Thornton Practice

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

This is the report of findings from our inspection of Thornton Family Health Clinic. Our inspection was a planned comprehensive inspection, which took place on 12 November 2014. The surgery is run by a large provider called SSP Health Ltd.

Our overall rating of the service is that it provided effective, responsive care that was rated as good. The practice is also rated as good for being well-led.

Our key findings were as follows:

- The locum GPs had been working at the practice for some time and had built constructive working relationships with members of the community nursing teams and with the patients they provided cared for.
- The locum GPs were familiar with governance processes. Patients commented that they valued seeing the same GP on a regular basis.
- Regular practice meetings took place which the locum GPs attended or led on. These enhanced communication to the practice team of areas for improvement at practice.
- Good working relationships were in place between the practice and community nursing and care teams which promoted patient welfare.
- Care plans were in place for those patients deemed to be at risk of unplanned admissions to hospital. Patients we spoke with were able to confirm their involvement in drawing up these care plans.
- Staff were well led by the practice manager and locum GPs. Staff were committed to providing patients with a caring service.

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

Importantly, the provider must:

- Review complaints about patient care and treatment using serious event analysis and investigation systems to promote learning and improve the quality of services.

Summary of findings

In addition the provider should:

- Improve steps to gain patient feedback, such as forming a Patient Participation Group (PPG) for the practice.
- Ensure adequate risk assessments are in place which detail the reasoning for having or not having DBS checks completed on staff who are used to chaperone patients.
- Provide practice level peer review and clinical supervision of GPs work.

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 provision of safe care and treatment. Systems were in place to report, record and investigate any serious events. The process for doing this was understood and followed by staff. Lessons were learned and communicated widely to support improvement. Information about safety was monitored and shared. The practice did not treat some complaints about patient outcomes and patient care, as serious events. This meant learning opportunities were missed. The practice did not provide a system of peer review and clinical supervision of GPs work at practice level.

Are services effective?

Good

The practice is rated as good for providing effective services. Care and treatment was delivered in line with best practice guidance. Information from a number of sources was used to drive improvement and a provider level system of clinical audit was in place to review the care and treatment delivered to patients. Data was used to provide focus on areas for improvement. Administrative and nursing staff were supported and received the training they needed to carry out their duties. Patient appointment systems were managed effectively to meet the needs of the patients.

Are services caring?

Good

The practice is rated as good for the provision of caring services. Patients we spoke to on the day of our inspection and those who had completed Care Quality Commission comment cards, described staff as being caring, respectful and thoughtful towards patients. Staff we spoke to were clear about their duty to protect confidential information. Patients told us they were offered a more private room to discuss any concerns they had if they were uncomfortable doing this at the reception desk.

Are services responsive to people's needs?

Good

The practice is rated as good for the provision of responsive services. Appointment availability was reviewed on a regular basis to check for any rise in demand. Appointments could be booked on- line, in person or by phone. Staff responded quickly to any cancelled appointments so that these were made immediately available to other patients. When required, patients were offered a double appointment to allow them sufficient time with the GP to discuss their health and care needs.

Summary of findings

Are services well-led?

Good

The service is rated as good for being well-led. The long term locum GPs and the practice manager provided clear leadership for all staff at the practice. The nursing staff worked well with other community clinicians who shared the building the practice was located in. Arrangements were in place to support any new staff through induction and to provide staff with mentors to help develop their skills.

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 needs of older patients were met. All patients over the age of 75 years had a named GP. Data available to us before our inspection showed that the practice had performed well in the referral of patients who had showed symptoms of dementia. The rate of patients diagnosed was significantly higher than the England average. This meant those patients who received a diagnosis could be properly treated and supported. The practice worked well with community clinicians to deliver planned care for older patients.

People with long term conditions

Good

The practice nurses ran effective disease management clinics. All newly registered patients completed a health questionnaire, which asked patients to highlight any long term health conditions they had. Staff used this information to update disease registers and ensure patients had access to nurse or GP appointments so their condition could be assessed. We saw that patients had regular reviews of their medication to ensure it continued to meet their needs.

Families, children and young people

Good

Patients in this population group were well served by the practice. The percentage of patients registered with the practice, between the ages of 0 -19 years old was in line with the England average. The practice nurse delivered childhood vaccinations and immunisations, along with other adult immunisations. Appointments were sufficiently well managed to allow for emergency cases, for example any child that needed to be seen by a GP on that day. The practice had systems in place to capture and follow up on patients who had not attended appointments. This supported safeguarding systems in place for any child or young person that was subject to a safeguarding plan.

Working age people (including those recently retired and students)

Good

The practice provided services which met the needs of this population group. Extended hours surgeries were available on one morning and one evening in the week. Staff worked hard to ensure that these appointments were used by patients who's working or educational commitments meant they could not attend the practice in normal working hours. A range of health screening initiatives and clinics were available to patients from this group, including well man and well woman appointments with the nurse if requested.

Summary of findings

People whose circumstances may make them vulnerable

Good

Staff maintained registers of those patients with learning disabilities. Systems were in place to ensure that these patients received regular health checks. Any patients who failed to attend planned appointments were contacted to organise a further appointment. The practice had worked to ensure continuity of care for these patients.

People experiencing poor mental health (including people with dementia)

Good

GPs used a recognised tool to screen patients who presented with symptoms that may indicate signs of dementia. This had led to timely referrals to the memory clinic where more detailed assessment of the patient could be conducted. GPs told us they were well supported by the community mental health teams, which were based nearby.

Summary of findings

What people who use the service say

Patients we spoke to on the day of our inspection told us they had previously complained about the lack of continuity of care but that this had improved over the last six months. Patients told us the regular locums at the practice had provided a good service and that they felt they received a good standard of care and treatment.

We spoke to six patients in total. One patient told us they received regular medicine reviews and that the GP always gave them sufficient time within the appointment to understand information on what medicines were prescribed and what they were for. Another patient told us they valued the services provided by the practice nurses; the patient confirmed they saw the practice nurse regularly regarding the management of a long-term condition and was given information on how their medicines should be taken to give them the maximum benefit.

We received two Care Quality Commission comment cards, which were available to patients before our inspection. The two responses received referred to patients not being able to see the same GP. Patients we spoke with on the day of our inspection commented that this had improved significantly in the past six months.

Patients we talked with told us they were offered a more private room to discuss any concerns they may have, if they were uncomfortable doing this at the reception desk. A recent patient survey (2014) conducted by the practice, identified this as something patients had not been aware they could ask for if they needed this facility. The feedback to us on the day of our inspection suggested that patients were now better informed about this. In the same patient survey 80% of patients responded that they did not have difficulty getting through to the practice when telephoning to book an appointment. This confirmed the information given to us by patients on the day of our inspection i.e. that only a minority of patients experienced difficulties in getting through to the practice by phone. The practice recognised that there were times of the day when this would happen and ensured that all phones were manned first thing in the morning and in the late afternoon.

Areas for improvement

Action the service MUST take to improve

Complaints about patient care and treatment must be effectively reviewed, investigated and analysed using serious event analysis and investigation systems to promote learning and improve the quality of services for patients.

Action the service SHOULD take to improve

- Improve steps to gain patient feedback, such as forming a Patient Participation Group (PPG) for the practice.
- Ensure adequate risk assessments are in place which detail the reasoning for having or not having DBS checks completed on staff who are used to chaperone patients.
- Provide practice level peer review and clinical supervision of GPs work.

Thornton 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, a practice manager and a second CQC Inspector. 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.

Background to Thornton Practice

Thornton Practice serves approximately 2,500 patients and falls within the Sefton area of Liverpool. The service is delivered by a large provider, SSP Health Ltd, who manage several other practices in the area. Locum GPs deliver clinics throughout the week, with the number of sessions equating to just over one full time GP. The GP team is made up of three long term locums, two female and one male. Two nurses work at the practice to deliver a range of services including regular disease management clinics and delivery of all childhood vaccinations and immunisations.

The practice delivers services under an alternative primary medical services contract (APMS).

The practice operates from a purpose built facility which is shared with the community health team. The building and facilities are step free and accessible for wheelchair users.

The practice does not provide out of hours services. Patients are referred to another provider, Urgent Care 24 (UC24).

The practice falls within the fourth most deprived decile of the deprivation measurement scale used by NHS England. Life expectancy of males in the area is approximately 77 years of age and for females, life expectancy is 82.3 years of age.

We reviewed data from a number of sources before our inspection. The CQC intelligent monitoring placed the practice in band six. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Why we carried out this inspection

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

How we carried out this inspection

Before our inspection we reviewed data from our intelligent monitoring system. We considered the results of the last

Detailed findings

NHS England patient survey, asked patients who use the service for their views, and left CQC comment cards for patients to complete before we visited the practice on 12 November 2014.

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)

During our visit we spoke with a range of staff including two GPs, the practice manager, a regional manager, reception staff and a practice nurse. We spoke to six patients who used the service. We observed how people were being cared for and talked with carers and/or family members. We reviewed CQC comment cards where patients and members of the public shared their views and experiences of the service. We also considered the results of a patient survey conducted by the practice in 2014.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice GPs worked with the provider pharmacist and CCG pharmacist to review patient medications when necessary, for example, on receipt of updated guidance or alerts from the Medicines and Healthcare Products Regulatory Agency (MHRA). The provider used information sources to inform them on areas for improvement. For example using Quality Outcomes Framework (QOF) data to create a QOF diary of areas of healthcare to be prioritised, such as blood pressure monitoring of patients in certain age groups.

Staff we spoke to were aware of their responsibilities to raise concerns, and how to report incidents and near misses. We observed that the locum GPs followed best practice guidance in relation to treatment of patients, and referred to National Institute of Health and Care Excellence. When we reviewed safety incidents we saw that these had been handled consistently. We did find that some complaints, which related to treatment received by patients, had not been treated as serious incidents. These had been treated as a complaint and followed the process for handling a complaint. As a result of this, data available on the safe track record of the practice could be inaccurate.

Learning and improvement from safety incidents

The Practice had a system in place for reporting, recording and monitoring significant events. The process for doing this was understood and followed by staff. We reviewed incidents recorded using this process and found learning was shared between all at the practice, although the two GPs we spoke to told us that they would appreciate more time together to discuss these and the particular outcomes of those incidents. We noted that some complaints received where not treated as serious incidents, for example, those were patient outcomes were affected. Because the complaint process did not include the level of analysis applied to serious events, learning opportunities were missed and any review of care and treatment provided, with a view to making improvements was limited. For example, we reviewed a complaint received by the practice, which related to the treatment of a patient, and the poor outcome experienced by the patient. Information on the patient's health condition was available to a GP. The patient was at greater risk of hospital admission due to this condition. It was apparent that this had not been considered in the treatment of the patient and as a result, the patient ended up being admitted to hospital. Investigation and analysis of this case as a serious event, would have provided learning opportunities for GPs and staff at the practice. Another example we reviewed of the practice treating an incident as a complaint, involved a patient on patient confrontation. This resulted in a GP leaving their treatment room to intervene and try to resolve the matter. The practice had CCTV operational cameras in place; if this was treated as a serious incident, the CCTV footage could have been used to look at how the incident came about and escalated, providing learning opportunities for all.

Reliable safety systems and processes including safeguarding

National patient safety alerts were disseminated by the practice manager to practice staff. These were also reported on by provider level governance teams, who contacted GPs to advise which patients on the practice register may be affected by the alert for example, of it was in relation to a particular medicine they were using. The locum GPs said they found this system worked well for them. Alerts were discussed at practice meetings.

The practice staff had all received safeguarding training for the protection of children and vulnerable adult patients and staff confirmed this was refreshed annually. Staff could name the person who was the lead on safeguarding, and demonstrated that they knew how to raise any concerns. GPs were able to confirm how many children were subject to a safeguarding plan and that they had met their commitments in the production of any reports required by safeguarding review boards. GPs had been trained to an appropriate level in safeguarding.

The practice had a chaperone policy. Some administrative support staff had received chaperone training and confirmed they had been used as a chaperone when a patient had requested this. A risk assessment on whether administrative staff required DBS background checks had been conducted. The conclusion of this assessment was that staff did not need DBS background checks. However the risk assessment used did not mention chaperone duties amongst the tasks performed by those staff. We also found that staff had not recorded the occasions they had been used as chaperones.

Requires improvement

Are services safe?

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so that staff were aware of any relevant issues when patients attended for appointments.

Medicines management

Safety checks on medicines were a routine part of the practice nurse's day. We saw that the medicines storage fridge was adequately stocked and well organised. We saw that temperatures were recorded and monitored. There was an alarm on the fridge which would sound if temperatures went outside of the specified range. The medicines we checked in the fridge were all in date and stored in date order. The nurse told us the safe storage of medicines had been raised at meetings and staff with access to the fridge where aware of the protocol for correct storage.

The practice worked with their own pharmacist who conducted audits at a corporate level to check local prescribing protocols were followed, for example, management of prescriptions for hypnotics and of antibiotics. The pharmacist from the area clinical commissioning group (CCG) also visited the practice on a regular basis to liaise with GPs on any changes to prescribing guidance, for examples in response to MHRA alerts.

Cleanliness and infection control

The practice had infection control policies and procedures in place. Cleaning was carried out by an external contractor. The infection control lead at the practice confirmed that this arrangement had been in place for a number of years and worked well. Cleaning schedules were in place for staff to follow. We saw that checks were in place to ensure standards were maintained. Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff where able to describe how they would use these in order to comply with the practice's infection control policy. Hand hygiene techniques signage was displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Our visual inspection of the building showed that all treatment areas were clean and clear of clutter. Staff confirmed that they had received training on infection control and that this was refreshed on a regular basis.

Equipment

All equipment we checked was clean, in working order and records for maintenance and calibration were available. Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Stocks of items such as syringes were for single use only, and were readily available in treatment rooms. As the practice shared a building with community health clinicians, they were not responsible for the testing and servicing of small portable appliances. However, we checked these and found appliances had been safety tested and there were stickers on these appliances giving the date they must be re-tested by.

Staffing and recruitment

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements. The practice used locum GPs to deliver patient appointments. There were three locum GPs at the practice all of whom had been there for six months or more. This provided continuity of care for patients which had been a problem previously. Patients commented on how much the valued continuity of care. The practice provided us with a copy of a service level agreement issued by the provider to the locum agency. This did not detail what the agency had committed to in terms of sending any replacement locum at short notice. The practice manager told us they had not had an occasion where a locum GP had failed to honour a booking. Therefore, we were unable to confirm that any contingency arrangements in place would be sufficient, for example, if a locum failed to honour a booking.

The locum GPs we spoke with confirmed that there was no clinical supervision in place. There was no system in place to provide peer review of the GPs work. Both GPs we spoke to commented that they would appreciate more time together to discuss patients' needs. The practice used four regular locums. One of the GPs we spent time talking to had worked at the practice for six months but had never met the GP who provided services on the Friday of each week. There was no time built into GPs working hours to allow clinical peer group meetings at the practice. On the day of our inspection, one of the GPs told us they had come in on their own time to attend practice meetings.

Requires improvement

Are services safe?

The practice manager told us that a member of staff was undergoing additional training to take on the duties of a healthcare assistant on a part-time basis. This would provide support for the practice nurse, for example in the collection of blood samples.

We checked the recruitment files of one of the locum GPs. This held details of qualifications, identity checks, information on when their GP re-validation was due, correspondence confirming their entry on the GP performers list and evidence that they had completed on-line training provided by the practice. A copy of the GP's Disclosure and Barring Service (DBS) check was not available for checking but we were able to confirm that they had supplied a copy of their DBS check to the provider. When we checked the staff file of the practice nurse, we saw that all the above documents plus confirmation of up to date professional registration and DBS check were all in place.

We checked recruitment records of three administrative staff who confirmed they had received chaperone training and had performed chaperone duties. All necessary recruitment checks had been conducted. All three files showed a risk assessment had been conducted in relation to the duties they performed and whether or not a Disclosure and Barring Service (DBS) background check should be conducted; the risk assessment did not detail chaperone duties as a task that these staff would perform. DBS checks can help employers decide whether a person would be suitable for work with children and vulnerable adults.

Monitoring safety and 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. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was available for staff to read and a record was kept of staff that had completed on-line health and safety training.

The practice had made arrangements to ensure sufficient staff were available to deliver extended hours appointments. For these, patients could be seen by a GP or nurse. A healthcare assistant would also be available. Consideration had been given to any lone-working and this had been risk assessed by the practice.

The practice kept registers of those patients who may be vulnerable, for example those with mental health conditions, people with learning disabilities, and patients who were also carers for a family member. Patients from these groups were offered a double appointment to ensure they had sufficient time with a GP. A register of patients with long-term health conditions was kept and regularly updated. The nurse used appointments with these patients to conduct reviews of treatment but also to ensure that vaccinations they may require were given at the same time, for example the flu vaccine or shingles vaccine.

Information on patients, for example those receiving palliative care, was regularly updated and shared with out-of-hours services.

Arrangements to deal with emergencies and major incidents

The practice had a business continuity plan; a sister practice close by was paired with Thornton Family Health Centre, in order to provide support in the event of any disruption to the service. 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. Emergency medicines were available in a secure area of the practice and all staff knew of their location. As the practice shared the building with the Liverpool Community Health team there was always nursing presence at the site, which facilitated any emergency medical response whilst waiting for paramedic services.

The practice had an evacuation plan for use in case of emergencies. We also saw that fire drills had been conducted and staff were aware of where the meeting and assembly points where located.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with were familiar with current best practice guidance for the treatment of particular health conditions. Management of chronic health conditions was reviewed on a regular basis to ensure medicines prescribed delivered the best possible outcome for patients. The practice was supported by a medicines management team, which provided information on any patients who may need to have their treatment reviewed, to take account of updates in guidance from the National Institute for Health and Care Excellence (NICE). The GP we spoke with on the day of our inspection was able to provide us with examples of how this worked in practice, and how patients' needs were re-assessed to take account of those updates.

The GPs used a risk stratification tool to help assess patients' needs and plan appropriate care and treatment, including the referral of patients to secondary (hospital) care. The practice had care plans in place for those patients who may be vulnerable to unplanned hospital admissions, for example, older patients or those with multiple health conditions. Practice staff booked appointments that allowed sufficient time for the GP to discuss and plan care for each patient. The GP we spoke with told us they felt this had 'empowered' patients and their carers and that carers had told the GP they felt more comfortable calling the practice for advice if needed.

Patients with a learning disability, mental health conditions, or a diagnosis of dementia had a named GP. These patients were offered longer appointments to ensure sufficient time was available to adequately assess their needs. Patients with multiple health conditions benefited from having all conditions reviewed at the same appointment. Where these patients were seen by a nurse, a follow-up appointment was booked if it was identified that any medication prescribed, needed changing.

Management, monitoring and improving outcomes for people

A provider level system of clinical audit was in place to review the care and treatment delivered to patients. Multiple data sources including Quality Outcomes Framework (QOF) information was used to provide focus on areas for improvement. QOF is a national performance measurement tool. QOF diaries were produced to target particular areas of treatment for review. We were shown an example of a completed cycle of audit on the treatment of patients with urinary tract infections. Small changes to the way patients' treatment was delivered had improved patient outcomes.

Staff we spoke with were able to describe other initiatives the practice was involved in to improve patient outcomes. These included a virtual ward, run by the multi-disciplinary care team. This team worked together to provide care to patients that meant hospital admission could be avoided. There was also an urgent care community team, run by a Geriatrician who could see patients quickly with a view to avoiding hospital admission for elderly patients where possible.

When we reviewed administrative systems in place to support the work of GPs, we saw that all hospital discharge information was handled effectively. These were reviewed by GPs, and any follow-up action was organised. Locum GPs were issued with a locum pack. This contained information on local referral pathways, for example, which organisations patients should be referred to for further treatment. The locum GPs we spoke with had been with the practice for some time, but did comment that this pack could be improved to give more detail and specific named contacts for some of the initiatives described above.

Effective staffing

Administrative and nursing staff were supported and received the training they needed to carry out their duties. The practice manager kept and maintained a training matrix to record training received by staff and to plan training for future dates. Training delivered included safeguarding of children and vulnerable adults, information governance, infection control, moving and handling, equality and diversity and training on the Mental Capacity Act 2005 and gaining patient consent.

The practice had offered a staff member further development and training to become a Healthcare Assistant on a part time basis. This staff member would assist the nursing staff in blood collection and blood pressure monitoring. From staff records we reviewed we saw that staff received regular appraisal and performance review meetings with the practice manager.

Good

Are services effective?

(for example, treatment is effective)

The locum GPs spoke of patient led learning. One of the GPs told us they were due for re-validation in spring of 2015 and described the work they were doing to support this, which was largely self-managed.

Working with colleagues and other services

The locum GPs and the practice nurses worked with other service providers to meet people's needs and manage complex cases. The practice benefited in that the Liverpool Community Health team shared the same building. Staff from that team commented to us during our inspection that this facilitated good communication.

Any tests, X ray results, letters from the local hospital including discharge summaries, and information from out of hours providers were received both electronically and by post. The practice staff were aware of their responsibilities in the passing on, reading and actioning of any issues arising from communications with other care providers on the day they were received. The locum GPs who received these documents and results were responsible for organising any further action required. All staff we spoke with understood their roles and felt the system in place worked well. One of the locum GPs told us the community mental health team, located nearby, offered good support in the care of mental health patients. Patients who may not have attended for planned health checks at the practice, had been followed up by the team, which effectively reduced any risk to the health of those patients.

Information sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's ease of use. Scanned paper communications, such as those from hospital could be saved on the system for future reference.

The practice managed the transfer of information well. Those patients who had moved away from the area and registered with other practices had their information sent on in a timely manner. Similarly, information received from a new patient's former practice was summarised and added to the system without unnecessary delay. Any child or vulnerable adult who was subject to a safeguarding plan was appropriately identified on the system. The practice nurse described how services had been easier to deliver for example, to patients with learning disabilities, through sharing of information. This had allowed the practice to work with carers of those patients to reduce patient anxiety, for example, by staff not wearing a clinical uniform.

The practice kept various patient registers and where necessary, would share details of those patients with out of hour's services. For example, palliative care registers and details of those patients who were expected to pass away during the out of hour's period.

Consent to care and treatment

The GPs and nursing staff at the practice demonstrated their knowledge of consent and other related issues, such as patients' capacity to make informed decisions. The locum GP demonstrated a good understanding of Gillick competency and the Mental Capacity Act 2005. We were told that in any cases where they thought a patient's ability to make an informed decision may be impaired, they could refer patients on to a psycho-geriatrician. The practice had identified those patients who had a lasting power of attorney in place, and this was marked on the patient record appropriately. When we checked training records we could see that GPs and nursing staff had received training on the Mental Capacity Act 2005 and on gaining patients' informed consent.

Health promotion and prevention

All new patients registering with the practice were offered a health check with the practice nurse. The GP was informed of any health concerns detected and these were followed-up in a timely manner. We noted GPs used their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, they offered opportunistic screening of blood pressure and advice on smoking cessation to patients in certain age groups, such as those over 40 years old. Any patients who had missed appointments for cytology screening were booked in with the nurse to have these checks completed. When the practice nurse saw blood testing was required for a number of conditions, collection of multiple blood samples were taken at the initial health check appointment for the convenience of the patient and to use appointments effectively. The practice manager was able to show us systems in place to follow up any patients who failed to attend appointments. Where there was multiple instance of

Good

Are services effective?

(for example, treatment is effective)

failing to attend appointments by a patient, this information was shared at practice meetings. If patients were deemed to be vulnerable or at risk, information was shared with health visitors and community nursing teams.

The patient waiting area of the practice had various health promotion literature displayed and available to patients. There was information on support groups and community services available locally. Any patient who was also a carer for a relative, was flagged on the computer and a carer's register was kept. This ensured that they were offered support, and their own physical health and well-being was monitored. Well-man and well-woman appointments were offered to patients on request. Community dieticians were available by appointment and GPs could offer patients the option of free gym membership to encourage healthier lifestyles for patients.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients we were able to talk with on the day of our inspection, told us they valued the service they received, that staff where always helpful and thoughtful when dealing with them. Patients told us they were treated with dignity and respect. Those patients we spoke to were aware of the chaperone service available and said they would ask for this if they needed it. The practice had conducted its own annual survey. Patients were asked to comment on the level of dignity and respect afforded them during their consultation with the GP or nurse, and that shown to them by reception staff. 99% of patients commented positively on this. Staff were aware of patients need for privacy; we referred to a lower score achieved by the practice in the NHS England GP-Patient Survey 2013-14, which showed patients felt they could be overheard when speaking to staff in the reception area. Staff told us that they would offer patients the use of a quieter room to discuss any queries or concerns. The practice manager told us that staff were instructed to offer this service, rather than waiting to be asked by a patient for use of a quieter room, if they could see that the patient needed more privacy.

Care planning and involvement in decisions about care and treatment

GPs we spoke with on the day of our inspection were able to demonstrate that patients were involved in the planning of their care and treatment. An exercise had just been completed at the practice, to produce care plans for those patients who were deemed vulnerable to admission to hospital. These patients had been offered an extended GP appointment and were invited to attend with their carer if needed. Patients were involved in care aimed at reducing the possibility of them entering hospital. Patients were also given the details of the named GP responsible for their care. Consent issues were also considered when planning care.

We spoke with a patient who was on a number of medications. They confirmed they had received sufficient explanation from the GP on what each medication was for, how it should be taken and told of any possible side effects. The patient told us they were happy with the service they received and spoke positively about the long-term locums who were working at the practice. They felt they were always treated with dignity and respect.

Patient/carer support to cope emotionally with care and treatment

The practice held a register of carers. When the practice received news of a bereavement they would share this with the GP so the carer could be contacted to see if they required any additional support. Services offered included an extended appointment with the GP, referral to counselling services and where appropriate, liaison with community health teams. The notice boards in the patient waiting area of the practice, were used to display contact details of support organisations and community groups, for example, details on how to access respite care services locally.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice nurse described how they met with nurse leads from the local Clinical Commissioning Group. Meetings were used to discuss any trends in patient care demands and they were consulted on what they wanted to cover at future meetings to enable them to meet patient care needs. The locum GPs at the practice at the time of our inspection regularly carried out home visits and sufficient time was allocated from appointments to facilitate this. The GPs also provided care to residents at two local care homes.

Tackling inequity and promoting equality

The practice was able to offer appointments with same gender GPs for those that required or requested this. The practice met the requirements of the Equality Act 2010, having ramp access at the entrance to the practice and bathroom facilities which were wheelchair accessible. All treatment rooms used by the practice were on the ground floor.

Appointments could be booked on-line or by phone. Repeat prescriptions could be ordered on-line or via a named pharmacist. People who were housebound could order their repeat prescriptions over the phone.

The practice allowed extended appointments for those patients that required more time with the GP, for example, those with learning disabilities, patients who came to the practice with carers, and people with mental health conditions. This could have a heavier impact when patients or carers cancelled these appointments but the practice responded quickly whenever possible too offer those appointments to patients that had requested appointments for that day.

The practice did not have patients on its register who were particularly vulnerable due to their circumstances, for example, patients from travelling communities or homeless people. The practice said wherever possible they would aim to meet the needs of those communities. The practice manager demonstrated that they were able to spot patients who may have difficulty reading, and would ensure they received support with completing any paperwork needed. Staff had access to translation services if they were required. The consulting and treatment rooms at the practice were fully accessible to wheelchair users and those patients who used mobility aids.

Access to the service

Appointment availability was reviewed on a regular basis to check any rise in demand. The practice provided extended hours surgeries once a week to meet the needs of those patients who needed to be seen outside of working hours. Appointments could be booked on- line, in person or by phone. Staff responded quickly to any cancelled appointments so that these were made immediately available to other patients. When required, patients were offered a double appointment to allow them sufficient time with the GP to meet their needs. Patients we spoke to on the day of our inspection told us they could get an appointment to see a GP within 48 hours. Patients also told us that if they needed to see a GP urgently, staff would always try to accommodate this. Telephone consultations were also offered.

We saw that patients had good access to secondary services and that referral of patients from the practice was prompt and not unduly delayed. Staff ensured that all information required was sent along with any referral for further investigations or tests. The locum GPs we spoke to were able to demonstrate a good understanding of referral links and care pathways which facilitated prompt referral.

Listening and learning from concerns and complaints

The practice had a complaints policy in place which was written in plain English and easy to follow. Patients we spoke to on the day of our inspection told us they knew how to raise a concern or a complaint and were comfortable doing this. The practice manager dealt with complaints and responded to patients in writing. If further input was needed from a GP, this was included in the response. The practice manager showed us records kept of staff meetings; these showed occasions when complaints had been discussed, what had happened and how the practice had responded. Information on how to make a complaint was available in the practice leaflet which was displayed on noticeboards. Copies of the practice leaflet were available for patients to take away with them.

Patients had previously complained to the practice about the lack of continuity of care provided by different locum GPs. In the past six months, this had improved. At the time

Good

Are services responsive to people's needs?

(for example, to feedback?)

of our inspection, one locum had been delivering services at the practice for 18 months and two further locums had been delivering services for over six months. Patients commented to us on the day of our inspection that they valued the continuity of care now being provided.

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 manager was able to refer to key points of the provider Statement of Purpose. We were told that when staff were supported through appraisal the Statement of Purpose was used as a guide to focus on areas for improvement, for example, areas such as patient involvement and improving communication with patients. The practice manager demonstrated to us how monitoring was in place to ensure key deliverables. For example, numbers of patient appointments in each morning and afternoon session and correct clinical coding input to patient records to facilitate accurate, up to date disease registers. The practice held regular meetings for all staff. These meetings highlighted any initiatives such as seasonal flu vaccinations and staff discussed how best to increase uptake of the vaccine by patients.

At the time of our inspection the practice did not have a Patient Participation Group (PPG). The practice manager had been visiting other practices within the SSP Health Ltd group to see how these worked and to gather ideas on how they could advertise effectively for members to start the group.

Governance arrangements

The practice had a number of policies and procedures in place. These were available to staff via the shared drive on computers within the practice. We reviewed these policies and procedures. Most staff had completed a training record which was dated to confirm they had read and understood the policy. All policies and procedures we looked at had been reviewed and were updated to reflect any change in law, for example on Health and Safety matters.

Staff where clear about their role within the practice and the scope of their responsibilities. Staff we spoke to were able to demonstrate their knowledge of how their daily tasks contributed to the performance of the practice, for example correct clinical coding of patient records.

Leadership, openness and transparency

The locum GPs at the practice provided leadership to all staff. The GP recognised that they could positively contribute to staff morale and spent time at the end of each day with the practice manager and support staff. This GP had identified areas they wished to develop to strengthen clinical leadership at practice level. These included increased clinical liaison between the locum GPs and the practice nurses. The GP commented that they did not have protected time within their working day to formally review and discuss particular patients and their treatments, with the other locum GPs who were providing services. The GP told us they had a very good relationship with community mental health teams and would like to become more involved in the practice meetings at CCG level for the sharing of ideas and best practice in the care of patients.

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

The practice did not have a Patient Participant Group at the time of our inspection. We were told that efforts to start a group had stalled. The practice manager was looking for ways to advertise effectively for members and was gathering ideas from other practices on how this could be done. Views had been gathered using an annual patient survey developed by the practice. Information taken from analysis of patient responses was used to focus on areas for improvement. Progress on these areas was discussed at staff meetings.

Staff we spoke with valued the support and leadership offered by the practice manager. We spoke with two administrative staff in more detail about the leadership of the practice. Both staff members told us they had confidence in the practice manager and said their concerns were listened to and acted upon. Staff told us that the practice manager fostered an open door culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

Management lead through learning and improvement

Staff were offered training and development opportunities. These were considered in line with team objectives and the practice manager's individual performance and review meetings with staff. In examples given to us, we saw that the coding of patient records was reviewed for quality and accuracy, and how further training needs were identified. The practice was actively advertising to patients how many missed appointments there were in each calendar month. The practice was reviewing how effective the cancellation of appointments by texts from patients was. All of this information was used to consider how the practice communicated with patients with the overall objective being to improve services.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The practice is failing to comply with regulation 10(1)(a) and (b) of Health & Social Care Act 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision. The practice had did not have sufficiently robust arrangements in place to identify issues raised in the form of a complaint which should have been treated as serious incidents. As a result, treatment of some patients was not reviewed as part of a serious incident analysis and learning opportunities were limited.