Townfield Health Centre - Dr Lee

Quality Report

Townfield Close
Prenton
Birkenhead
Wirral
CH43 9JW
Tel: 0151 488 7511
Website: www.townfieldhealthcentre.co.uk

Date of inspection visit: 27 January 2015
Date of publication: 31/03/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This is the report of findings from our inspection of Townfield Health Centre - Dr Lee which is registered with the Care Quality Commission to provide primary care services.

We undertook a planned, comprehensive inspection on 27 January 2015 at the practice location in Townfield Health Centre. We spoke with patients, relatives, members of the patient participation group, staff and the practice management team.

The practice was rated as good. A safe, caring, effective, responsive and well- led service was provided that met the needs of the population it served.

Our key findings were as follows:

- Systems were in place to ensure patients were safe from risks and harm. Incidents and significant events were identified, investigated and reported. Lessons learnt were disseminated to staff. Improvements were needed to ensure staff were safely recruited, including locum GPs. Infection risks and medicines were overall safely managed.
- Patients care needs were assessed and care and treatment was considered in line with best practice national guidelines. Staff were proactive in promoting good health and referrals were made to other agencies to ensure patients received the treatments they needed.
- Feedback from patients showed overall they were happy with the care given by all staff. They told us staff listened to them, were kind, caring and compassionate and treated them with dignity and respect.
- The practice planned its services in response to the differing needs of patients. The appointment system provided access to the service. Patients were encouraged to give their views about the service and the practice listened to them.
- There was a clear leadership structure in place. Quality and performance were monitored, risks were identified and managed. The practice ensured that staff had access to learning and improvement opportunities.

There were some areas of practice where the provider needs to make improvements.

Summary of findings

The provider should:

- Ensure that infection control training and update is undertaken by all staff on a regular basis.
- Ensure that full checks are undertaken on independent locum GPs prior to employment.
- Ensure that the environmental risk assessment is specific to the practice.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

Effective systems were in place to provide oversight of the safety of patients. Incidents and significant events were identified, investigated and reported. Lessons learnt were disseminated to staff. Child and adult safeguarding was well managed, staff were trained and supported by a safeguarding lead and deputy. There were systems in place to protect patients from the risks associated with medicines and cross infection, however staff had not received refresher training in infection control and there was not a formal system in place to ensure prescriptions were checked when they were produced or amended. The staffing numbers and skill mix were reviewed to ensure that patients were safe and their care and treatment needs were met.

Are services effective?

Good

Patients care needs were assessed and care and treatment was considered in line with best practice national guidelines. Staff were provided with the training needed to carry out their roles and they were appropriately supported. Staff were proactive in promoting good health and referrals were made to other agencies to ensure patients received the treatments they needed. The practice monitored its performance and had systems in place to improve outcomes for patients. The practice worked with other health and social care services to promote patient care.

National and local data showed that the practice performed poorly last year for some patient outcome indicators, including the Quality and Outcomes Framework (QOF). This practice had achieved a low score for QOF last year (74%). However we saw evidence that demonstrated improvements had been made for the current year and the practice had implemented plans to achieve targets for these indicators. The practice had identified the specific needs of their patients and was proactive in assessing and planning care particularly for older patients and those with long term conditions.

Are services caring?

Good

Results from the national GP patient survey, patients we spoke with and those who completed the CQC comment cards were positive about the service. They said all the staff were kind, considerate and helpful. They told us they were treated with dignity and respect. We observed a patient-centred culture in which staff provided kind and compassionate care. Staff we spoke with were aware of the importance of providing patients with privacy and respect.

Summary of findings

Are services responsive to people's needs?

Good

The practice planned its services to meet the differing needs of patients. The practice was accessible for people with a physical disability. Staff were knowledgeable about interpreter services for patients where English was not their first language. Access to appointments was good with the practice performing well in patient surveys in respect of this.

Complaints were responded to appropriately and there was an accessible complaints policy and procedure.

Are services well-led?

Good

Staff were clear about and able to articulate the practice values and vision and their responsibilities in relation to these. There was a clear leadership structure with staff taking responsibility for lead roles in the practice. The practice had policies and procedures in place to govern activity. Regular practice and clinical governance meetings took place and were documented. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and acted upon this.

There was an active Patient Participation Group (PPG) which worked well with the practice and were valued and listened to.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice was knowledgeable about the number and health needs of older patients using the service. They kept registers of patients' health conditions and information was held to alert staff if a patient was housebound. The practice had a record of carers and used this information to discuss any support needed. The practice actively promoted carers support services and actively identified and supported people to join carer support groups.

The practice offered a range of enhanced services, for example, avoiding unplanned admissions, and seasonal flu vaccinations. It was responsive to the needs of older patients, and offered home visits and extended appointments for those with enhanced needs. The GPs supported older patients living in care and nursing homes locally. The practice had identified all patients at risk of unplanned hospital admissions. The majority of these patients had a completed care plan to support them and the practice was well on their way to complete care plans for all at risk patients by the end of the year.

The practice safeguarded older vulnerable patients from the risk of harm or abuse. There were policies in place, staff had been trained and demonstrated knowledge regarding vulnerable older people and how to safeguard them.

People with long term conditions

Good

The practice had a higher than average number of patients with long standing health conditions (60% of its population). Patients with long term conditions were supported by a healthcare team that cared for them using good practice guidelines and were attentive to their changing needs. There was proactive intervention for patients with long term conditions. Patients had health reviews at regular intervals depending on their health needs and condition. The practice maintained and monitored registers of patients with long term conditions for example cardiovascular disease, diabetes, chronic obstructive pulmonary disease and heart failure. These registers enabled the practice to monitor and review patient with long term conditions effectively.

The practice also maintained a register of housebound patients to ensure that they received a home visit from a nurse at the practice to review any long term conditions. Clinical staff kept up to date in specialist areas which helped them ensure best practice guidance was always being considered. The practice had identified all

Summary of findings

patients at risk of unplanned hospital admissions and a care plan had been developed to support them. The practice had a palliative care register and held regular multidisciplinary meetings to discuss the care and support needs of patients and their families.

We spoke to patients with long term conditions at the inspection, they all said they received very good care and treatment and were reviewed regularly. Staff treated them with care, compassion and respect.

Families, children and young people

Good

Child health surveillance and immunisation clinics were run on a weekly basis. The practice monitored any non-attendance of babies and children at vaccination clinics and worked with the health visiting service to follow up any concerns. The staff were responsive to parents' concerns and ensured children and babies had access to urgent and same day appointments as needed.

Staff were knowledgeable about child protection and a GP took the lead for safeguarding. Staff put alerts onto the patient's electronic record when safeguarding concerns were raised. Regular meetings were held with the health visiting service to discuss any children who were at risk of abuse and to review if all necessary GP services had been provided.

We received positive feedback regarding care and treatment at the practice for this group. Patients we spoke with told us they were confident with the care and treatment provided to them.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of working-age people (including those recently retired and students). We found the practice had a range of appointments available including pre-bookable, on the day and telephone consultations. The practice cared for this population group well within line with national guidelines and legislation. The practice was open 8.00am until 7.00pm Monday to Friday with every Saturday morning 9.00am until 12.00n noon for pre bookable appointments that were convenient to patients who worked. Telephone consultations were available and supported working patients.

Staff told us they would try to accommodate patients who were working to have early or late appointments wherever possible. The practice monitored patient satisfaction with access to the service

Summary of findings

through patient feedback. Patient feedback indicated patients were satisfied with the range of appointments available. Health checks were being offered to patients who were 40 – 74 years of age to promote patient well-being and prevent any health concerns.

People whose circumstances may make them vulnerable

Good

The practice was aware of, and identified their vulnerable patients. This was highlighted within patient records. The practice discussed any concerning patients as a team and with the extended multi-disciplinary teams. Safeguarding policies and protocols were in place and staff were trained in safeguarding vulnerable adults and children. The safeguarding lead was a GP who had received appropriate training.

The practice held a register of patients living in vulnerable circumstances including those with a learning disability. They carried out annual health checks for people with a learning disability and offered longer appointments for people with a learning disability when needed

People experiencing poor mental health (including people with dementia)

Good

The practice maintained a register of patients who experienced poor mental health, including those with dementia. The register supported clinical staff undertake annual reviews and we found that nearly all patients (97%) registered as having had dementia had been reviewed. The practice monitored patients with poor mental health according to clinical quality indicators and in line with good practice guidelines.

The practice had information for patients in the waiting areas to inform them of other services available. For example, for patients who may experience depression or those who would benefit from counselling services for bereavement. The practice referred patients to appropriate services such as psychiatry and counselling services. Members of the practice staff had undertaken additional training in counselling and were able to assist identifying and supporting patients with specific needs.

Summary of findings

What people who use the service say

We spoke with five patients on the day of our inspection (including two members of the Patient Participation Group) and one family member. We received 20 completed CQC comment cards. Patients whom we spoke with varied in age and population group. They included older people, those with long term conditions and those with children.

All patients were positive about the practice, the staff and the service they received. They told us staff were helpful, caring, and compassionate and that they were always treated well with dignity and respect. Patients told us staff gave them time, listened to them and they were treated as individuals. Doctors were professional and caring and nothing was too much trouble for them. Patients had confidence in the staff and the GPs who cared for and treated them. The results of the national GP patient survey published in July 2014 told us that 85% of respondents had confidence and trust in the last GP they saw or spoke with. Seventy nine percent said the last GP they saw or spoke to was good at treating them with care and concern, 95% of respondents said the last nurse they saw or spoke to was good at treating them with care and concern. Eighty one percent said they last GP they spoke to or saw was good at listening to them, whilst 72% said the GP was good at explaining treatment and tests. The data demonstrated the practice was performing average and above for the majority of questions asked.

We received no concerns regarding the appointment system on the day of inspection from patients we spoke with and the comments cards reviewed. Eighty five percent of patients responding to the NHS GP patient survey said it was easy to get through to the surgery by phone. Eighty three percent described their experience of making an appointment as good, with 98% saying the last appointment they got was convenient. However only 36% of respondents with a preferred GP got to see or speak to that GP. All patients told us they were able to get an appointment or speak to a GP on the same day in the case of urgent need.

Patients told us they considered that the environment was clean and hygienic.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that infection control training and update is undertaken by all staff on a regular basis.
- Ensure that full checks are undertaken on independent locum GPs prior to employment.
- Ensure that the environmental risk assessment is specific to the practice.

Townfield Health Centre - Dr Lee

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC inspector and the team included a GP and a Specialist Advisor who was a practice manager.

Background to Townfield Health Centre - Dr Lee

Townfield Health Centre- Dr Lee is registered with the Care Quality Commission to provide primary care services. It provides GP services for approximately 6600 patients living in and around the Prenton area of Birkenhead. The practice has one GP partner (male), one salaried GP (female), a vacant GP post covered by locum doctors, a practice manager, practice nurses, healthcare assistant, administration, IT and reception staff. Townfield Health Centre holds an APMS contract with NHS England (Cheshire, Wirral and Warrington area team).

The practice is open Monday to Friday from 8.00am to 7.00pm with an extended surgery on Saturday mornings (9.00am to 11.45am) for pre bookable appointments. Patients can book appointments in person or via the telephone. The practice provides telephone consultations, pre bookable consultations, urgent consultations and home visits. The practice treats patients of all ages and provides a range of primary medical services.

The practice is part of Wirral Clinical Commissioning Group (CCG). The practice is situated in an economically mixed area with some areas of affluence and some deprived areas. The practice population is near the national average for most age groups with a slightly higher than national older population aged over 65 years of age. Sixty percent of the patient population has a long standing health condition whilst 73% of patients claim disability allowance (these are higher than the national average). There is a lower than national average number of unemployed.

The practice does not deliver out-of-hours services. These are delivered by Wirral Community NHS Trust.

As part of this inspection we followed up areas of concerns identified at a previous inspection carried out in August 2014. The provider had submitted an action plan telling us how they would meet the regulations breached. We followed up these actions and improvements were evident.

The CQC intelligent monitoring placed the practice in band 1. 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. We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our

Detailed findings

regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

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

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

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

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

Before our inspection we carried out an analysis of the data from our Intelligent Monitoring system. We also reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We reviewed the practice's policies, procedures and other information the practice provided before the inspection.

We reviewed all areas of the practice including the administrative areas. We sought views from patients face-to-face, looked at survey results and reviewed comment cards left for us on the day of our inspection.

We spoke with the practice manager, registered manager, GPs, practice nurse, administrative staff and reception staff on duty. We spoke with patients and a family member who were using the service on the day of the inspection.

We observed how staff handled patient information, spoke to patients face to face and talked to those patients telephoning the practice. We discussed how GPs made clinical decisions. We reviewed a variety of documents used by the practice to run the service.

Good

Are services safe?

Our findings

Safe track record

NHS Wirral Clinical Commissioning Group and NHS England reported no concerns to us about the safety of the service. GPs told us they completed incident reports and carried out significant event analysis as part of their on-going professional development in order to reflect on their practice and identify any training or policy changes required. These were shared within the practice. We looked at a sample of significant events and saw that they were appropriately reported and investigated with a plan of action indicated. Appropriate actions had been taken to prevent recurrence and mitigate risks.

Staff were able to describe the incident reporting process and were encouraged to report in an open, no blame culture. They told us they felt confident in reporting and raising concerns and felt they would be dealt with appropriately and professionally. Staff were able to describe how changes had been made to the operation of the practice as a result of reviewing significant events and complaints.

The minutes of practice meetings we reviewed showed that complaints, incidents and significant events, were discussed. The staff we spoke with were positive about the use of incident analysis and how this assisted them to develop the care provided.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring safety incidents and significant events. We looked at the records of five significant events that had occurred in the last 12 months. There was evidence that appropriate learning had taken place where necessary and that findings were disseminated to staff. Staff told us and we saw evidence that significant events, incidents and complaints were investigated and reflected on by the clinical and non-clinical staff as appropriate. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at meetings and they felt encouraged to do so.

The events analysis and action points demonstrated improvements had been made to prevent recurrence and mitigate risks. For example a vaccine error identified a training need and this was implemented. Records showed that significant events were discussed at weekly practice meetings and at monthly clinical governance meetings.

A central log/summary of significant events was held that allowed patterns and trends to be easily identified and enabled a record to be made of actions undertaken and reviewed.

National patient safety alerts were disseminated by the practice manager to relevant staff. Staff we spoke with were able to give an example of recent alerts/guidance that were relevant to the care they were responsible for. For example the recent guidance on Ebola (Ebola is a contagious viral infection causing severe symptoms and is currently causing an epidemic in West Africa). They also told us relevant alerts were discussed at team meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had up to date safeguarding child and at risk adults, policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse and at risk patients. The policies were easily available to staff on their computers and in hard copy. Staff had access to contact details for both child protection and adult safeguarding teams. We saw evidence of such information displayed in all clinical and administrative areas.

Staff had received training on safeguarding children and adults. Clinical staff had a higher level of training than other staff; GPs were trained to level three and nurses to level two. Staff we spoke with were knowledgeable about the types of abuse to look out for and how to raise concerns. Staff were able to discuss examples of at risk children and how they were cared for. Staff were made aware through an alert system on the computer, electronic records of vulnerable people and their immediate families and by discussion at weekly meetings.

The principal GP was the lead for safeguarding. They had attended appropriate training to support them in carrying out their work. They were knowledgeable about the contribution the practice could make to patients at risk and we discussed some cases where concerns had been raised and discussed further with the appropriate authorities. All

staff we spoke to were aware of the leads and who to speak to in the practice if they had a safeguarding concern. Codes and alerts were applied on the electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The clinical and non-clinical staff were aware of the vulnerable children and adult patients at the practice and discussed them at regular clinical meetings

The practice had a current chaperone policy. Staff who had undertaken chaperone training acted as a chaperone, however we found that one member of staff had on occasion acted as a chaperone and had not received formal training. They did have a suitable Disclosure and Barring Service (DBS) check and they demonstrated a good knowledge of the role of chaperone. A chaperone policy notice was displayed in the reception area and in all treatment and consultation rooms.

Medicines management

There were systems in place for safe medicine management. We checked medicines stored in the treatment rooms and fridges. We found that they were stored appropriately. There was a current policy and procedures in place for medicines management including cold storage of vaccinations and other drugs requiring this. (Cold chain refers to the process used to maintain optimal conditions during the transport, storage, and handling of vaccines).

The practice had a medicines lead administrative role supported by the GPs. Their role was to ensure patient safety in prescribing, including repeat prescribing. They were also supported by the medicines management team of the Clinical Commissioning Group (CCG) in keeping up to date with medication and prescribing trends. A system was in place to ensure that any changes made to medication by the out of hours service or following hospital discharge were actioned without a delay. We found that prescriptions were produced and information regarding medicines from secondary care were acted upon in a timely manner. The medicines lead demonstrated knowledge and experience in preparing and reviewing prescriptions. Any changes to prescriptions were highlighted to the GPs who signed the prescription for them to check, however there were no formal checks or audits carried out on their work to ensure safe prescription management.

GPs reviewed their prescribing practices as and when medication alerts or new guidance was received. Patient medicine reviews were undertaken on a regular basis in line with current guidance and legislation depending on the nature and stability of their condition.

The GPs re-authorised repeat medication on a six monthly basis or more frequently if necessary.

Medicines for use in medical emergencies were kept securely in a locked room. We saw evidence that expiry dates were checked and recorded on a regular basis. Staff knew where the emergency equipment was held and how to access it. There was oxygen kept by the practice for use in case of an emergency. This was checked for function regularly and checks recorded. The practice also had emergency medicine kits for anaphylaxis in each treatment/consultation room.

We looked at how the practice stored and monitored emergency drugs and vaccines, to ensure patients received medicines that were in date and ready to use. Vaccines were securely stored and were in date and organised with stock rotation evident. We saw the fridges were checked daily to ensure the temperature was within the required range for the safe use of the vaccines. All medicines that we checked were found to be in date. Prescription pads and repeat prescriptions were stored securely.

Cleanliness and infection control

Patients commented that the practice was clean and appeared hygienic. The practice had undertaken an infection control audit in November 2014. We saw the outcome report with actions implemented. Improvements had been made to the environment as a result, for example replacement of cleaning equipment and revised storage of mops. Cleaning was carried out under contract and the cleaning standards and schedule was monitored. The practice nurse was lead for infection control. They had received training in infection control.

There was an up-to-date infection control policy and associated procedures in place. A needle stick injury policy was in place, which outlined what to do and who to contact in the event of accidental injury. We saw current protocols for the safe storage and handling of specimens and for the safe storage of vaccines. These provided staff with clear guidance and were in line with current best practice.

Good

Are services safe?

We found no evidence to demonstrate that infection control training had been undertaken by staff except for the nurses and practice manager. However staff could describe their roles in infection prevention and control, for example reception staff knew how to safely handle specimens.

We inspected the treatment and clinical rooms. We saw that all areas of the practice were clean and processes were in place to manage the risk of infection. We noted that all consultation and treatment rooms had adequate hand washing facilities. Instructions about hand hygiene were available throughout the practice. We found protective equipment such as gloves were available in the treatment/ consulting rooms. Couches were washable. Privacy curtains in the treatment rooms were dated to identify when they were last replaced.

We were told the practice did not use any instruments which required decontamination between patients and that all instruments were for single use only. Procedures for the safe storage and disposal of needles and clinical waste products were evident in order to protect the staff and patients from harm.

Legionella testing was carried out.

.

Equipment

Staff we spoke with told us they had sufficient and suitable equipment to enable them to carry out diagnostic examinations, assessments and treatments.

All equipment was tested and maintained regularly and we saw equipment asset logs and contracts that confirmed this. There were contracts in place for annual checks of fire extinguishers and less frequently portable appliance testing (PAT). We saw that annual calibration and servicing of medical equipment was up to date.

Emergency equipment included an oxygen cylinder, nebulisers, masks, airways and an automated external defibrillator. These were maintained and checked regularly.

Staffing and recruitment

An up to date recruitment policy was in place. This was in line with current guidance and regulations and included guidelines about seeking references, checking qualifications/clinical registration, checking an applicant's physical and mental fitness and obtaining Disclosure and Barring service (DBS), formerly Criminal Records Bureau (CRB) checks (these checks provide employers with an individual's full criminal record and other information to assess the individual's suitability for the post).

We looked at a sample of recruitment files for reception, administrative and IT staff and practice nurses. The practice employed locum GPs through a contract with agencies. The practice had received assurance that these GPs had had the necessary recruitment checks undertaken by the agency. However the practice was not able to show us evidence that these checks had been undertaken prior to employing these GPs. We also found that they had used an independent locum GP that had not been thoroughly checked through the practice recruitment process. They had checked this GP was suitable to work as a GP by checking they were on NHS England's performers list. (Doctors and other healthcare professionals may not perform NHS primary care services in England unless they are included on a performers list. This is part of the National Health Service (Performers Lists) Regulations 2013.)

We looked at a sample of files and found that improvements had been made since our last inspection. Recruitment procedures had in general been followed and the required checks had been undertaken to show the applicants were suitable for their posts. Risk assessments were in place for employees that were employed and the practice had not been able to obtain references. We saw records for two candidates currently undergoing the recruitment process and were told they were coming into the practice to shadow staff and undertake some further assessment. The practice was advised that full employment checks must be carried out prior to them commencing employment at the practice.

The professional registration of clinical staff was checked prior to appointment and we saw that professional registration with the General Medical Council (GMC) and Nursing Midwifery Council (NMC) for GPs and nurses were up to date. The practice did not have a formal system in place to record these checks, however information was found held in staff records.

Staff told us there were generally enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff

Good

Are services safe?

sickness. The staff worked well as a team and as such supported each other in times of absence and unexpected increased need and demand. The practice manager and GP oversaw the rota for clinicians. Sometimes this was difficult to manage as locum GPs were not always available. However we saw they managed to ensure that sufficient staff were on duty

The practice had developed clear lines of accountability for all aspects of care and treatment. Clinical staff had lead roles for which they were appropriately trained. Staff were skilled and knowledgeable in their field of expertise and were able to demonstrate how they could support each other when the need arose.

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 regular required checks of the building, the environment, medicines, staffing and equipment. The practice had a health and safety policy. Health and safety information was displayed for staff to see. Up to date risk assessments were in place. Each risk was assessed, rated and control measures recorded to reduce and manage the risk. The practice environmental risk assessment was general and not localised to the practice.

The practice used electronic record systems that were protected by passwords and smart cards on the computer system. Historical paper records were stored securely in suitable cabinets in a locked room.

Arrangements to deal with emergencies and major incidents

A current business continuity plan was in place. This comprehensive plan detailed risk identification and risk assessments for the business. It covered business continuity, staffing, records/electronic systems, clinical and environmental events. Key contact numbers were included and paper and electronic copies of the plan were held. Staff we spoke with were aware of the business continuity plans and could describe what to do in the event of a disaster or serious event occurring for example in the event of an IT failure. We saw an example of a reported significant event where the IT system had failed. Procedures where undertaken in line with guidelines and the problem had been rectified quickly.

Staff could describe how they would alert others to emergency situations by use of the panic button on the computer system. Staff had received training in dealing with medical emergencies including cardiopulmonary resuscitation (CPR). This was updated annually. There was suitable emergency equipment and medicines available that were checked and maintained.

Routine checks for utilities including fire safety systems, heating and cooling systems and electrical systems were undertaken under contract.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The clinicians were familiar with, and using current best practice guidance. The staff we spoke with and evidence we reviewed confirmed that care and treatment delivered was aimed at ensuring each patient was given support to achieve the best health outcomes for them. We found from our discussions that staff completed, in line with The National Institute for Health and Clinical Excellence (NICE) and local commissioners' guidelines, assessments and care plans of patients' needs and these were reviewed appropriately. NICE guidance was accessible to staff and there was evidence that clinical conditions, patient care and treatment was discussed at regular clinical meetings. The practice had coding and alerts within the clinical record system to ensure that patients with specific needs were highlighted to staff on opening the clinical record. For example, patients on the 'at risk' register and palliative care register.

The Quality and Outcomes Framework (QOF) is a system for the performance management and payment of GPs in the NHS. It was intended to improve the quality of general practice and the QOF rewards GPs for implementing "good practice" in their surgeries. This practice had performed poorly last year (they obtained 74%) which indicated the care and treatment patients received may not be effective. We reviewed QOF data for this current year and found that steps had been taken to improve practice in relation to QOF indicators and improvements were evident. For example, 95% of patients at risk of unplanned admission had completed care plans; this was well on target for 100% completion at the end of the current year. We saw plenty of evidence that the practice was actively working to meet their targets and improve performance with QOF. For example 97% of patients on the dementia register had documented reviews with the remaining patient review planned. Sixty three percent of learning disability checks had been completed with plans in place to complete the remainder.

QOF information (2013/2014) indicated the practice performed better in some areas/indicators than the national and Clinical Commissioning Group (CCG) average. For example patients with long term conditions such as asthma. The percentage of patients with asthma on the register who had an asthma review in the preceding 12 months and included asthma control was above both the CCG and national average. They also performed above average for asthmatic patients aged between 14 and 19 in whom there was a record of smoking status. Other QOF indicators demonstrated older patients received care and treatment as expected for example patients aged 65 and older who had received their seasonal flu vaccinations.

We found GPs and other staff were familiar with the needs of each patient and the impact of the socio-economic environment. GPs and practice nurses managed specialist clinical areas such as diabetes, heart disease and asthma. This meant they were able to focus on specific conditions and provide patients with regular support based on up to date information. The practice nurses and GPs had completed accredited training around checking patients' physical health and around the management of the various specific diseases and long term conditions. Additional role specific training had been undertaken by clinical staff to support them in these roles. GPs also specialised and led in clinical areas such as safeguarding, minor surgical procedures and various chronic diseases. Clinical meeting minutes demonstrated that staff discussed patient treatments and care and this supported staff to continually review and discuss new best practice guidelines. Multi-disciplinary team meetings also demonstrated sharing and evaluation of care and treatment for older people, those with long term conditions and those on the palliative care register.

GPs we spoke with used national standards for the referral of patients for tests for health conditions, for example patients with suspected cancers were referred to hospital. Referrals were monitored to ensure an appointment was provided within two weeks. We found that audits of referrals were regularly undertaken to ensure that referrals were being completed in a timely manner that protected the welfare of patients. We saw an example of one significant event relating to referral that was investigated and analysed with action taken to improve patient care and outcome.

The practice provided a service for all age groups. They provided services for patients in the local community with diverse cultural and ethnic needs, patients with learning disabilities, patients living in deprived areas and care

Good

Are services effective?

(for example, treatment is effective)

homes and for patients experiencing poor mental health. The practice had access to language translator services and provided health promotion services in accordance with the needs of patients.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on the basis of need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

There were systems in place to evaluate the operation of the service and the care and treatment given. The practice routinely collected information about patients' care and treatment. It used the Quality and Outcomes Framework (QOF) to assess its performance and undertook clinical audits. The practice regularly monitored its performance against QOF standards and we saw evidence in the meeting minutes of monitoring of QOF data with a development plan in place to address any areas where the outcomes for patients needed to be improved. These were led by individual clinicians or other staff.

We saw that audits of clinical practice were undertaken and that these were based on best practice national guidelines. We looked at and discussed some of the clinical audits that had been undertaken in the last 12 months. Examples of clinical audits seen included an audit of dermatological referrals, prescribing of omega-3-acid ethyl esters in line with NICE guidance and audit of patients prescribed Warfarin who are concurrently prescribed non-steroidal anti-inflammatory drugs (NSAIDs). Only one of these was a completed audit where the practice was able to demonstrate the changes resulting since the initial audit, improved patient outcomes and ensured the practice worked within NICE guidelines. Others needed re audit or review to ensure improvements had been evident.

The practice had systems in place which supported GPs and other clinical staff to improve clinical outcomes for patients. The practice kept up to date disease registers for patients with long term conditions such as asthma and chronic heart disease which were used to arrange annual health reviews. They also provided annual reviews to check the health of patients with learning disabilities and patients on long term medication, for example for mental health conditions.

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included managing long term conditions, medicines management, safeguarding, unplanned admissions to hospital and infection control. The practice had a palliative care register and held regular multidisciplinary meetings to discuss the care and support needs of patients and their families. There was a process in place for informing the out of hours services of any particular needs of patients who were coming towards the end of their lives.

Effective staffing

An induction protocol and check list were in place which identified the essential knowledge and skills needed for new employees. There had been no recent new employees and therefore we could not confirm that the process had been completed

We looked at training records and saw the range of core topics undertaken. The records demonstrated that non clinical staff were mostly up to date with mandatory training such as health and safety, fire safety, basic life support skills and safeguarding. The practice manager kept a record of training carried out by clinical and administration staff. This did not contain an up to date record of all clinical training undertaken. The GPs and nurses kept a record of their own training. The practice did not have a training matrix which would have enabled training to be monitored across all staff and to easily identify gaps in training for staff. Clinical and non clinical staff told us they had the training they needed to support them in their roles and in any specialist roles. For example, the health care assistant (HCA) had undertaken training in stop smoking, weight management and diabetes, the practice nurse had undertaken training in diabetes and the practice manager taken a course in infection control . Staff also had access to additional training related to their role. For example reception/administration staff had received training in dementia awareness and clinical coding. Staff we spoke with told us they felt they were well trained and received good support to undertake training including that which was required by the practice and for training and development personal to their role.

An appraisal policy was in place. We found that all staff had received an annual appraisal. Staff had supervision on an informal basis including individual, group sessions and at team meetings.

Good

Are services effective?

(for example, treatment is effective)

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

The practice ensured that all of the clinical equipment used in the practice was regularly calibrated and that relevant staff were competent to use it.

Working with colleagues and other services

The practice worked well with other agencies and professionals to support continuity of care for patients. We were shown how the practice provided the out of hours service with information, to support, for example, end of life care. Information received from other agencies, for example the accident and emergency department or hospital outpatient departments were read and actioned by the GPs in a timely manner. Information was also scanned onto electronic patient records in a timely manner.

Multi-professional working took place to support patients and promote their welfare. Clinical staff met with other health professionals to discuss child health and safeguarding issues and patients on the palliative care register. The health centre also housed an in-house physiotherapy service to which they could refer their patients. This service also attended multi-disciplinary meetings on occasions to discuss patients needing their care.

Information sharing

There was a confidentiality policy and data sharing policy which gave clear guidance to staff. Information about access to records and data protection was available for patients to refer to. Staff spoken with demonstrated knowledge around confidentiality, sharing of information and data protection.

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. This software enabled scanned paper communications, such as those from hospital, to be saved in the computer system for future reference. All members of staff were trained on the system, and could demonstrate how information was shared. However the practice had identified limitations to this system and was considering other options in order to improve information storage, sharing and use.

The practice had systems in place to communicate with other providers. For example, there was a system for communicating with the local out of hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the capacity to consent to medical examination and treatment). The consent policy and procedures included Gillick competency and how to assess this and had links to further national and professional body guidance.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures and joint injections a patient's written consent was obtained and documented in the patient notes. Patients we spoke with confirmed they were asked for their consent to examinations and chaperones were offered.

Health promotion and prevention

The practice supported patients to manage their health and well-being. The practice offered national screening programmes, vaccination programmes, long term condition reviews and provided health promotion information to patients. They provided information to patients via their website and in leaflets and information in the waiting area about the services available.

Within the practice there were notice boards advising and signposting to support services. For example there was information about carers' support offered by the practice.

Good

Are services effective?

(for example, treatment is effective)

The practice had a carers policy and offered registration as a carer to enable access to support. Staff we spoke with were knowledgeable about advisory and support services and how to access them.

The practice used the coding of health conditions in patients' electronic records and disease registers to plan and manage services. For example, patients on disease registers were offered reviews with the nurse.

The practice offered a health check to all new patients registering with the practice and also offered NHS Health Checks to all its patients aged over 40. The practice offered a full range of immunisations for children and flu vaccinations in line with current national guidance.

The practice had ways of identifying patients who needed additional support. The practice kept up to date disease registers for patients with long term conditions such as diabetes, asthma and chronic heart disease which were used to arrange annual health reviews. The practice also kept registers of vulnerable patients such as those with mental health needs and learning disabilities and used these to plan annual health checks.

Health promotion advice was provided to patients. This included smoking cessation, obesity management and travel advice.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We looked at 20 CQC comment cards that patients had completed prior to the inspection and spoke with five patients. Patients were very positive about the care they received from the practice. They commented that they were treated with respect and dignity, staff were caring, kind and helpful. Patients we spoke with told us staff gave them time to discuss things fully, treatments were explained and that they felt listened to.

Staff we spoke with were aware of the importance of providing patients with privacy and of the importance of confidentiality. The computers at reception were shielded from view for confidentiality and staff took patient phone calls away from the main reception area so as to avoid being overheard. There was a quiet room adjacent to reception where patients could speak to staff in private. One person we spoke with told us they liked the availability of this room and this made them feel safe and able to talk in private.

Consultations took place in purposely designed rooms with an appropriate couch for examinations and screens to maintain privacy and dignity. We observed staff were discreet and respectful to patients. Patients we spoke with told us they were always treated with dignity and respect.

The practice offered patients a chaperone prior to any examination or procedure. Information about having a chaperone was seen displayed in the reception area and all treatment and consultation rooms. There was a clear notice in the reception area stating the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

Data from the National GP Patient Survey in July 2014 showed the practice performed poorly in relation to questions about their involvement in planning and making decisions about their care and treatment and rated the practice below average. Results showed only 64% of practice respondents said the GPs were good at involving them in decisions about their care however 97% felt the nurses were good at listening to them and 82 % said that the nurse was good at explaining tests and treatments.

Patients we spoke told us they felt listened to and were involved in decision making about the care and treatment they received. Patient feedback on the comment cards we received indicated they felt listened to and were well supported.

Patient/carer support to cope emotionally with care and treatment

Patients were positive about the care they received from the practice. Patients felt supported by the GPs, nurses and all staff. They felt clinicians were empathetic and compassionate. Results from the national GP patient survey told us that 82% of patients said the last GP they saw or spoke to was good at giving them enough time, 81% said the GP was good at listening to them and 72% said they were good at explaining tests and treatment. Seventy nine percent of responses said the last GP they saw or spoke to was good at treating them with care and concern.

The practice had a GP lead for patients coming towards the end of their lives and terminally ill and were supported by the practice nurse and administratively. They had a palliative care register and held regular multidisciplinary meetings with community healthcare staff to discuss the care plans and support needs of patients and their families. Patient care plans and supportive information informed out of hours services of any particular needs of patients who were coming towards the end of their lives.

GPs and clinical staff had a method of identifying and supporting bereaved patients through the flag system on the medical records. They provided support and signposted patients to bereavement support services. The practice informed the wider multi-disciplinary team of any deaths and this was highlighted to staff so that they could offer support if a family member was on the phone or present in the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to improve and maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice held information and registers about the prevalence of specific diseases within their patient population and patient demographics. This information was reflected in the services provided, for example screening programmes, vaccination programmes, home visits and reviews for elderly patients and extended appointments for those patients with enhanced needs.

The practice cared for a number of elderly patients who lived in a local care home. The GPs and nurses undertook visits to the homes as needed to review care plans and medications. Patients with dementia and learning disabilities were reviewed annually. The practice had implemented the 'named GP' for patients over 75 to support continuity of care. The practice was proactive in contacting patients who failed to attend vaccination and screening programmes.

The practice had a palliative care register and had monthly multidisciplinary meetings to discuss patients and their families' care and support needs. They regularly updated shared information to ensure good communication of changes in care and treatment.

The practice had a mix of male and female GPs so that patients were able to choose to see a GP of the gender of their choice.

The practice had a protocol for patients with learning disabilities and how to care and support them. These patients had annual health checks and care plan reviewed. Currently the practice had completed 63% of learning disability checks and had a plan to get the remainder in for appointments and follow up the non-attenders.

The practice had an active Patient Participation Group (PPG). We spoke with two members of the group and looked at their constitution and sample meeting minutes. The GP attended the PPG meetings on a regular basis where good information exchange took place. The PPG told us the practice listened to them and they were able to contribute views and suggestions that, if appropriate, were acted upon.

Tackling inequity and promoting equality.

The majority of the practices patients spoke English although it could cater for other languages as it had access to translation services. The practice did not provide equality and diversity training for staff, however on discussion with staff they demonstrated knowledge and awareness of equality and diversity issues and how it related to their everyday work, for example receptionists dealing with homeless or substance misuse patients.

The premises and services met the needs of people with disabilities. The medical centre was a purpose built centre. There were disabled toilet facilities and an audio loop system in place in reception. There was a comfortable waiting area for patients attending an appointment and car parking was available nearby. Patients with limited mobility were catered for with consultations and treatments delivered in ground floor rooms. There was a passenger lift to the first floor which had offices and meeting rooms where the PPG met regularly.

Access to the service

The practice is open Monday to Friday from 8.00am to 7.00pm with an extended surgery on Saturday mornings (9.00am to 11.45am) for pre bookable appointments. Patients can book appointments in person or via the telephone. The practice provides telephone consultations, pre bookable consultations, urgent consultations and home visits. The practice treats patients of all ages and provides a range of primary medical services.

Information was available to patients about appointments on the practice website and in the practice information leaflet. This included who to contact for advice and appointments out of normal working hours when the practice was closed such as contact details for the out of hours medical provider. Priority was given to children, babies and vulnerable or patients identified as at risk due to their condition and these patients would be offered a same day urgent appointment.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Appointments were tailored to meet the needs of patients, for example those with long term conditions and those with learning disabilities were given longer appointments. Home visits were made to care homes, older patients and those vulnerable housebound patients.

Patients whom we spoke with, comment cards and patient survey results told us patients were generally satisfied with the appointment system. They told us there was usually no difficulty getting through to the practice on the telephone. The practice performed well in patient surveys for access to the appointments system with 85% saying they found it easy to through to the practice by phone and 83% described their experience of making an appointment as good. Ninety eight percent of respondents said the last appointment they got was convenient.

We looked at 20 CQC comment cards that patients had completed prior to the inspection. A number of the comments indicated that patients were happy with the system for booking appointments and that they could get an appointment when one was needed.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. This was the practice manager who liaised with all relevant staff in dealing with the complaints on an individual basis.

We looked at the complaints log for the last 12 months and found that complaints had been dealt with and responded to appropriately. The practice took action in response to complaints to help improve the service. Complaints were investigated and a summary and overview log was recorded which helped identify themes. Complaints were reviewed regularly at meetings to analyse themes and trends in order to improve learning and practice.

Patients we spoke with were aware of the complaints procedure and some had seen information in reception relating to this. An appropriate information leaflet detailing the process for making complaints or comments about the practice was available to take away at the reception desk. Staff we spoke with were able to tell us how they would handle initial complaints made at reception or by telephone.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had clear vision, values and mission statement "to provide a high standard of patient centred care." Staff were able to articulate the values of the practice. The practice had recently been through a period of stress with a lack of consistent GP cover for the two vacant salaried GP posts, however in the last few months a salaried GP had been appointed whom the patients thought highly of and the practice manager had returned from a period of absence. All staff felt positive about the future and were able to articulate their plans and aim to become a high performing practice with high standards of patient care once more.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the computer shared drive and in hard copy in the offices. Policies and procedures were dated and reviewed appropriately and were up to date. Staff confirmed they had read them and were aware of how to access them. Staff could describe in detail some of the policies that governed how they worked for example the safeguarding children's policy and procedures.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it performed poorly in 2013/14 when the practice obtained only 74%. However we found that QOF data was regularly discussed at practice meetings, plans were in place and improvements had been made for the current year with the practice well on their way to achieving targets for the majority of indicators.

Clinical audits were undertaken by nursing and medical staff. We looked at a selection of these. Some of these were completed well, however improvements could be made to ensure an audit programme was in place and audits were fully completed with re-audits undertaken to demonstrate improvements made.

The practice had arrangements in place for identifying and managing risks. Risk assessments and risk management was in place.

Leadership, openness and transparency

There was a clear organisational and leadership structure with named members of staff in lead roles. For example, there was a lead nurse and GP for infection control. GPs and practice nurses took the lead for various conditions and non-clinical practice business such as IT and information governance. We spoke with staff of varying roles and they were all clear about their own roles and responsibilities. They all told us there was a friendly, open culture within the practice and they felt very much part of a team. They all felt valued, well supported and knew who to go to in the practice with any concerns. They felt any concerns raised would be dealt with appropriately.

Regular practice and clinical governance meetings took place to share information, look at what was working well and where any improvements needed to be made. For example, there was a weekly practice meeting and monthly clinical governance meetings, with minutes demonstrating discussion of new protocols, review of complex patient needs and best practice guidelines and legislation.

We reviewed a number of human resource policies and procedures that were available for staff to refer to, for example, the induction, sickness and absence and disciplinary procedures.

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

Patient feedback was obtained through carrying out surveys, reviewing the results of national surveys, comments and suggestions book located in the reception, on-line feedback and through the complaint procedure. The last practice patient survey was undertaken by the Patient Participation Group (PPG) in February 2014. One hundred and sixty three surveys were completed and the results showed that patients were generally satisfied with the overall experience at the practice.

There was an active PPG which had a good relationship with the practice. Information was promoted in reception on a visual display unit to patients encouraging them to participate in feedback and join the PPG. There was also information in reception regarding the NHS friends and family test (FFT). This test is an opportunity for patients to provide feedback on the services that provide their care and treatment. It was available in GP practices from 1 December 2014.

We met with two members of the PPG who told us they met bi-monthly, they felt listened to and improvements had

Are services well-led?

Good

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

been made to the practice as a result of their suggestions. For example, improvements had been made to the waiting area and notice boards. The PPG told us that services improvements were discussed at meetings and the views of the PPG obtained.

Staff told us they felt able to give their views at practice meetings. Staff told us they could raise concerns and felt they were listened to. A whistle blowing policy and procedure was available for staff.

Management lead through learning and improvement

We saw that all staff were up to date with annual appraisals which included looking at their performance and development needs. These had been done in the last month. The practice had an induction programme and a training and development policy and procedures to ensure staff were equipped with the knowledge and skills needed for their specific individual roles. Staff undertook a wide range of relevant training.

Staff told us they had regular training and were supported to undertake further development in relation to their role. The training records did not easily demonstrate that all staff had undertaken all mandatory and core subjects. We discussed this with the practice manager who told us they were considering a system such as a training matrix which would enable better management of training.

Regular practice and clinical governance meetings took place to share information, look at what was working well and where any improvements needed to be made. Significant events were recorded, analysed and results discussed at practice meetings with changes made to the procedures where needed to improve patient care.