Quayside Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Quayside Medical Centre on 19 January 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for the population groups of older people, families, children and young people, working age people (including those recently retired and students), people whose circumstances may make them vulnerable, people experiencing poor mental health (including people with dementia). It requires improvement for the population group of people with long-term conditions.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and prioritised.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Most staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Most patients said the appointment system was satisfactory, although not all patients reported continuity of care due to the use of locums on certain days. Most patients said they could be seen in an emergency but they may have to wait.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

Summary of findings

Importantly the provider should:

- Ensure that full cycle clinical audits are completed.
- Ensure the safeguarding lead is trained to Level 3 in safeguarding adults and children.
- Ensure GPs are involved and aware of the practice business plan.
- Ensure that where applicable, that care plans for patients are used.
- Ensure vacant posts are filled in a timely manner so as not to impact on patient care.
- Ensure all clinical staff meet on a regular basis as a team.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General 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

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multi-disciplinary teams. We saw evidence that's some audits were driving improvement in performance to improve patient outcomes but there were no full cycle clinical audits completed. Staff told us that currently they needed more staff to be more effective.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with patients, although not always shared with all staff. Feedback from patients reported that access to a

Summary of findings

preferred named GP and continuity of care was not always available. Most patients said urgent appointments were usually available the same day. Records showed the practice was acutely aware of these issues and was proactively monitoring and managing these issues. For example by recruiting to vacant clinical roles.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions and regular performance reviews.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Staff recognised signs of abuse or neglect in older people and knew how to escalate or refer those concerns. Carer status was recorded and when identified were recorded on patient notes and invited for a health check. An action plan for the care of the over 75's was in place and 44 out of the 49 patients had a care plan in place that had been reviewed. However, we were told by some clinical staff that care plans were not being used as well as they should. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. The practice offered mini mental tests to patients as part of dementia screening. The feedback received from patients in this population group was excellent. Patients could access appointments through drop-in clinics, advanced bookable appointments or telephone consultation.

People with long term conditions

Requires improvement

The practice is rated as requiring improvement for the care of people with long-term conditions. The nurse and health care assistant had had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. The provision of in-house smoking cessation clinics and health trainers were available to provide lifestyle advice to patients. However, we were told by some clinical staff that use of care plans was low. The chronic disease register was reviewed monthly to ensure patients were invited to the practice for the appropriate health checks. For those people with the most complex needs, the practice worked with relevant health and care professionals to deliver a multidisciplinary package of care. Patients could access appointments through drop-in clinics, advanced bookable appointments or telephone consultation.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. A large percentage of the practice demographic fall within this population group. Staff recognised signs of abuse or neglect in this group and knew how to escalate or refer those concerns. The practice had good links with the Local Authority safeguarding team. There were systems in place to identify and follow up children living in disadvantaged circumstances and who

were at risk, for example, children and young people who had a high number of A&E attendances. The practice proactively worked with the Asgard project in Grimsby, a project set up to improve the health and well-being of disadvantaged young people in the area. At the time of the inspection immunisation rates were 100%. Appointments were available outside of school hours and the premises were suitable for children and babies. On site sexual health and maternity services were not available at the practice but we were told good facilities were available in the area which patients were signposted to. We were told the practice had good access to local drug and alcohol services. We were told the practice had fractured relationships with the health visiting team following a restructure of their team. Patients could access appointments through drop-in clinics, advanced bookable appointments or telephone consultation.

Working age people (including those recently retired and students)

Good

GOOD

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible and flexible. Health checks were available and promoted at the practice for patients in this group. We saw that HGV medicals were made available for heavy goods vehicle workers at weekends. The practice was proactive in offering online services. The practice used a system called MJOG which was a text based service which allowed patients to send and receive texts from the surgery using their mobile phones. This system allowed the patient to book, cancel and change appointments via text message, as well as ordering repeat prescriptions. Patients could access appointments through drop-in clinics, advanced bookable appointments or telephone consultation.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances and those with a learning disability. It had carried out annual health checks and longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in

Summary of findings

vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Data showed 100% people experiencing poor mental health had received an annual physical health check and 90.48% of patients had received an assessment for depression. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on the Mental Capacity Act 2005.

Summary of findings

What people who use the service say

We spoke with six patients, three of whom were members of the PPG who were using the service and reviewed 17 completed CQC comment cards. The majority of feedback from patients was positive. Patients told us their needs were met and they were listened to. They told us they were treated with dignity and respect. Most patients said staff were excellent. The negative comments we received related to access to appointments and the inability of the practice to recruit regular salaried GPs.

National GP survey results published in July 2014 indicated that the practice was best in the following areas when compared to the local CCG average:

- 90% of respondents were satisfied with the surgery's opening hours - Local (CCG) average: 82%
- 82% of respondents found it easy to get through to this surgery by phone - Local (CCG) average: 75%
- 82% of respondents described their experience of making an appointment as good - Local (CCG) average: 76%

The national GP survey results published in July 2014 indicated that the practice could improve in the following areas when compared to the local CCG average:

- 48% of respondents usually waited 15 minutes or less after their appointment time to be seen - Local (CCG) average: 61%
- 76% of respondents were able to get an appointment to see or speak to someone the last time they tried - Local (CCG) average: 87%
- 69% of respondents would recommend this surgery to someone new to the area - Local (CCG) average: 79%

Areas for improvement

Action the service SHOULD take to improve

- Ensure that full cycle clinical audits are completed.
- Ensure the safeguarding lead is trained to Level 3 in safeguarding adults and children.
- Ensure GPs are involved and aware of the practice business plan.
- Ensure that where applicable, that care plans for patients are used.
- Ensure vacant posts are filled in a timely manner so as not to impact on patient care.
- Ensure all clinical staff meet on a regular basis as a team.

Quayside Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a **CQC Lead Inspector.** The team included a GP and a practice manager.

Background to Quayside Medical Centre

Quayside Medical Centre, 76b Cleethorpe Road, Grimsby, North East Lincolnshire is situated in the centre of Grimsby. This is an inner city practice working with approximately 2,600 patients in the most deprived decile. The practice has 0.95 WTE GPs (three GPs, one salaried and two long term locums, covering four days a week and a locum covering Wednesdays. An additional GP joins the practice in March 2015. Nursing staff are reduced to one nurse doing five hours a week due to a recent unplanned nurse vacancy. An additional five hours of nursing time commences in February 2015. The practice also has a part time health care assistant and phlebotomist. This equates to over 2,600 patients per WTE GP.

The practice has an APMS contract.

The CQC intelligent monitoring placed the practice in band 4. 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 comprehensive inspection programme. We carried out the inspection under Section 60 of the Health and Social Care Act as part of our regulatory functions. This inspection was planned to check whether the provider was 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.

This practice had not been inspected before and was selected at random to be inspected under North East Lincolnshire Clinical Commissioning Group (CCG).

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

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?

Detailed findings

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

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Before our inspection we reviewed a range of information we held about the practice and asked other organisations to share what they knew. We asked North East Lincolnshire CCG to tell us what they knew about the practice and the service provided. We reviewed some policies and procedures and other information received from the practice prior to the inspection.

We carried out an announced inspection on 19 January 2015. During our inspection we spoke with a range of staff. This included the one salaried GP, a locum GP, a nurse, a health care assistant, the practice manager an administrator and a phlebotomist/receptionist. We also spoke to three patients who attended the service that day for treatment and three patients who were part of the patient participation group. We reviewed comments from 17 CQC comments cards which had been completed.

We observed interaction between staff and patients in the waiting room.

Good

Are services safe?

Our findings

Safe track record

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

The practice held regular meetings where safety was reviewed, both at practice and provider level. For example, provider wide monthly clinical governance meetings took place. We reviewed safety records, incident reports and minutes of meetings where these were discussed.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last 12 months and we were able to review these. A provider wide and practice based meeting was held regularly to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet which were received by the practice manager electronically. They showed us the system used to manage and monitor incidents. We tracked all the incidents recorded in the last 12 months and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example there had been a number of incidents of patient verbal abuse in the reception area. The practice had acted on this and arranged training in this area for staff to manage conflict. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at practice 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 systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that the majority of staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children. However, they had not completed all the required to training to enable them to fulfil this role. All staff we spoke with were aware who was the lead and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records which a member of our team observed. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. The practice made appropriate referrals to the local authority safeguarding team and provided us with an example where they had liaised with other agencies following concerns identified by practice staff. The practice had arrangements in place for following up and identifying children with a high number of A&E attendances and following up children who failed to attend appointments for childhood immunisations. The practice nurse attended quarterly meetings which looked at immunisations rates with the local authority safeguarding lead. Records showed that reviewing patients of concern was a standard item for discussion at bi-weekly clinical practice meetings.

Good

Are services safe?

There was a chaperone policy, which was visible in consulting rooms but not the patient waiting room. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Records showed medication audits were completed. We saw patients who were on certain medications were checked they were appropriately coded on the system to make sure they were captured on the correct disease register and subsequently receiving the correct level of care. For example patients with osteoporosis, psychoses and asthma. The results showed a positive outcome for patients, as new patients were identified, the coding amended and the records and patient reviewed, however, some clinical staff told us the disease registers could be more up to date.

The practice had previously had regular input from the local medicines management team but this had not taken place for many months due to availability of the medicines management team to support the practice. The practice told us they were meeting with the team to discuss a way forward to ensure the practice was supported with medicines management.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Cleaning items were appropriately stored and labelled to show recognised guidance was followed. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who attended quarterly infection control meetings for practice nurses. All staff received infection control training which was regularly updated. We saw evidence that audits for infection control were carried out and improvements identified for action were completed on time.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. The sample of single use instruments we looked at were within their sterile date.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. The practice had recently completed a hand hygiene audit and no concerns were identified in this audit. Special kits to be used in the event of a spillage of blood or body fluids were available and stored appropriately.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in

contaminated water and can be potentially fatal).We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

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

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

The practice had arrangements to monitor the number and mix of staff needed to meet patients' needs. At the time of the inspection the practice manager was closely monitoring staffing levels and recruitment as the practice had recently had an unplanned nurse vacancy and was in the process of recruiting to this vacant post and to additional GP hours. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave by flexible working and overtime. The provider had a policy in place to ensure that when locums attended the practice that they were recruited through an agency approved by the provider. The practice could also access the service of a neighbouring practice if required and the services of clinical staff from the providers other practices.

Staff told us they were challenged in terms of clinical staff due to recent unplanned vacancies and the difficulties in recruiting clinical staff to the area. However, they told us they prioritised their work to ensure there was enough staff to ensure the smooth running of the practice and to keep patients safe. The practice manager showed us records to demonstrate that staffing and recruitment was being actively monitored and how they were being flexible in their approach to staffing at times of risk. For example, we were told that a GP from the providers other practice had carried out telephone appointments from another practice rather than the appointments not being available.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were recorded. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at team meetings.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment appropriate for children and adults was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

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

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, incapacity of staff, adverse weather,

Good

Are services safe?

unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire and bomb evacuation drills. There was designated staff to act as fire wardens.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

The clinical staff had lead roles, for example pain management and palliative care. The nurses had defined roles and lead areas, for example asthma and COPD Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

Data from the GPHLI showed the practice was an outlier in the area of recovery from illness as the practices performance for antibiotic prescribing was high. It should be noted that the practices prescribing data included all prescribing carried out for the walk in service (which up until September was a seven day service) as well as that given to registered patients. We spoke with the GPs about this and one member of staff told us they felt this was due to the practice having to use locums. The practice had completed an antibiotic audit although this was not a completed cycle audit. The data also showed that A&E attendances and emergency admissions were much higher than the national average. The practice showed us data to demonstrate that they had made vast improvements in the CCG area due to close monitoring of attendances and working with patients who frequently attended A&E. However, they also told us that these rates had increased recently as they had not been able to monitor as closely due to staff vacancies and the need for more GP and nurse time.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included medicines management, asthma reviews and new patient health checks.

The practice was unable to provide us with evidence of full audit cycles that had been completed in the last two years. They had carried out some audits but these were not full cycle clinical audits. One locum GP had recently started an audit of the use of certain drugs but this was not a completed audit cycle. We discussed this with staff and they told us the lack of permanent GPs at the practice had impacted on the ability to complete full audit cycles. The practice manager acknowledged the need to address this issue and to formalise some of the other audits they completed. The practice provided us with a range of other audits that were completed.

The GPs told us audits were often linked to issues such as medicines management, feedback from the CCG or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, a medicine review had identified the practice as being below the national prevalence levels and as a result the practice had identified that there was an issue with patient coding which resulted in the medication audits referred to above.

The GPHLI showed the practice had 2 outlying points; COPD prevalence; diabetes admissions and antibacterial prescribing. The practice had identified some issues with the coding of patients with COPD which could attribute to the prevalence issue. The practice was also monitoring unplanned admissions but there was no evidence of action to address the antibacterial prescribing rates.

The team was making use of clinical supervision and staff meetings to assess the performance of clinical staff. The

Good

Are services effective?

(for example, treatment is effective)

salaried GP told us they reflected on the outcomes being achieved and the areas where this could be improved but the staffing situation and the use of locums meant that it was difficult to meet together as a whole team.

There was a protocol for repeat prescribing which was in line with national guidance. There was a system in place for checking that patients receiving repeat prescriptions had been reviewed by the GP and records showed that patients had been recalled to the practice where there were concerns about potential medicines abuse. However, records showed that medication reviews had not been completed for all the required patients since August 2014. One member of staff told us they needed more time to do the medicine reviews. We were told the practice was prioritising those patients most at risk and evidence confirmed this. Staff told us that despite the shortage of staff those patients deemed at risk, for example, patients with a long term condition or on warfarin were being prioritised and recalled to the practice to be reviewed. This was confirmed by patients we spoke with.

The practice had a palliative care register and attended multidisciplinary meetings to discuss the care and support needs of patients and their families. Records also showed such patients were discussed at the bi-weekly practice meeting. The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example referral rates.

Effective staffing

Practice staffing included 0.95 WTE GP, made up of one salaried GP, two regular locums and other locums. There was one 0.13WTE nurse and 0.49 WTE HCA and 0.63 phlebotomist (who also covered reception) All the staff we spoke with told us they needed more GP and nurse time, particularly as the only salaried GP was reducing their hours in the near future. We were told a nurse would be joining the practice in February for 0.13 WTE. The practice manager told us they were reviewing the vacant hours in terms of nursing and GP time to determine the most effective way to fill these posts to be of most benefit to patients. We saw records to confirm this. We saw evidence on the provider website that they were actively recruiting a salaried GP.

We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. A comprehensive locum pack was in place for locums working at the practice with the provider expecting locums to have completed a range of training before working at the practice.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles, such as seeing patients with long term conditions such as asthma, diabetes and COPD were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The practice had a system in place so that the GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were a small number of incidents noted on the events record where results and referrals had not been acted on or followed up appropriately. The records relating to these incidents showed measures had been put in place to mitigate the risk of such incidents occurring again.

Good

Are services effective?

(for example, treatment is effective)

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect.

The practice attended multidisciplinary team meetings when required and met bi-weekly as a practice to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in the patient's record. Staff told us they could access the support of multi-disciplinary teams and commented on the importance of working together to achieve the best outcome for patients.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals. The practice told us they were only making some referrals through Choose and Book as they experienced problems with this. They said most referrals were done manually. Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.

The practice used a number of other communication systems. MJOG, a text messaging service was used by patients and the practice to communicate between each other. The practice had implemented the Summary Care Record (SCR). The SCR provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours. The practice had also implemented GP2GP record transfers. GP2GP means patients electronic records would be transferred much sooner when patients move between practices. The practice was appropriately registered with the Information Commissioner to handle patients' records and we saw audits were carried out and staff had received training in records management.

The practice had systems to provide staff with clinical and non-clinical information. Staff used an electronic patient record, SystmOne to coordinate, document and manage patients' care. All staff were fully trained on the system. The software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. . Systems, such as web based and electronic messaging were used for sharing information with staff.

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 with understood the key parts of the legislation and were able to describe how they implemented it in their practice. Staff had received training on the Mental Capacity Act. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff, for example with making do not attempt resuscitation orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans. Care plans were in place but we were told by clinical staff that these were not being used as well as they should due to current staff vacancies. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Health promotion and prevention

The practice offered health checks by the health care assistant to all new patients registering with the practice. Any concerns were identified and passed on to the GP and these were followed up. The practice did not provide in-house sexual health clinics or on site maternity services. These services were based out of other practices or at the local hospital. A health trainer provided by the Local Authority attended the practice for two hours once a week. A smoking cessation service was also available. NHS Health Checks were offered to all its patients aged 40 to 75 years.

Data from the GPHLI financial year 2013 - 2014 showed the practice's performance was above the national average in a number of areas. For example, cervical smear uptake was

Good

Are services effective?

(for example, treatment is effective)

82.86%, diabetes BP monitoring was 91.38% and health checks for patients with a mental illness were 100%. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice had previously had a high rate of patients that did not attend for immunisations but the practice had put in arrangements to follow up patients that did not attend and worked closely with the local Asgard team to ensure patients who were hard to reach received their vaccines. The latest performance figure for this quarter of the year was 100%. The Asgard project in Grimsby was set up in 2008. The project was set up to improve the health and well-being of disadvantaged young people in the area.

The practice promoted a monthly health awareness campaign at the practice. We observed information on the practice website and in the patient waiting area to confirm this. We also saw evidence that the practice had been involved in a number of events to raise health awareness, for example 'Wear it Pink', 'Blue September' and setting up a stand at a health event in the local park in the summer.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP patient survey from 2014 and the practice patient survey from 2013. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. The practice was rated well for its satisfaction scores on consultations with doctors and nurses with 80% of practice respondents saying the GP and 85% saying the nurse was good at listening to them and 82% saying the GP and 89% saying the nurse gave them enough time.

The majority of completed CQC comment cards were positive about the service they experienced. Patients said they felt they were listened to and their needs were met. They said staff treated them with dignity and respect. Two comments were less positive and these related to access to future appointments but not including access to emergency appointments. We also spoke with six patients on the day of our inspection. All told us their dignity and privacy was respected and that they didn't feel rushed during their appointment. Two patients told us they experienced difficulty accessing appointments.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. We observed staff treating patients with dignity and respect.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. We did not overhear any conversations whilst in the patient waiting area.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' and staffs privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff. We were told by a patient that they had reported to the practice, dissatisfaction with the way they had been treated by a locum GP and that that locum GP had not returned to the practice.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Records showed staff had undertaken some training in conflict resolution following a number of incidents of verbal abuse towards staff. We saw further training was planned for staff.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 74% of practice respondents said the GP involved them in care decisions, which was below the national average and 88% said the nurse involved them in care decisions, which was above the national average. The results from the practice's own satisfaction survey showed this question was not asked of patients.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. One patient told us they had discussed with clinical staff whether they should have a care plan in place. Patients told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception area informing patients this service was available. The practice website also provided information about translation services.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 79%

Good

Are services caring?

respondents to the National GP survey said the GP and 89% said the nurse was good at treating them with care and concern. The majority of patients we spoke with on the day of the inspection and all the completed CQC comment cards were positive about the care and support they received. Patients we spoke with who had had a bereavement, confirmed they had received excellent support from the practice. Data showed 90.48% of patients had received an assessment for depression which was higher than the national average.

Notices in the patient waiting room and website showed patients how to access a number of support groups and organisations.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice was pro-active in contacting patients who failed to attend vaccination and screening programmes and worked to support patients who were unable to attend the practice. We saw that the practice utilised the time when patients attended the practice well. For example, practice staff told us that recently when patients attended for flu jabs they used this as an opportunity to carry out a number of other checks, such as blood pressure.

The NHS England Area Team and CCG told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. The practice engaged in a number of meetings with the CCG, for example a referral subgroup, delivery assurance committee and practice manager forum, although the one salaried GP told us they did not engage with the CCG. We saw minutes of meetings, clinical and PPG, to show a range of issues had been discussed, such as improving accessing to clinicians and appointments and actions agreed to implement service improvements and manage delivery challenges to its population.

The practice was proactively involved in the ongoing development and maintenance of good quality services through the PPG. The practice actively engaged, responded and implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the PPG. For example, increasing access to clinicians by trialling the use of telephone triage and looking at repeat attendees.

Tackling inequity and promoting equality

The practice provided equality and diversity training for staff. Records we looked at and the staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months.

The practice was situated on the ground and first floors of the building with all services for patients on the ground floor. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. The seats in the waiting area were basic and all of one height and size. There was no variation for diversity in physical health. There was an audio loop available for patients who were hard of hearing. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

The practice had a population of less than 5% English speaking patients though it could cater for other different languages through translation services. Non-registered patients were able to access appointments through the weekend walk in service.

Access to the service

Appointments were available from 8am to 6:30pm on weekdays. A walk in clinic for registered and non-registered patients was available from 10am to 3pm on a Saturday, Sunday and bank holidays. The practice's extended opening hours was particularly useful to patients with work commitments. The national patient survey data showed 91% of patients were satisfied with the opening hours, which was above the England average.

Information was available to patients about booking appointments on the practice website. This included how to arrange urgent appointments but not how to request a home visit. The practice was in the final stages of the on-line booking system being launched, planned for February 2015. The website also provided detail of the arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Patients could also use MJOG. This facility allowed patients to cancel and book their appointment using a text message.

Longer appointments were available for people who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Appointments were set aside so that clinical staff could book follow up appointments during consultations. When appropriate, home visits were made.

The majority of patients we received feedback from were generally satisfied with the appointment system. They confirmed that they could see a doctor in an emergency

Good

Are services responsive to people's needs?

(for example, to feedback?)

but may have to wait for a period of time. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. They said they could see another doctor if there was a wait to see the doctor of their choice. The practice was utilising the resources of two locum GPs but these had been with the practice for a considerable amount of time which offered patients continuity of care. The practice was aware of the issue of continuity of care and was proactively trying to secure the employment of salaried GPs and nursing staff. When additional locums were needed the practice tried to utilise the services of locums who were familiar with the practice. The practice was aware of issues regarding accessibility of appointments and records showed they were proactively monitoring this to improve the service. For example, the practice was recruiting more clinical staff, they were trialling increased telephone appointments and they were reviewing those patients who had a high level of appointments at the practice to see what support they could receive to reduce their attendance. We reviewed data relating to the number of appointments available to patients over a week and these were at the level expected.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. The complaints information was displayed in the waiting area and included details of the Ombudsman and the CCG. Patients we spoke with were aware of the process to follow if they wished to make a complaint. The practice also displayed information on the notice board in the waiting area to show what action the practice had taken in response to feedback.

We looked at 16 complaints received in the last 12 months and found these were handled in a timely way and attempted to resolve the complaint in the best interest of the patient. We also saw the practice recorded and responded to any informal verbal concerns in the same way.

The practice reviewed complaints as part of the providers' monthly meeting but also at the practice bi-weekly meeting. We looked at the record of action the practice had taken in response to the complaints and saw that lessons learned from individual complaints had been acted on. For example the practice had agreed they could source support from a neighbouring practice if they were short of nursing staff at short notice.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The organisation statement of purpose identified a range of aims and objectives relating to patient care. The practice had in place an annual business plan, although this had not been shared with the GPs.

We spoke with seven members of staff and they all knew and understood the aims and objectives and what their responsibilities were in relation to these.

Governance arrangements

The practice had a wide range of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at 10 of these policies and procedures and all 10 policies and procedures we looked at had been reviewed annually and were up to date.

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

The practice used a range of data to measure its performance. The practice used QOF data, LES (Local Enhanced Services), DES (Direct Enhanced Services) and other available data to monitor quality and performance of the practice and to compare this with other practices in the area. QOF data for this practice showed it was performing in line with national standards. We saw that performance data was regularly discussed at team meetings and actions recorded.

We were told the practice engaged in local peer review with other practices. We saw records which showed the practice had the opportunity to measure its service against others and to identify areas for improvement. For example, referral rates. The medical director for the organisation was also available as support for the practice staff.

The practice had arrangements for identifying, recording and managing risks. The practice had in place a risk register and the risks were collated into a central risk register held at provider (Group) level. The practice also maintained individual risk assessments. Any risks were discussed at practice meetings and actions plans put in place to address. For example, improving access to appointments.

The practice participated in a range of governance meetings; provider and practice led. The practice also reported certain information relating to the practices performance which was reviewed at provider level. However, the salaried GP and the two regular locums rarely met as a clinical team.

The practice had an ongoing programme of audits which were used to monitor quality and systems to identify where action should be taken. For example, health and safety and infection control. However, the practice did not have an ongoing programme of clinical audits in place. Some clinical audits were taking place but they were not completed clinical cycles. The practice acknowledged the need for this and attributed it to the lack of salaried GPs being at the practice for the required time to enable them to complete a full audit cycle. The practice told us they would review this area.

Leadership, openness and transparency

Records showed that clinical meetings were held regularly and meetings with the practice manager and head receptionist. However, staff told us that whole team meetings did not happen frequently as it was difficult getting all staff together. All the staff we spoke with told us there was an open culture at the practice and they were happy to raise any issues with the practice manager.

Staff at the practice were supported by an organisational structure external from the practice staff. For example, the organisation had a separate HR function. The practice manager was responsible for the day to day issues. Staff had access to a comprehensive range of policies and procedures to support them in their role. For example, disciplinary procedures, induction policy, management of sickness were in place to support staff.

Seeking and acting on feedback from patients, public and staff

Are services well-led?

Good

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

The practice had various ways of gathering feedback from patients; patient surveys, Friends and Family Test, PPG, complaints and question of the month, although we noted some of these had not been utilised in recent months. The practice last carried out a patient survey in late 2013 and the most recent minutes of the PPG minutes showed they had devised a new questionnaire to survey patients about the impact of the new GP telephone triage system that was being trialled. It was evidence from the records we looked at that the practice promoted feedback and where appropriate tried to put measures in place to address issues raised.

The practice had a small but active patient participation group (PPG). The PPG was not representative of the area demographic. The PPG had regular meetings and records showed the group was actively involved in reviewing patient surveys, complaints and planning of future surveys.

The practice had gathered feedback from staff generally via staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. One member of staff also told us they would like to have more whole team staff meetings.

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files which showed regular appraisals took place and staff had personal development plans. Staff told us that the practice was supportive of training.

The practice had completed reviews of significant events and other incidents and the majority, but not all of these had been shared with staff. Some staff told us communication around this area could improve.