Welton Family Health Centre

Quality Report

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

Summary of findings

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Summary of findings

Overall summary

Welton Family Health Centre serves around 9,400 patients in Welton in Lincolnshire covering an area of approximately 135 square miles. It is registered with the Care Quality Commission to provide the regulated activities of : Diagnostic and screening procedures, family planning, maternity and midwifery services, surgical procedures, and treatment of disease, disorder and injury.

Welton Family Health Centre services are provided by six doctors, a nurse practitioner, nurses, practice managers, administration and reception staff, and dispensary staff. The practice has an on-site dispensing service and is a training practice for GP Registrars who are fully qualified doctors and hope to pursue a career in general practice.

During our inspection we spoke with eight patients and three members of the Patient and Doctors Association (PDA), clinical and non-clinical staff and managers. We received 20 completed comments cards with many positive comments about the service.

We saw that the practice was responsive to the needs of people with long term conditions. People with long term conditions such as diabetes or coronary heart disease received regular reviews of their health conditions at the practice. The practice encouraged people experiencing poor mental health to attend regular health reviews and liaised closely with the mental health recovery teams.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

We found that the services provided by the practice were safe. The practice had effective recruitment procedures in place to ensure that people employed were of good character, had the skills, experience and qualifications required for the work to be performed. However, the practice did not have processes in place for regular checks of clinicians' registration with their professional body in order to ensure staff remained registered, and fit to practice.

We found processes for recording patient safety incidents, concerns and complaints, and near misses were in place. The provider had taken steps to investigate such incidents and inform staff of the findings. There were child and adult safeguarding policies and procedures in place. These were not current and did not reflect working practice and needed review. The policy did not provide staff with current guidance to report on concerns about poor practice or wrongdoing at work. The raising concerns at work (whistleblowing) policy and procedure also needed review.

The practice had not ensured rooms for storing medicines and equipment were held safely, securely and appropriately. However the provider took steps to make improvements during the inspection. The dispensary service was well organised with safe systems and well trained staff. In some parts of the practice the cleanliness and health and safety of the premises were not maintained. We asked for infection control checks and found these had not been completed. Once identified to the practice they took steps to make improvements during the inspection.

Patients told us that they were happy with the care and treatment they received and felt safe.

Are services effective?

The service was effective.

We found the service was providing effective care to a range of population groups with differing levels of need. These included people with long term conditions, older people, and people experiencing poor mental health.

We found staff were appropriately qualified and competent to carry out their roles effectively.

Summary of findings

Staff received a range of training and yearly appraisals which identified any learning needs. An appraisal is where the job performance of an employee is measured and recorded. We found some staff appraisals records needed improvement.

Doctors told us they would meet informally throughout the day to support each other. These meetings provided doctors with the opportunity to discuss patient care, share information, problem solve and ensure consistency of patient care.

Are services caring?

Patients and carers described the service provided as very positive. They told us they found staff caring, and treated them with kindness, dignity and respect. Members of staff we spoke with told us the provider treated them well and co-workers were friendly.

We found an established patient transport scheme run by the patients' group with another service provider. One patient, who was also a transport scheme driver, told us they enjoyed meeting and helping people.

Are services responsive to people's needs?

We found the provider was responsive to patients' needs. They had organised services to ensure they met the needs of different population groups.

The provider regularly reviewed complaints. They had listened and learnt from patients concerns and complaints to improve the quality of care.

Patients were able to make appointments and access the right care at the right time. The practice provided an acute illness service. Reception staff prioritised patients who urgently needed to see a clinician when they contacted the practice, and arranged urgent care to ensure they were seen by a doctor on the same day.

The opening hours to meet the needs of the patient groups were clearly stated in the practice leaflet, on the website and on signs around the practice. Patients we spoke with were clear how to access the out-of-hours service.

Are services well-led?

The service was well-led.

Members of staff we spoke with were positive about working at the practice and felt they were well managed, and there was an open

Summary of findings

and fair culture. Doctors and nurses told us this was a friendly practice and there was “a spirit of openness and for anything to be discussed.” They told us there was a “no blame culture” and were encouraged to ask if they did not know something.

Some staff were unable to perform their full responsibilities around quality and performance arrangements in particular around infection prevention and control.

The Patient and Doctors Association (PDA) consulted regularly with patients and had acted on the results of a recent patient survey and made improvements. This is a group of patients and staff that meet regularly and represent the views of the practice.

Good feedback was shared and celebrated with staff. We saw the results from the last Friends and Family test were positive. The Friends and Family test is a NHS survey which asked patients whether they would recommend the service they received from their GP practice to their friends and family.

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
The service was responsive to the needs of older patients The practice had suitable access for people with wheelchairs. There was one care home for older people located within the practices' area. The second care home is for patients with learning disabilities of all ages. Representatives from these services told us they were in regular contact with the practice and always received a good service including the prescriptions and pharmacy services. Patients usually saw the same doctor and received continuity and a personalised service

People with long-term conditions
The service provided chronic disease clinics throughout the week such as coronary heart disease, asthma, diabetes and hypertension. Some doctors and nurses had specific responsibilities and interest for particularly groups of patients. We found patients had a named doctor or nurse for their long-term conditions.

Mothers, babies, children and young people
We did not inspect this population group at this inspection but will follow this up at the next inspection.

The working-age population and those recently retired
We did not inspect this population group at this inspection but will follow this up at the next inspection.

People in vulnerable circumstances who may have poor access to primary care
We did not inspect this population group at this inspection but will follow this up at the next inspection.

People experiencing poor mental health
The service was responsive to patients experiencing poor mental health. The practice offered regular health care reviews of peoples' conditions, treatment and medication and liaised closely with the mental health recovery teams.

Summary of findings

What people who use the service say

Patients who used the service, their relatives and carers told us staff were kind and caring and found the service met their needs and was well run. Patients said they had not experienced difficulty accessing the service. Some patients told us they had a built a firm relationship with the dispensary staff and valued the service.

Representatives from two care homes located within the practices' area told us they were in regular contact with the practice, and always received an efficient service including the prescriptions and pharmacy services. Patients usually saw the same doctor and received continuity of care.

Members of the Patient and Doctors Association (PDA). This is a group of patients and staff that meet regularly and represent the views of the practice, they told us they provided regular feedback to the provider. PDA members told us they felt their views were encouraged, heard and acted upon. We found there was a wider patient reference group whose members were regularly asked for their views on services within the practice by means of surveys.

The CQC provided comment cards to enable patients and carers to comment upon the service provided by Welton Family Health Centre. Twenty comment cards were returned and were very positive and emphasised a high level of satisfaction for the service and complimented the professionalism of all staff.

Areas for improvement

Action the service COULD take to improve

- The practice could update infection control policies to ensure effective cleaning arrangements and infection control systems are in place.
- Some clinicians told us they did not have "protected time" to undertake monitoring tasks and checks associated with their roles and responsibilities around aspects of medicine management and infection control.
- The safeguarding children and adults policies and procedures could be reviewed to bring them up to date and in line with local area procedures. The whistleblowing policy and procedure were out of date and did not provide staff with contact organisations and current guidance on how to raise concerns at work.
- A complaints procedure could be made available on the practice website.

Good practice

Our inspection team highlighted the following areas of good practice:

- We found the practice had a service of voluntary drivers that escorted patients to hospital appointments across the country including hospitals in London.

Welton Family Health CentreWelton Family Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Lead Inspector and a GP. The team also included a further CQC Inspector a GP and a practice manager who helped us to capture the experiences of patients who used the service.

Background to Welton Family Health Centre

Welton Family Health Centre is situated in the village of Welton in a rural area. The practice serves 9,400 patients covering an area of approximately 135 square miles. The practice is located in converted premises with limited car parking available. The patient area is on the ground floor with suitable access for patients. The practice has an on-site dispensing surgery. Alternatively for those patients who are not eligible to receive their medication at the medical practice there are a number of pharmacies within the area.

Welton Family Health Centre is a training practice with two doctors who are qualified GP Registrar trainers. GP Registrars are fully qualified doctors who hope to pursue a career in general practice and as part of this need to gain experience.

This is our first inspection visit to the Welton Family Health Centre. This area of Lincolnshire where the practice was located is according to government statistics 'affluent with low levels of social deprivation'. The practice does not have many patients with health needs related to their poor social circumstances.

Why we carried out this inspection

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

How we carried out this inspection

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

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

The inspection team always looks at the following six population areas at each inspection:

Detailed findings

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problem.

Before visiting, we reviewed a range of information we held about the Welton Family Health Centre and asked other organisations to share what they knew about the service. We contacted two care homes in the local area, that had patients registered at the practice, to gain their views of the service provided. We also reviewed information that we had requested from the provider.

We carried out an announced visit to the Welton Family Health Centre on 2 May 2014. During our visit we spoke with ten members of the staff team including the general practitioners, practice managers, nurses, trained phlebotomists, reception staff and those staff that dealt directly with patients.

We spoke with eight patients and three members of the Patients and Doctors Association (PDA). We reviewed 20 comment cards where patients had shared their views and experiences of the service. We reviewed information that had been provided to us by the provider and other information that was available in the public domain. We conducted a tour of the practice.

Are services safe?

Summary of findings

We found that the services provided by the practice were safe. The practice had effective recruitment procedures in place to ensure that people employed were of good character, had the skills, experience and qualifications required for the work to be performed. However, the practice did not have processes in place for regular checks of clinicians' registration with their professional body in order to ensure staff remained registered, and fit to practice.

We found processes for recording patient safety incidents, concerns and complaints, and near misses were in place. The provider had taken steps to investigate such incidents and inform staff of the findings. There were child and adult safeguarding policies and procedures in place. These were not current and did not reflect working practice and needed review. The policy did not provide staff with current guidance to report on concerns about poor practice or wrongdoing at work. The raising concerns at work (whistleblowing) policy and procedure also needed review.

The practice had not ensured rooms for storing medicines and equipment were held safely, securely and appropriately. However the provider took steps to make improvements during the inspection. The dispensary service was well organised with safe systems and well trained staff. In some parts of the practice the cleanliness and health and safety of the premises were not maintained. We asked for infection control checks and found these had not been completed. Once identified to the practice they took steps to make improvements during the inspection.

Patients told us that they were happy with the care and treatment they received and felt safe.

Our findings

Safe patient care

We spoke with eight patients and three members of the Patients and Doctors Association (PDA) during the course of our inspection. This is a group of patients and staff that meet regularly and represent the views of the practice. Members of the PDA group told us about equipment and resources they had purchased through fundraising which benefited patients. For example they had purchased an inspection lamp, twelve new chairs for the waiting room, an information screen, fridge thermometers, scales, and notice boards in waiting areas. The PDA also ran a wheelchair hire scheme. We found that the PDA was very active and committed to improving the patient experience.

Patients told us they had been referred for further treatment or specialist advice when such a referral was necessary. Patients told us they were confident when a referral was made it would be followed up with a hospital appointment. We saw from completed comment cards that patients were satisfied they received appropriate referrals. There was a duty doctor system in place to check test results and clinical information on a daily basis.

We found there were regular meetings held by different staff groups for reporting health and safety incidents concerns and near misses. When we asked staff they were able to explain their role in incident reporting, and were encouraged to report and record past safety performance. We saw that safety alerts were received by the practice and shared electronically with the GPs. We looked at audits related to safety alerts and saw that these provided a clear audit trial of actions taken by GPs to ensure patients safety. This ensured that data collected from incidents/events and alerts were monitored, assessed and used to improve patient safety.

Learning from incidents

We found that where accidents, near misses and significant events had occurred in the service these had been documented and learning and action points had been identified. We saw from records that this information was regularly discussed at team meetings with both clinical and non-clinical staff. The practice made staff aware of important information relating to the running of the practice and learning from past events and incidents.

Are services safe?

Safeguarding

The practice had identified two doctors as safeguarding leads for vulnerable children and adults. We found both doctors had received appropriate levels of training for both children and adults. Records showed that other staff had received training in safeguarding people. Members of the Patients and Doctors Association (PDA) told us they had recently completed safeguarding training which would be shared with drivers of the transport scheme. When we asked staff they were able to explain the correct procedure for reporting any concerns. However when we examined safeguarding policies and procedures they lacked detail and depth. The written policies did not reflect what staff had told us about protecting children and adults. We saw the raising concerns at work (whistleblowing) policy was out of date and guidance not current. This meant the approach and systems for safeguarding adults and children needed review. The practice agreed steps would be taken to make these improvements.

Monitoring safety and responding to risk

When the surgery was closed an out-of-hours service was provided by Lincolnshire Community Health Services NHS Trust. The service operated from 6.30pm to 8am Monday to Thursday, 6.30pm Friday to 8am Monday and all public holidays.

We asked staff about responding to emergencies in the practice. They told us an alert was raised and doctors would be immediately called and staff present in the building would assist. We saw a copy of the responding to emergency procedure on the practice intranet. We were told these policies and procedures were still being developed.. The practice was able to respond quickly when a medical situation occurred. Staff told us they had experienced two incidents where they had responded in an emergency. They had followed practice procedures and involved the emergency services.

We found the practice had the right staffing levels and skill mix. We found each clinician had a lead role, for example, chronic disease. There were two practice managers; their role was to make sure the right systems were in place to provide safe patient care. They supported doctors and other clinicians to deliver patients services.

We spoke with both clinical and non-clinical staff who were knowledgeable about prioritising appointments and working with the GPs to ensure patients were seen according to the urgency of their health care needs. There was a duty doctor system in place to ensure that the practice could cover busy periods and any emerging risks to patients throughout the day.

Medicines management

We found the emergency trolley was situated in a corridor accessible to patients and visitors. The trolley stored resuscitation equipment, emergency medicines and included needles and syringes. These items were found to be easily accessible and could pose a risk to patients and visitors. The room where medicines and equipment was stored was next to the emergency trolley. The medicine storage room was found unlocked, although there was a sign on the door which stated the door must be kept locked.

We checked the childhood immunisations and travel vaccines medicines in the two fridges. The medicines we checked were all within the manufacturers recommended use by date. The fridge temperatures were being recorded daily to ensure drugs were kept in optimum condition. We found although the fridges were kept locked, the keys were held in the unlocked medicine storage room. The medicines could be easily accessed and were not held safely.

We asked the practice to take immediate action on the day of our inspection to make improvements to their medicine management systems and to keep patients safe. The room where medicines and equipment was stored was secured and the emergency trolley moved to a locked area. The practice confirmed other steps would be taken to make improvements around medicine management.

We found the dispensary service was well organised with reliable systems and processes. The staff had received on going training, supervision and support.

Cleanliness and infection control

The practice had an identified infection prevention and control lead who had received training. However, infection control and related policies were not dated or review dates set. We found staff had not followed protocols to ensure safe systems were operating. Infection control checks had not been carried out in order to minimise the risk and spread of infection. There were some areas around the practice that were not clean and well maintained. Within one treatment room where patients receive consultation and physical examinations and treatments the curtain rail

Are services safe?

around a treatment couch was thick with dust and debris. Staff told us these curtains were changed every six months for cleaning but we found no evidence of these checks. Surgery was being carried out in these areas and the systems for infection control were not safe for patient care. We found a locked sharps bin on the store room floor which had not been signed and dated by the person who had locked it, in line with the practices' infection control procedures. The practice made improvements on the day of our inspection.

We saw other parts of the premises were visibly clean and well presented in the waiting areas and patients' toilet facilities.

Staffing and recruitment

All staff were subject to recruitment checks to ensure their suitability to work with patients. Checks were undertaken of the GPs and nurses to ensure their fitness to practice, for example checking their General Medical Council registration. These were recorded when clinicians joined the practice. The practice did not perform ongoing checks with their professional body. The practice could not be assured that clinicians were registered, and fit to practice. We asked the practice to carry out these checks during our visit for some named clinicians, to check staff had remained registered and fit to practice. The practice manager confirmed later during the inspection the checks were found to be satisfactory.

We saw some staff recruitment records. We saw enhanced disclosures and baring service (DBS) checks were undertaken for clinical staff to ensure their suitability to work with vulnerable people. We found completed application forms, job descriptions, references and identification checks. The practice told us they intended to risk assess every non-clinical staff member instead of undertaking regular DBS checks.

We found there were separate Induction programmes for different staff roles. We saw a comprehensive induction programme which covered for example Caldicott (the Caldicott report is around the use of patient information and understanding and complying with the law), health and safety, Control of Substances Hazardous to Health (COSHH) and manual handling.

Dealing with Emergencies

The practice had both an emergency and business continuity plan in plan. We found that the plan included details of how patients would continue to be supported during periods of unexpected and /or prolonged disruption to services. For example extreme weather that caused staff shortages and any interruptions to the facilities available.

Equipment

We found from records that equipment on the emergency trolley had been checked, but the checks had not been carried out effectively. There was a defibrillator pad (a defibrillator is a medical device used to restore a patients normal heart rhythm following a heart attack) which had passed the expiry date from April 2014. The spare pad had passed its expiry date of January 2014. We discussed this with the practice at the time of our inspection, and they agreed to take immediate action to resolve the issues we found. The practice did not have current equipment available, or equipment maintenance checks in relation to the emergency trolley. All other equipment was available and procedures for maintenance checks were in place.

Are services effective?

(for example, treatment is effective)

Summary of findings

We found the service was providing effective care to a range of population groups with differing levels of need. For example people with long term conditions, older people, and people experiencing poor mental health.

We found staff were appropriately qualified and competent to carry out their roles effectively.

Doctors told us they would meet informally throughout the day to support each other. These meetings provided doctors with the opportunity to discuss patient care, share information, problem solve and ensure consistency of patient care.

Our findings

Promoting best practice

Doctors told us they would meet informally throughout the day to support each other. For example twenty minutes before surgery started doctors would meet together. This provided doctors with the opportunity to discuss patient care, share information and problem solve. Doctors told us they would "happily" ask for a second opinion of clinicians if required. Regular sharing of information around patient care took place which benefited staff and consistency of patient care. Doctors told us they also followed the electronic guidelines developed and supplied by the National Institute for Health and Clinical Excellence (NICE). This ensured patients' care and treatment was delivered in line with recognised guidance, standards and best practice.

Management, monitoring and improving outcomes for people

We spoke with eight patients, and three members of the Patient and Doctors Association (PDA). The PDA is a group of patients and staff that meet regularly and represent the views of the practice. We also received feedback from the representatives of two care homes for people who used the service. Representatives from the care home and patients told us they had a good relationship with the practice and the doctors and nurses listened to their views, and took these into account when providing care and treatment.

There was a system of audits in place to assure the quality of clinical care and ensure positive outcomes for patients. From minutes of clinical meetings we saw that information from audits were shared and discussed amongst relevant staff. Actions were agreed with regards to specific treatments and therapies if required, in order to improve outcomes for patients. This demonstrated a commitment to improvement. We found that the practice had achieved high scores against the Quality and Outcomes Framework (QOF) audits. We were told by a doctor that they had performed their own audits which they had used as evidence for their appraisal. An appraisal is where the job performance of an employee is measured and recorded.

Staffing

Some clinicians told us they had no "protected time" to undertake administration tasks and checks associated with their roles and responsibilities. They told us they had tasks

Are services effective?

(for example, treatment is effective)

to perform around quality monitoring arrangements. This meant some staff were unable to deliver effective care and treatment which may impact on the quality of care patients received.

We looked at records and found all staff had received annual appraisals with identified objectives and learning needs. An appraisal is where the job performance of an employee is measured and recorded. These were led by the practice manager and a doctor for clinical staff. For non-clinical staff these were led by the practice manager and the deputy practice manager. The practice manager told us she had received her appraisal with one of the doctors.

The nurse practitioner and nurses told us they were able to attend regular meetings and ensure patients' needs were assessed and care and treatment was delivered. One doctor told us they invested, as a priority, in support and training for nurses. Nurses told us they received opportunities for further training and professional development. This ensured staff were appropriately qualified and competent with the right skills and experience.

Working with other services

We saw records that regular joint team meetings took place to discuss end of life care for the terminally ill. These meetings were attended by doctors and representatives of the community care team. We found the practice had developed close working relationships with multi-disciplinary professionals such as community nursing team, community liaison - older people, and mental health teams.

One of the health professionals (not employed by the practice) told us they attended the practice meetings and if not able to attend, was provided with written minutes. A doctor told us they tried to work together as a team and provide a seamless service. We saw evidence of collaborative working between the practice and other healthcare and social care agencies to ensure patients received the best outcomes.

Health, promotion and prevention

A doctor told us about their experience of a home visit to treat a patient who had a stroke and identified the needs of the patient and their carer. The doctor took a holistic approach to both the patients' and carers' needs, by identifying and facilitating the extra support they needed to live healthier lives. The doctor told us this was what he liked about his job, dealing with families and developing relationships.

We spoke with one person who had been a patient for some years and had chronic obstructive pulmonary disease (COPD). They felt the doctors knew enough about their condition but tried to see the same doctor as they knew more about their medical history. They attended the surgery on average once a month. The patient told us their needs were continually assessed. They had an annual medication check with their doctor and six monthly checks with a COPD nurse.

We saw a range of information leaflets and posters in the waiting room for patients to get information about the practice and promoting good health. Information about how to access other healthcare services was also displayed. This helped patients access the services they needed and promoted their welfare.

Are services caring?

Summary of findings

Patients and carers described the service provided as very positive. They told us they found staff caring, and treated them with kindness, dignity and respect. Members of staff we spoke with told us the provider treated them well and co-workers were friendly.

We found an established patient transport scheme run by the patients' group with another service provider. One patient who was also a transport scheme driver told us they enjoyed meeting and helping people.

We found patients had a good relationship with the dispensary and valued the service.

Our findings

Respect, dignity, compassion and empathy

All the staff we spoke with complimented the service and spoke of positive interactions and relationships between staff and patients. We observed staff were polite and friendly in the reception area when greeting patients. We saw staff speak in quiet tones in the reception area with patients so as to maintain confidentiality. We spoke with two patients waiting at the dispensary service. They told us staff were very efficient and they would telephone them directly if they had any issues around their medication. Two other patients told us of their satisfaction for the dispensary service. We found patients had a good relationship with the dispensary and valued the service.

Members of the Patients and Doctors Association (PDA) told us about a recent patient survey. This is a group of patients and staff that meet regularly and represent the views of the practice. Issues were raised around the lack of privacy and confidentiality, practice seating arrangements, and unsightliness of wheelchairs in the waiting room. Acting on the results of the survey, the privacy barrier at the reception area was moved further back, and there was a sign to direct patients who wanted to speak privately to a side window. The waiting room seating arrangements were changed to increase privacy for patients, and the wheelchair area was screened off. We saw these changes when observing the waiting room and reception area and from talking with patients.

We found information in respect of bereavement support available within the practice.

Involvement in decisions and consent

We looked at how the practice involved patients in the care and treatment they received. We were told by patients that we spoke with that they felt listened to and included in their consultations. They told us they felt involved in the decision making process in relation to their care and treatment and were able to ask questions if they had any. They told us their consent to tests and treatment was informed. We were told by staff that patients could see the doctor of their choice, although they acknowledged that patients sometimes had to wait a longer period of time if they wanted to see a specific doctor.

The practice had procedures in place for patients to consent to treatment and a form was used gain the written

Are services caring?

consent of patients undergoing specific treatments, for example minor operations. A doctor described how they managed issues with gaining consent from patients who were unable to read or write. The process in place was clear and documents would document on electronic records the reason why written consent had not been obtained and the reason for accepting verbal consent. This meant that consent to care and treatment was appropriately obtained and recorded. The staff we spoke with were aware of consent issues in respect of children, young people and adults. Clinical staff had been trained in the Mental Capacity Act 2005. The Mental Capacity Act 2005 (MCA) creates a framework to provide protection for people who cannot make decisions for themselves. Doctors would undertake mental capacity assessments. Staff were aware of how this would be affected if the person had (for example) dementia or a learning disability which may affect their ability to retain and weigh certain complex information, and how this would affect their ability to give informed consent to any proposed care or treatment. This meant patients who lacked capacity were appropriately assessed and referred where applicable.

Staff told us there were interpretation services available for people who did not speak English as their first language, for example a telephone language line was available. Staff told us family and friends and advocates were involved as appropriate and according to the patients' wishes in treatment consultations.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

We found the provider was responsive to patients' needs. They had organised services to ensure they meet the needs of different population groups.

The provider had listened and learnt from patients concerns and complaints to improve the quality of care.

Patients were able to make appointments and access the right care at the right time. The practice provided an acute illness service. Reception staff identified people most ill when they contacted the practice and arranged urgent care, and were seen by a doctor on the same day.

The opening hours to meet the needs of the patient groups were clearly stated in the practice leaflet, on the website and on signs around the practice. Patients we spoke with were clear how to access the out-of-hours -service.

Our findings

Responding to and meeting people's needs

The practice provided an acute illness clinic which ran each day early in the morning for a sit-and-wait appointment. A dedicated staff member was based at reception and would arrange for patients most unwell to access the right care and be seen by a doctor on the same day. Patients told us about their experiences using this service. One patient told us it was hard to get an appointment when you were very unwell and wanted to see a certain doctor. They told us in the past they had secured urgent appointments and were seen quickly. Two other patients told us they were satisfied that appointments had been arranged to meet their individual health needs. We found from comments in the patient comment cards people were easily able to contact the practice to make an appointment.

Patients told us opening hours had been extended to 8pm on Monday and 7pm on a Wednesday. This meant the practice made sure patients could access services in a timely way. Other patients told us they were happy with the online booking system. We found there was no telephone triage but the on call doctor provided telephone consultations. Some patients we spoke with confirmed that the practice followed up test results and they felt cared for and supported.

Patients told us and knew about the organisation that provided out-of-hours service when the practice was closed. We saw information about the service was displayed around the practice and in the patients information pack.

Nurses told us they ran clinics for long term health conditions such as asthma, diabetes, minor ailments clinics, disease management, travel health and family planning, and carried out cervical smears. Staff told us they provided personalised care to ensure patients maximised their health and wellbeing and had a good quality of life.

Access to the service

We found that the practice was accessible. Appointments could be made in person, on line or on the telephone. Patients who needed to see a doctor that day would be seen if their needs were urgent. Patients we spoke with told

Are services responsive to people's needs?

(for example, to feedback?)

us that they found the telephone appointment booking system worked well. The practice were able to respond to patients urgent needs or medical emergency appointments promptly.

Concerns and complaints

We found the practice took comments and complaints seriously and patients were listened to. We saw records with the summary of complaints and the learning points for the year. The lessons learnt were evidenced as being discussed in minutes of a partners meeting in June 2013 and a team meeting in April 2014. Information given was all in accordance with NHS complaints procedure regarding timescales and expectations. There was also information available on different stages of the complaints process.

We found the complaints procedure was not on the practice website and patients were directed to the practice.

Ensuring a complaints procedure is made available on the practice website may be helpful to patients. We saw complaints information available displayed in the waiting room and information on support and advice about making a complaint for both PALS (Patient Advice and Liaison Service) and Pohwer (correct spelling) an independent complaints advocacy service. They provide information, advice, support and advocacy to people who experience disability, vulnerability, distress and social exclusion.

One doctor told us this was a responsive practice and they tried hard to respond to patient feedback and change the systems as a result. The issues were often around accessibility.

Are services well-led?

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

Summary of findings

Members of staff we spoke with were positive about working at the practice and felt they were well managed, and there was an open and fair culture. Doctors and nurses told us this was a friendly practice and there was "a spirit of openness and for anything to be discussed." They told us there was a "no blame culture" and were encouraged to ask if they did not know something.

Some staff were unable to perform their full responsibilities around quality and performance arrangements in particular around infection prevention and control.

The Patient and Doctors Association (PDA) a group of patients and staff that meet regularly and represent the views of the practice. The practice consulted regularly with patients and had acted on the results of a recent patient survey and made improvements.

Good feedback was shared and celebrated with staff. We saw the results from the last Friends and Family test were positive. The Friends and Family test is a NHS survey which asked patients whether they would recommend the service they received from their GP practice to their friends and family.

Our findings

Leadership and culture

Staff consistently told us they enjoyed working at Welton Family Health Centre and the friendliness, ethos and leadership style. There was a stable management structure and staff group. We found when concerns emerged during our inspection which identified risks to patient care around medication management; managers were quick to make changes and were open about shortfalls. There was clear leadership, and staff aimed at improving the service and patient experience.

A clinician told us the practice had responded positively when they had requested special equipment to support them in their role. Staff told us they could ask any questions raise concerns and make suggestions and would be listened to and responded to. When they made suggestions at team meetings and it was not agreed to, managers would always explain why. Staff felt supported and that the staff skill mix worked well.

Governance arrangements

The systems to monitor quality were shared between the practice manager and the GP partners. Records confirmed regular reviews of accidents, incidents and significant events which had taken place, including lessons learnt from them. Doctors told us they had a leaders meeting once a month, regular partnership meetings and clinical meetings. They had invited health and social care professionals from other teams to share good practice and promote delivery of high quality care. Doctors told us there was good communication amongst the staff team.

Systems to monitor and improve quality and improvement

<Please describe evidence obtained for KLOE W2. Note - please state whether the provider is a member of Urgent Health UK and participates in external peer review and audit>

Patient experience and involvement

The Patient and Doctors Association (PDA) a group of patients and staff that meet regularly and represent the views of the practice, provided regular feedback to the provider. We found there was a wider patient reference group whose members were regularly asked for their views on services within the practice by means of survey. The membership, at the time of our inspection, was 284

Are services well-led?

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

patients. The deputy practice manager was actively trying to widen the group to be as representative of the patient population as possible, by targeting groups which were under represented. Examples of the varied and innovative ways they had tried to achieve this were by district nurses and doctors giving out sign up forms to housebound patients, adding sign up forms to recall letters, encouraging complainants to participate in the group as a means of having their views represented. The PDA met on a monthly basis and minutes from the most recent meetings reflected liaison with the practice regarding changes to appointment system, fund raising, and information about the transport scheme. The committee members we spoke with reported that they were consulted about potential subjects and questions to be used in future surveys.

Staff engagement and involvement

We found that staff were encouraged to attend and participate in regular staff meetings. We found minutes of meetings included discussions about changes to procedures, clinical practice and staffing arrangements. Staff members we spoke with told us that they felt valued by managers and part of the team.

Learning and improvement

Staff who worked at the practice received appropriate professional development and training. We saw evidence of regular training and course attendance supported by certificates. We spoke with the lead doctor with responsibilities for safeguarding about Deprivation of Liberties (DoLS) training. The Deprivation of Liberty Safeguards are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. The doctor immediately confirmed he had received DoLS training and would share the training materials with the staff group at the next team meeting. This would ensure staff received helpful training.

Identification and management of risk

Appropriate arrangements had not taken place to ensure protected time for relevant staff to complete all the necessary checks in respect of medicine management and infection control. The practice had not undertaken regular checks of clinician's registration with their professional body. Managers confirmed responsibilities were not clear and the risks had not been identified and understood. They confirmed systems would now be put in place to ensure improved patient care.

The safeguarding children and adults policies and procedures had not been reviewed and updated in line local area procedures. The whistleblowing policy and procedure were out of date and did not provide staff with contact organisations and current guidance on how to raise concerns at work.

Older people

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

Summary of findings

The service was responsive to the needs of older patients The practice had suitable access for people with wheelchairs. There was one care home for older people located within the practices' area. The second care home is for patients with learning disabilities of all ages. Representatives from these services told us they were in regular contact with the practice and always received a good service including the prescriptions and pharmacy services. Patients usually saw the same doctor and received continuity and a personalised service.

Our findings

During our inspection staff spoke about clinical staff that supported older people. Members of the team had responsibilities for special treatment clinics. Nurses told us they ran clinics for diabetes, minor ailments clinics, disease management, and health checks for older people. There were joint team meetings with local district nurses and Macmillan nurses. These meetings gave the practice the opportunity to discuss and review patient care. Patients who use the services felt supported and well-cared for.

People with long term conditions

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

Summary of findings

The service was responsive to people with long-term conditions such as diabetes, coronary heart disease (CHD) and hypertension. The service provided chronic disease clinics throughout the week such as coronary heart disease, asthma, diabetes and hypertension. Some doctors and nurses had specific responsibilities and interest for particularly groups of patients. We found patients had a named doctor or nurse for their long-term conditions.

Our findings

Patients we spoke with told us they felt the practice was responsive to their long-term conditions such as diabetes, coronary heart disease (CHD) and hypertension. The practice provided chronic disease clinics throughout the week such as coronary heart disease, asthma, diabetes and hypertension. People who used the services felt supported and well-cared for. They felt staff listened to them and involved them in decisions about their care and treatment

Mothers, babies, children and young people

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

Summary of findings

We did not inspect this population group at this inspection but will follow this up at the next inspection.

Our findings

We did not inspect this population group at this inspection but will follow this up at the next inspection.

Working age people (and those recently retired)

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

Summary of findings

We did not inspect this population group at this inspection but will follow this up at the next inspection.

Our findings

We did not inspect this population group at this inspection but will follow this up at the next inspection.

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

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

Summary of findings

We did not inspect this population group at this inspection but will follow this up at the next inspection.

Our findings

We did not inspect this population group at this inspection but will follow this up at the next inspection.

People experiencing poor mental health

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

Summary of findings

The service was responsive to patients experiencing poor mental health. The practice offered regular health care reviews of peoples' conditions, treatment and medication and liaised closely with the mental health recovery teams.

Our findings

Patients with on-going mental health conditions were invited for physical health checks for care and well being at the practice. There was a follow up process for non-attendance with reminders sent to patients. The practice liaised closely with other health services for example the community mental health team. One doctor confirmed that they visited local care homes to undertake physical health checks for patients who had mental health difficulties. All staff had received safeguarding training from basic to an advanced level which included Mental Capacity Act 2005 training and working with people experiencing mental health illnesses. The Mental Capacity Act 2005 (MCA) creates a framework to provide protection for people who cannot make decisions for themselves.