Knowsley 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.

Ratings

Overall rating for this service	Good
Are services safe?	Requires improvement
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 Knowsley Medical Centre on 27 May 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. We found the practice required improvements for safe. It was also good for providing services for the populations groups we rate.

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.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand, with evidence demonstrating that the practice responded quickly to issues raised.
- Patients' views on the appointment system varied. Many patients were happy with the system and found it easy to make an appointment with a clinician, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management.

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

Importantly the provider must:

- Ensure checks are carried out on portable electrical equipment and calibration of medical equipment is undertaken.

Summary of findings

- Ensure the recruitment and selection of staff is carried out in line with policies and procedures including Disclosure and Barring Service (DBS) checks on clinical staff. Ensure checks are routinely carried out to ensure clinical staff are registered with their appropriate professional bodies.

In addition the provider should:

- Staff acting as chaperones should have access to appropriate guidance.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated via team meetings to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Recruitment and selection systems were not in line with practice policy. Checks had not been carried out to ensure portable electrical equipment was safe, and medical equipment had not been calibrated for over 18months. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were the same or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. Staff had received training appropriate to their roles and any further training and updates had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans in place for staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for caring. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS England Area Teams and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised.

Summary of findings

Are services well-led?

Good

The practice is rated as good for well-led. The practice had clear aims to deliver good outcomes for patients. Staff were clear about the aims and their responsibilities in relation to the practice. There was a clear leadership and staff felt supported by management. The practice had a number of policies and procedures to govern activity. There were systems in place to monitor and identify risk. The practice sought feedback from staff and patients and this had been acted upon. Staff had received inductions, annual appraisals and attended staff meetings.

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 population group of older people. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example in dementia, shingles vaccinations and end of life care. The care for patients at the end of life was in line with the Gold Standard Framework.

The practice was responsive to the needs of older people, the GPs and nurse provided home visits with rapid access appointments for those with enhanced needs. Using a risk stratification tool, the practice had identified patients who appeared to be medium to high risk of hospital admission. Patients at risk are supported alongside GPs and other health and social care providers to develop personalised care plans. One GP was allocated as standard with 15 minute appointments to support the most vulnerable patients.

The practice had achieved 60% vaccination rate for the influenza vaccine for those over 65, below the local average.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed longer appointments and home visits were available. The practice has an electronic register of patients with long term conditions and has a recall system in place to ensure patients are called for a review annually so their condition could be monitored and reviewed.

The national Quality Outcome Framework (QOF) 2013/14 showed majority of clinical outcomes for patients with long term health conditions were above or the same as the local CCG. For example 100% of outcomes for patients with asthma or Chronic Obstructive Pulmonary Disease (COPD) had been achieved, however for diabetes and dementia the practice outcomes were below the local average.

A GP lead clinic was provided weekly with longer appointments for patient with multiple long term conditions.

For those people with the most complex needs GPs worked with relevant health and social care professionals to deliver a multidisciplinary package of care.

Summary of findings

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up vulnerable families and who were at risk.

A contraceptive service was available which included counselling for options such as long acting reversible contraception such as implants and coils.

Babies were seen in the assessment clinic run by the Health Visitor and GP for all babies between the ages of 6 and 8 weeks. Post-natal reviews and immunisation clinics were provided.

Immunisation rates were high for all standard childhood immunisations and where children and babies failed to attend for immunisations they would be followed up by the practice nurse. The practice are to introduce more clinics for children during school holidays following the successful trial earlier in the year. All of the staff were responsive to parents' concerns and would ensure parents could have same day appointments or telephone consultations for children who were unwell.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age people (including those recently retired and students). The practice offered online services as well as a full range of health promotion and screening which reflects the needs for this age group. Patients were provided with a range of healthy lifestyle support including smoking cessation. The practice offered NHS health checks to patients including elderly health checks to patients who are 60 plus and not reached the age of 75.

Appointments could be booked online or via telephone 48 hours advance. Early morning appointments were available three days a week as well as telephone consultations to accommodate patient's needs.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice had carried out annual health checks for people with learning disabilities and offered longer appointments for people where required. For patients where English was their second language, an interpreter could be arranged.

The practice worked with multi-disciplinary teams in the case management of vulnerable people.

Staff knew how to recognise signs of abuse in vulnerable adults and children.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). The practice maintained a register of patients who experienced mental health problems. The register supported clinical staff to offer patients an annual appointment for a health check and a medication review. The practice worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia.

The practice had sign-posted patients experiencing poor mental health to various support groups and voluntary organisations, including referrals to counselling services. For children and young people, referrals were made to the child and adolescence mental health service (CAMHS).

The practice worked with a voluntary organisation to specifically identify patients with or at risk of dementia in the South East Asian communities and have been running a walk in clinic for those who are concerned about possible memory problems. From April 2015, GPs engaged with a local dementia diagnosis and management enhanced service which meant more patients could be diagnosed and managed at the practice by familiar GPs rather than going to secondary care.

For patients who experienced difficulties attending appointments at busy periods they would be offered appointments at the beginning or end of the day to reduce anxiety.

Summary of findings

What people who use the service say

During our inspection we spoke with 16 patients. We reviewed six CQC comment cards which patients had completed leading up to the inspection.

The 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.

Feedback included individual praise of staff for their care and kindness and going the extra mile. We reviewed the results of the GP national survey carried out in 2013/14 and noted 80% described their overall experience of this surgery as good and 97% had confidence and trust in the last GP they saw or spoke to.

Areas for improvement

Action the service MUST take to improve

We saw maintenance contracts were in place for all equipment and appropriate fire safety checks, gas and electric checks had taken place, however we noted checks had not been carried out on portable electrical equipment and the calibration of medical equipment was over 12 months out of date. Following our inspection the practice manager arranged for PAT testing to take place and told us they were in the process of arranging for equipment to be calibrated.

There were formal processes in place for the recruitment of staff to check their suitability and character for employment. The practice had a recruitment policy in place which was up-to-date, however we found that the policy and procedure had not been followed for staff recently recruited. We looked at the recruitment and personnel records of five staff, including two recently appointed staff, we found several gaps including gaps in references, induction checklists not completed, professional registration for nursing staff not being checked and a Disclosure and Barring Service (DBS) check had not been carried out for one member of clinical staff. It was also noted annual checks were not carried out on nursing staff to ensure they had maintained their registration with the professional body, The Nursing and Midwifery Council (NMC).

Action the service SHOULD take to improve

Chaperones were available for patients, staff had received chaperone training, however they told us when acting as a chaperone they would stand outside of the dignity curtain. General Medical Council (GMC) Intimate examinations and chaperones (2013) guidance advises that chaperones should: 'stay for the whole examination and be able to see what the doctor is doing, if practicable.' Following our inspection the practice manager provided us with a revised policy reflecting current guidance and had arranged new training for staff.

Knowsley Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor, practice manager and an expert by experience. Experts by Experience are members of the public who have direct experience of using services.

Background to Knowsley Medical Centre

Knowsley Medical Centre provides primary medical services in Bury from Monday to Friday. The practice is open between 8.30am – 6.00pm Monday to Friday.

Knowsley Medical Centre is situated within the geographical area of NHS Bury Clinical Commissioning Group (CCG).

The practice has a General Medical Services (GMS) contract. The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities.

Knowsley Medical Centre is responsible for providing care to 4600 patients of whom, 52% are male and 48% are female. Patients are from the third most deprived decile. Approximately 35% of patients were black and minority ethnic (BME) , mainly Pakistani heritage.

The practice consists of three GPs, two female and one male, a practice nurse and health care assistant. The practice was supported by a practice manager, receptionists and secretaries.

When the practice is closed patients were directed to the out of hours service.

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.

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 27 May 2015. We reviewed information provided on the day by the practice and observed how patients were being cared for.

We spoke with 16 patients and nine members of staff. We spoke with a range of staff, including the GPs, practice manager, practice nurse, health care assistant and reception staff.

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

Detailed findings

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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Requires improvement

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and spoke with staff which confirmed incidents were routinely discussed. This showed the practice had managed these consistently over time and demonstrated a safe track record over the long term.

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 investigated complaints and responded to patient feedback in order to maintain safe patient care.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording significant events, We saw from the practice significant events records and speaking with staff investigations had been carried. All staff told us the practice was open and willing to learn when things went wrong.

Staff told us they received updates relating to safety alerts they needed to be aware of via meetings and emails. The nurses told us they received regular updates as part of their ongoing training, self-directed learning and attending learning events.

Reliable safety systems and processes including safeguarding

The 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 and vulnerable adults' policy and procedure incorporating the Mental Capacity Act 2005 within the adults safeguarding policy. Where concerns already existed about a family, child or vulnerable adult, alerts were placed on patient records to ensure information was shared between staff to ensure continuity of care.

We spoke with the GP who was the safeguarding lead; they had completed adult and children's safeguarding training. All other staff had completed safeguarding training delivered by the lead GP and practice manager.

Chaperones were available for patients, staff had received chaperone training, however they told us when acting as a chaperone they would stand outside of the dignity curtain. General Medical Council (GMC) Intimate examinations and chaperones (2013) guidance advises that chaperones should: 'stay for the whole examination and be able to see what the doctor is doing, if practicable.' Following our inspection the practice manager provided us with a revised policy reflecting current guidance and had arranged new training for staff.

Medicines Management

The practice held medicines on site for use in an emergency or for administration during consultations such as administration of vaccinations.

The nurse practitioner was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed. The health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that the nurse and health care assistant had received appropriate training to administer vaccines.

We saw emergency medicines were checked to ensure they were in date and safe to use, however we noted there were needles used to administer emergency drugs were out of date, these were removed and replaced immediately. We checked a sample of medicines and found these were in date, stored safely and where required, were refrigerated. Medicine fridge temperatures were checked and recorded to ensure the medicines were being kept at the correct temperature.

We saw an up to date policy and procedure was in place for repeat prescribing and medicine review.

Requires improvement

Are services safe?

The practice had identified a higher than average number of patients had been prescribed Benzodiazepine, for long periods of time, which can lead to addiction. Benzodiazepine should be prescribed for short periods to ease symptoms of anxiety or sleeping difficulty. As a result the practice was working with patients on a reduction programme and offering patients the support of an external drugs counsellor to support them to reduce and ultimately cease taking the medication.

Speaking with reception staff they explained to us the system in place to ensure where changes to prescriptions had been requested by other health professionals such as NHS consultants and/or following hospital discharge, the changes were reviewed by the GP daily and the changes implemented in a timely manner. We were shown the safety checks carried out prior to repeat prescriptions being issued and where there were any queries or concerns these were flagged with the GP before any repeat prescriptions were authorised.

The practice maintained a register to track prescriptions received and distributed. This was kept separate from the prescription pads which were securely locked away. Prescription pads held by the GP were locked away. A nominated member of staff was responsible for prescription ordering and management of prescriptions.

We saw prescriptions for collection were stored behind the reception desk, out of reach of a patient. Reception staff we spoke with were aware of the necessary checks required when giving out prescriptions to patients who attended the practice to collect them, i.e. date of birth, address of patient.

Cleanliness & Infection Control

The practice was seen to be clean and tidy. The nurse took the lead for infection control and actioning the outcomes of the infection control audit. We noted the actions following the last audit in 2013 had been completed.

Cleaners were employed by the practice who attended every day. There was a cleaning schedule in place to make sure each area was thoroughly cleaned on a regular basis. We looked in several consulting rooms, including the treatment room. All the rooms had hand wash facilities and work surfaces which were free of damage, enabling them to be cleaned thoroughly.

We saw the dignity curtains in each room were disposable with notices displayed showing when they required replacing.

All the patients we spoke with were happy with the level of cleanliness within the practice.

We saw up to date policies and procedures were in place. The policy included protocols for the safe storage and handling of specimens and for the safe storage of vaccines. These provided staff with clear guidance for sharps, needle stick and splashing incidents which were in line with current best practice.

All staff we spoke with were clear about their roles and responsibilities for maintaining a clean and safe environment. We saw rooms were well stocked with gloves, aprons, alcohol gel, and hand washing facilities.

The practice only used single use patient instruments, we saw these were stored correctly and stock rotation was in place.

Equipment

We saw maintenance contracts were in place for all equipment and appropriate fire safety checks, gas and electric checks had taken place, however we noted checks had not been carried out on portable electrical equipment and the calibration of medical equipment was over 12 months out of date. Following our inspection the practice manager arranged for PAT testing to take place and told us they were in the process of arranging for equipment to be calibrated.

All staff we spoke with told us they had access to the necessary equipment and were skilled in its use.

A panic alarm system was in place in consulting rooms and behind reception for staff to call for assistance.

Staffing & Recruitment

There were formal processes in place for the recruitment of staff to check their suitability and character for employment. The practice had a recruitment policy in place which was up-to-date, however we found that the policy and procedure had not been followed for staff recently recruited. We looked at the recruitment and personnel records of five staff, including two recently appointed staff, we found several gaps including gaps in

references, induction checklists not completed, professional registration for nursing staff not being checked and a Disclosure and Barring Service (DBS) check had not been carried out for one member of clinical staff.

Following our inspection the practice manager provided evidence for some of the gaps including interview summaries, references and a record of clinical staff Hepatitis B immunisation, which were not within the personnel files at the time of our inspection.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. The practice had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

The practice manager had responsibility for all maintenance contracts and risk management associated with the building. We saw that data sheets were not in place for Control of Substances Hazardous to Health (COSHH), we raised this with the practice manager who told us they would address this immediately following our inspection.

The practice manager had clear staffing levels identified and procedures in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness; this was recorded within the business continuity plan. Staff told us they worked together to manage staff shortages and plan annual leave so as not to leave the practice short of staff.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and resuscitation equipment. When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

We saw emergency procedures for staff to follow if a patient informed staff face to face or over the telephone if they were experiencing chest pains, this included guidance form the Resuscitation Council and calling 999 for patients where required. Staff were able to clearly describe to us how they would respond in an emergency situation.

A business continuity 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 the building management, CCG and associated health and social care professionals.

Records showed that staff were up to date with fire training and fire drills were carried out.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs, nurse and health care assistant 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. 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 clinicians that they completed thorough assessments of patients' needs in line with NICE guidelines.

The nurses we spoke with explained how they reviewed patients with chronic diseases such as asthma on an annual basis. The national Quality Outcome Framework (QOF) 2013/14 showed majority of clinical and public health outcomes had been achieved above or the same as the local CCG. For example 100% of outcomes for patients with asthma or Chronic obstructive pulmonary disease (COPD) had been achieved, however for diabetes and dementia the practice outcomes were below the local average.

Speaking with the GP and nurse they were aware of the challenges in achieving the outcomes for patients with diabetes and discussed the challenges of the population group in complying with healthy lifestyle advice due to cultural identity. We were provided with a number of examples of patient education they were providing during consultation. The practice also referred patients to external education programmes and health trainers to help patients understand diet and lifestyle choices. We were told they were monitoring QOF data in year and we saw initial data in year showed improvements had been made.

We saw the practice maintained a register of patients with a learning disability to help ensure they received the required health checks and annual reviews. For patients with learning disabilities or poor mental health again the practice had achieved 100% of outcomes higher than the local or national averages.

We saw from QOF that 100% of child development checks were offered at intervals that were consistent with national guidelines and policy.

Clinical staff were able to describe to us how they assessed patient's capacity to consent in line with the Mental Capacity Act 2005.

The practice worked within the Gold Standard Framework for end of life care, where they held a register of patients requiring palliative care. A pathway was in place to enable appropriate referrals and support packages for patients at the end stages of life. Multi-disciplinary palliative care review meetings were held with other health and social care providers. Individual cases were discussed regularly between clinical staff to ensure patients and relatives needs were reviewed on a regular basis to meet patient's physical and emotional needs and ensured that whenever possible patients die in the place of their choosing.

We were told for patients where English was their second language an interpreter could be booked in advance or accessed via the telephone. This was in line with good practice to ensure people were able to understand treatment options available.

Management, monitoring and improving outcomes for people

Speaking with clinical staff, we were told assessments of care and treatment were in place and support provided to enable people to self-manage their condition, such as asthma or COPD. We saw asthma plans for example were in place for children.

A range of patient information was available for staff to give out to patients which helped them understand their conditions and treatments. The practice nurse provided a range of examples of patient information leaflets they provided to patient to self manage conditions such as COPD and asthma.

Staff said they could openly raise and share concerns about patients with colleagues to enable them to improve patient's outcomes.

The practice showed us how they monitored patient data which included full clinical audits taking place which demonstrated changes to patient outcomes. Clinical audit is a process or cycle of events that help ensure patients receive the right care and the right treatment. We were shown a number of audits including patients at risk of diabetes and a review of patients diagnosed with cancer.

The practice used the information they collected for the QOF and their performance against national screening

Good

Are services effective?

(for example, treatment is effective)

programmes to monitor outcomes for patients. QOF was used to monitor the quality of services provided. The QOF report from 2013-2014 showed the practice was supporting patients with long term health conditions such as, asthma and for patients with COPD above the local CCG and national average.

The practice was also ensuring childhood immunisations were being taken up by parents. NHS England figures showed in 2014 94% of children at 24 months had received the measles, mumps and rubella (MMR) vaccination, slightly below the local average of 95%

Information from the QOF 2013-2014 indicated the practice had maintained a high level of achievement with 98% of outcomes achieved above the local CCG and national average.

Patients told us they were happy the doctor and nurses at the practice managed their conditions well and if changes were needed they were fully discussed with them before being made.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw evidence staff had attended mandatory courses such as annual basic life support and safeguarding. We noted a good skill mix among the doctors, nurse and health care assistant with a number having additional training and qualifications. All GPs were up to date with their yearly continuing professional development requirements and all either had 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 practice and remain on the performers list with NHS England). We noted however annual checks were not carried out on nursing staff to ensure they had maintained their registration with the professional body, The Nursing and Midwifery Council.

Speaking with staff and reviewing records we saw all staff were appropriately qualified and competent to carry out their roles safely and effectively. The practice had an appraisal system in place for all staff.

The nurse practitioner was expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and treating minor ailments.

All staff we spoke with told us they were happy with the support they received from the practice. Staff told us they received updates and new guidance during team meetings and via email. The practice had recently implemented monthly protected education and meeting time to ensure all staff had access to training and updates as part of their professional development.

Working with colleagues and other services

We found staff at the practice worked closely as a team. The practice worked with other agencies and professionals to support continuity of care for patients and ensure care plans were in place for the most vulnerable patients. Mutli-disciplinary meetings were arranged with other health and social care providers where required and communication took place on a daily basis with community midwives, health visitors and district nurses by telephone and fax. A fortnightly joint clinic was held between health visitors and GPs and from June 2015 midwives would be based within the practice.

The practice worked with other service providers to meet patients' needs and manage patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The GPs took the lead responsibility for reading and acting on any issues arising from communications with other care providers on the day they were received and disseminating to appropriate staff for action such as reception staff to arrange appointments or home visits. All staff we spoke with understood their roles and felt the system in place worked well.

The practice was able to refer patients to receive support from the community drug and alcohol services and where appropriate accommodated drug workers at the practice to meet the needs of patients.

Information Sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to

Good

Are services effective?

(for example, treatment is effective)

enable patient data to be shared in a secure and timely manner. The practice sent referrals directly to a central referral unit and those referrals such as two week wait referrals were sent electronically.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

The GPs described how the practice provided the 'out of hours' service with information, to support, for example 'end of life care.' Information received from other agencies, for example accident and emergency or hospital outpatient departments were seen and actioned by the GP on the same day. Information was scanned onto electronic patient records in a timely manner.

The practice worked within the Gold Standard Framework for end of life care (EoLC), where they provided a summary care record and EoLC which was shared with local care services and out of hour providers.

Consent to care and treatment

A procedure was in place for staff in relation to consent for procedures such as minor surgery and incorporated a detailed consent form for patients to sign, however there was no policy in place which gave guidance to staff on areas such implied consent, how to obtain consent, recording consent, consent from under 16s and consent for immunisations.

Speaking with staff they were clear about their responsibility to gain and where required record consent. We found staff were aware of the Mental Capacity Act 2005 (MCA), the Childrens' Acts 1989 and 2004 and their duties in fulfilling it. Clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice, this included best interest decisions and do not attempt resuscitation (DNACPR). Clinical staff had received training in relation to the MCA.

All clinical staff we spoke with 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 allows professionals to demonstrate they have checked the person understands of the proposed treatment and consequences of agreeing or disagreeing with the treatment. Where capacity to consent was unclear staff would seek guidance prior to providing any care or treatment.

Health Promotion & Prevention

New patients looking to register with the practice were able to find details of how to register on the practice website or by asking at reception. New patients were offered an appointment for a health check.

The practice had a range of written information for patients in the waiting area which could be taken away on a range of health related issues, local services health promotion and support for carers.

We were provided with details of how staff promoted healthy lifestyles during consultations. The

clinical system had built in prompts for clinicians to alert them when consulting with patients who smoked or had weight management needs. We were told health promotion formed a key part of patients' annual reviews and health checks.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed 85% of patients eligible to health checks took up the offer.

The nurse and health care assistant provided lifestyle advice to patients this included, dietary advice for raised cholesterol, alcohol screening and advice, weight management and smoking cessation. Referrals were made to health trainers in the community to provide additional support to help patients maintain healthy lifestyles.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice had achieved 60% vaccination rate for the influenza vaccine for those over 65.

A children's immunisation and vaccination programme was in place. Data from NHS England showed the practice was achieving high levels of child immunisation including the MMR a combined vaccine that protects against measles, mumps and rubella. We saw from QOF 100% of child development checks were offered at intervals that are consistent with national guidelines and policy. There was a clear policy for following up non-attenders by the practice nurse.

Good

Are services effective?

(for example, treatment is effective)

The practice's performance for cervical smear uptake was 75%, lower than the local and national averages.

The practice was proactive in following up patients when they were discharged from hospital. When the practice received a discharge letter from the hospital, details were passed onto the GP and where any follow up was required staff would arrange an appointment or home visit.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & 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 16 patients and reviewed 6 CQC comment cards received the week leading up to our inspection. All were positive about the level of respect they received and dignity offered during consultations.

The practice had information available to patients in the waiting area and on the website that informed patients of confidentiality and how their information and care data was used, who may have access to that information, such as other health and social care professionals. Patients were provided with an opt out process if they did not want their data shared.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located at reception and a back office, staff told us and we observed, where any private conversations were required these were transferred to the back office to maintain privacy.

We observed staff speaking to 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 a private area.

Patients we spoke with gave positive feedback about the helpfulness and support they received from the reception staff. Looking at the results from the GP national survey, 94% of respondents found the receptionists at this surgery helpful above the local CCG average.

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

We found all rooms had dignity screens and lockable doors in place to maintain patients' dignity and privacy whilst they were undergoing examination or treatment.

Care planning and involvement in decisions about care and treatment

The patients told us they were happy to see any GP or nurse as they felt all were competent and knowledgeable.

Patients we spoke with told us the GP and the nurses were patient, listened and took time to explain their condition and treatment options. The results from the GP national survey 97% had confidence and trust in the last GP they saw or spoke to and 95% had confidence and trust in the last nurse they saw or spoke to, above the local CCG average.

We saw from The Quality and Outcomes framework (QOF) data for 2013/14, 92% of patients with poor mental health had a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate; this was above the local and national average.

The practice had formal care plans in place for patients; they included care plans for vulnerable patients over 75 year of age, patients with poor mental health and those patients at risk of unplanned hospital admissions.

We noted where required patients were provided with extended appointments for example reviews with patients with learning disabilities, required an interpreter or multiple conditions to ensure they had the time to help patients be involved in decisions. One GP was routinely allocated 15minute appointment as opposed to standard 10 minute appointment to support the care and treatment of vulnerable patients and those with multiple long term health conditions.

Patient/carer support to cope emotionally with care and treatment

All staff we spoke to were articulate in expressing the importance of good patient care, and having an understanding of the emotional needs as well as physical needs of patients and relatives.

From the GP national survey 96% of respondents stated the last GP they saw or spoke to was good at listening to them, 93% say the last GP they saw or spoke to was good at giving them enough time and 91% said the last nurse they saw or spoke to was good at giving them enough time, all above the local CCG average.

Good

Are services caring?

Patients who were receiving care at the end of life were identified and joint arrangements were put in place as part of a multi-disciplinary approach with the palliative care team.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs.

The practice worked with patients and families and also worked collaboratively with other providers in providing palliative care and ensuring patient's wishes were recorded and shared with consent with out of hours providers at the end of life.

The practice made reasonable adjustments to meet people's needs. Staff and patients we spoke with provided a range of examples of how this worked, such as, opportunistic screening and reviews, accommodating home visits, booking extended appointments and arranging translators.

We saw where patients required referrals to another service these took place in a timely manner.

A repeat prescription service was available to patients, via the telephone, website, and a box at reception or requesting repeat prescriptions with staff at the reception desk. We saw patients accessing repeat prescriptions at reception without any difficulties.

The practice had a well established patient reference group (PRG); the group were representative of the patient population and used a variety of methods to engage members such as face to face and email. The group met regularly to discuss outcomes and actions as a result of practice surveys and questionnaires and were active in reviewing the practice appointment system.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities or those who required an interpreter. The majority of the practice population were English speaking patients, for all other non-English speaking patients a translation service was available.

We were provided with a number of examples where the practice supported patients to access services, for example a deaf patient who could only communicate face to face.

The practice supported the patients by offering longer appointments at the surgery and used text messaging to communicate regarding appointments, reviews, results and hospital appointments.

The practice was over two floors with patients accessing services on both floors. For those patients unable to negotiate the stairs they would be seen within one of the ground floor consulting rooms. The practice was accessible for patients with disabilities. A disabled toilet was available as were baby changing facilities.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

Access to the service

The practice is open between 8.30am – 6.00pm Monday to Friday. Urgent on the day appointments could be booked on the day, with children and vulnerable adults always seen on the day where required. Appointments were pre bookable online or via the telephone for appointments in 48 hours up to two weeks. The nurse practitioner operated a telephone consultation service for minor illness and where required an appointment would be made with a GP or nurse. Where all appointments were booked details would be passed to GPs, or the nurse practitioner to speak with the patient, to see if an urgent appointment would be required. Patients were also referred to the local walk in centre should the practice have no appointment available.

Appointments with the nurse and health care assistant were available Monday to Friday and could be pre booked.

Patients' views on the appointment system varied with many patients happy with the system. We saw from the GP national survey 80% were able to get an appointment to see or speak to someone the last time they tried. 89% said the last appointment they got was convenient and 67% were satisfied with the surgery's opening hours, all were below the local CCG average. The practice worked with the PRG to improve access by introducing 48 hour pre bookable appointments, in addition to this the practice introduced a GP lead long terms conditions clinic, and for one GP all appointments were 15 minutes to enable those patients with complex needs to have the time required to discuss treatment options.

Comprehensive information was available to patients about appointments on the practice website. This included information about the appointment system and home visits.

Good

Are services responsive to people's needs?

(for example, to feedback?)

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed, this information was detailed on the practice website. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances.

Longer appointments were available for patients who needed them for example those with long-term conditions, patients with learning disabilities or patients who required a translator. This also included appointments with a named GP or nurse.

Listening and learning from concerns & complaints

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

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 investigated with actions documented. Lessons learnt were shared with staff.

Patients we spoke with told us they knew how to make a complaint if they felt the need to do so, speaking with reception staff they told us any verbal complaints or issues they felt could be resolved informally they would give patients the option of speaking with the practice manager at the time to resolve any concerns.

We saw where patients left comments on NHS choice, and here comments constituted a complaint, patients were invited to contact the practice manager.

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 clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice statement of purpose. The practice aims and objectives included: 'To provide the best possible quality service for our patients within a confidential and safe environment by working together,' and 'To involve our patients in decisions regarding their treatment.' We saw this demonstrated in the way staff interacted with patients and spoke of the professional relationship developed with patients over a number of years.

We spoke with eight members of staff and they all expressed their understanding of the aims and objectives, and the value placed on being a friendly 'family' practice. We saw evidence of the latest guidance and best practice being used to deliver care and treatment.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff electronically on any computer within the practice. We looked at several of the policies and saw these were up to date and reflected current guidance and legislation; however we noted there was no policy for consent or equal opportunities.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a GP partner was the lead for safeguarding. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

We identified some areas of improvement were required in relation to the recruitment and selection of staff, which included seeking references and disclosure and barring check on clinical staff. Following our inspection the practice manager provided evidence of actions taken to improve on comply with regulations associated with the recruitment of staff.

The practice used the range of data available to them, to improve outcomes for patients and worked with the local CCG. The practice also used the Quality and Outcomes Framework (QOF) and General Practice Outcome Standards (GPOS) to monitor quality and outcomes for patients such as services for avoiding unplanned admissions.to measure their performance. The QOF 2013/14 data for this practice showed it was performing in line with national standards achieving 98% of outcomes, above the local and national average. One GP took the lead within the CCG for long term health conditions and the practice were actively involved in local pilots, using a risk tool to identify patients who appeared to be medium to high risk of hospital admission.

The GPs met on a daily basis to discuss patient care and seek advice and guidance from colleagues. The practice manger and GPs met regularly to discuss practice issues, practice development. In May 2015 the practice took the decision to have monthly protected time, in which the practice would close to allow staff to meet and for learning events to take place. These monthly events would be minuted and reviewing the minute of the initial meeting we noted the complaints policy and complaints were discussed as well as the safeguarding policy and training.

All staff told us of an open culture among colleagues in which they talked daily and sought each other's advice.

From the summary of significant events we were provided with and speaking with staff we saw learning had taken place. The GPs within the practice conducted individual clinical audits, in which outcomes were shared to monitor quality and share learning.

The practice had arrangements for identifying, recording and managing risks. The practice manager provided us with details of the maintenance and equipment checks which had been carried out in the past twelve months. We noted that checks on portable equipment had not been carried out and the calibration of clinical equipment was over 12months out of date. Following our inspection the practice provided evidence of checks being carried out on portable equipment and told us they were arranging for calibration to take place as soon as possible. We also noted there were no data sheets or risk assessments in place for Control of Substances Hazardous to Health (COSHH).Leadership, openness and transparency

The GPs met daily. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues with GPs or the practice manager, staff told us there was never a time when there was no one to speak to seek support, advice or guidance.

Are services well-led?

Good

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

We were told that staff as part of induction had access to policies and procedures and all staff were able to access policies and procedure via the policies and procedure file, located in reception, which included sections on health and safety, equality, leave entitlements, sickness, whistleblowing and bullying and harassment. Staff we spoke with knew where to find these policies and new members of staff confirmed they formed part of the induction process, however this had not been formally recorded on staff induction checklists.

Practice seeks and acts on feedback from users, public and staff

The practice had gathered feedback from patients through the national patient survey, The NHS friends and family test, internal questionnaires, compliments and complaints.

We saw that there was a complaints procedure in place. We reviewed complaints made to the practice over the past twelve months and found they were investigated with actions documented with lessons learnt shared with staff.

We reviewed the results of the GP national survey carried out in 2014/15 and noted 80% described their overall experience of the practice as good and 63% would recommend this surgery to someone new to the area, both below the local CCQ average. In January 2015 the practice began to ask patients to participate in the friends and family test (The NHS friends and family test (FFT) is an opportunity for patients to provide feedback on the services). We saw since January 2015, out of three responses, all selected extremely likely that they recommend the GP practice to friends & family if they needed similar care or treatment.

The PRG carried out an annual survey with patients, The main themes from the feedback in 2014/15 included, more appointments, better access to non-urgent appointments earlier than in a couple of weeks and afternoon blood taking. As a result of the survey the practice had provided 48 hour appointments to improve access for non-urgent appointments and approached the NHS trust to explore the possibility of a second, afternoon collection of blood samples to allow for those patients for whom it was more convenient to attend the practice in an afternoon.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistle blowing policy which was available to all staff electronically on any computer within the practice.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us that the practice was very supportive of training and development opportunities.

The practice had reviewed significant events and other incidents and shared with staff informally.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 1.Care and treatment must be provided in a safe way for service users. 2. Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— e. ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way; We saw maintenance contracts were in place for all equipment and appropriate fire safety checks, gas and electric checks had taken place, however we noted checks had not been carried out on portable electrical equipment and the calibration of medical equipment was over 12 months out of date. Following our inspection the practice manager arranged for PAT testing to take place and told us they were in the process of arranging for equipment to be calibrated.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed 2. Recruitment procedures must be established and operated effectively to ensure that persons employed meet the conditions in— a. paragraph (1), or b. in a case to which regulation 5 applies, paragraph (3) of that regulation. 3. The following information must be available in relation to each such person employed— a. the information specified in Schedule 3, and

This section is primarily information for the provider

Requirement notices

b. such other information as is required under any enactment to be kept by the registered person in relation to such persons employed.

4. Persons employed must be registered with the relevant professional body where such registration is required by, or under, any enactment in relation to—

a. the work that the person is to perform, or

b. the title that the person takes or uses.

There were formal processes in place for the recruitment of staff to check their suitability and character for employment. The practice had a recruitment policy in place which was up-to-date, however we found that the policy and procedure had not been followed for staff recently recruited. We looked at the recruitment and personnel records of five staff, including two recently appointed staff, we found several gaps including gaps in references, induction checklists not completed, professional registration for nursing staff not being checked and a Disclosure and Barring Service (DBS) check had not been carried out for one member of clinical staff. It was also noted annual checks were not carried out on nursing staff to ensure they had maintained their registration with the professional body, The Nursing and Midwifery Council.