continuous efforts were made to encourage younger age groups and different cultures to the group. This was done through the surgery website, leaflets and prompts by clinicians during consultations. Letter invitations were also sent out to a number or patients.

The practice had responded to their in-house patient survey and feedback from patients. They had made changes to improve their appointment system and re-surveyed patients to see if they had benefited. 51% commented that they had received a benefit and felt that the appointment system was improving. They had also

Are services well-led?

Good

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

created a private area for patients to speak with reception staff to increase confidentiality, provided customer care training for their reception staff and issued name badges for all staff in response to feedback from patients.

Management lead through learning and improvement

We looked at the staff training matrix. We saw that staff were trained to the appropriate levels for their roles and had received expected mandatory training such as cardio pulmonary resuscitation (CPR), Fire, Health and Safety, safeguarding and infection control.

Regular staff training events took place on Wednesday afternoons and the practice administration team had been undertaking National Vocational Qualifications in Customer service, Team Leadership and Business Management for the past 18 months. All had been successful in obtaining their qualifications.

The practice nurses attended peer meetings where they identified training needs which were then supported by the GPs. The practice nurse we spoke with provided examples whereby a clinical audit had created a training need in the administration of insulin because of a high number of the practice population who had diabetes. Once the training was complete, patients would receive a much improved service with reduced waiting times for treatment.

The assistant practitioner reported that they had been mentored throughout their five year employment with the practice from receptionist in 2009 to a qualified assistant practitioner in 2014. They were now going back to being a full time student to train as a nurse. They told us they had not known this was their path when they started and felt very appreciative that the practice had encouraged and supported them into this new career.

The practice had been accredited to undertake training of junior doctors and two new trainees were due to begin their training in August 2015.