Salters Meadow Health Centre

Quality Report

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

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?	**Requires improvement**

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Salters Meadow Health Centre on 25 February 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring and responsive services. It was also good for providing services for older people; people with long-term conditions; families, children and young people; working age people; people whose circumstances may make them vulnerable and people experiencing poor mental health. It required improvement for providing well led services.

Our key findings were as follows:

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice offered good continuity of care as all patients had a named GP. However some patients told us they had experienced difficulty in accessing appointments with GPs.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. However, information about safety was not always recorded, monitored, appropriately reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned. However, records were not available to support this.

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

Importantly, the provider must:

- Ensure the methods used for review and dissemination of learning from significant events, near misses and complaints are robust.

In addition the provider should:

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- Ensure the risks to patients and staff from infection control are minimised by completing, recording and acting upon findings from regular infection control audits.
- Introduce regular staff meetings to support and involve all practice staff.
- Ensure that accurate records of meetings are kept.
- Ensure that staff are aware of and identify with the practice vision and values
- Ensure outcomes from the innovative projects the practice is involved are collated as part of quality improvement work.
- Ensure all training is recorded.

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. Staff told us lessons were learned and communicated widely to support improvement, although the minutes of meetings lacked detail. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Staff referred to guidance from 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 obtaining appropriate consent but not accessing patient's mental capacity. Health promotion and prevention was routinely and opportunistically offered to reduce risks to patients' health. Staff had received training appropriate to their roles, although records were not in place to support this. 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 multidisciplinary teams.

We saw limited evidence to demonstrate that the results of clinical audits were shared amongst the clinical staff team.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. 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. Most patients we spoke with and a number of comment cards received showed people did not find it easy to make an appointment with their named GP, although on the day appointments with the advanced nurse practitioner were available. The practice had good

Summary of findings

facilities and was well equipped to treat people and meet their needs. The practice provided co-ordinated and integrated care for the patients registered with them. There were a range of clinics to provide help and support for patients with long-term conditions.

There was an accessible complaints system and evidence which demonstrated that the practice responded to issues raised. However there was no evidence of shared learning from complaints with staff.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led.

Staff felt supported by management and a clear leadership structure was in place. They were aware of their roles and responsibilities; however some of them did not understand the practice vision and values. There was a limited approach to obtaining staff feedback. The practice had a number of policies and procedures to govern activity, but some of these were overdue a review and / or were not always implemented by staff. Appropriate records were not always maintained in relation to the management of the service and regulated activities.

The systems in place for assessing and monitoring service provision were not always robust to ensure all risks were appropriately managed. Whilst clinical audits had been completed, we did not see evidence of an ongoing audit programme to promote continuous improvements to patient care. There was no evidence to support that governance meetings were held. Minutes of meetings in general were poorly documented and lacked detail. Agendas and minutes were not available for all meetings.

The practice engaged with the patient participation group (PPG) to seek patient feedback and improve the service. The PPG is a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them

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

Every patient over the age of 75 years had a named GP. The practice had identified vulnerable older patients and had developed individual care plans to support their care needs. These care plans had been shared with the out of hours provider with patients' permission. Influenza and shingles vaccinations were offered to older patients in accordance with national guidance. Named GPs were responsible for care of patients in care homes and carried out visits when requested. Monthly multi-disciplinary care meetings were held to ensure integrated care for older people with complex health care needs.

People with long term conditions

Good

We found that the nursing staff had the knowledge, skills and competencies to respond to the needs of patients with a long term condition such as heart disease and asthma. Longer appointments and home visits were available when needed. The practice maintained registers of patients with long term conditions.All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. Robust recall systems were in place to ensure patients attended.

Families, children and young people

Good

We saw that the practice provided services to meet the needs of this population group. Urgent appointments with the advanced nurse practitioner were available for children who were unwell. Staff were generally knowledgeable about how to safeguard children from the risk of abuse. Systems were in place for identifying children who were at risk, and there was a good working relationship with the health visitor attached to the practice.

There were effective screening and vaccination programmes in place to support patients and health promotion advice was provided. Information was available to young people regarding sexual health and family planning advice was provided by staff at the practice.

Working age people (including those recently retired and students)

Good

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, flexible and offered continuity of care. The practice was pro-active in offering on line services as well as a full range of health promotion and

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screening services which reflected the needs of this age group. The practice offered all patients aged 40 to 74 years old a health check. Family planning services were provided by the practice for women of working age. Diagnostic tests, that reflected the needs of this age group, were carried out at the practice.

People whose circumstances may make them vulnerable

Good

The practice held a register of patients with a learning disability. It had carried out annual health checks for patients with a learning disability. It offered longer appointments for patients in this population group.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. Most staff knew how to recognise signs of abuse in vulnerable adults and children. Most 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 was proactively assessing patients with risk factors associated with dementia. The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health. It carried out advance care planning for patients with dementia.

Summary of findings

What people who use the service say

We spoke with four patients on the day of the inspection. Patients were mostly satisfied with the service they received at the practice. They told us that clinical staff treated them with care and concern. However, they also told us that it was difficult to access GP appointments, especially as appointments had to be made with their named GP. They said same day appointments were usually available with the advanced nurse practitioner.

We reviewed the 28 patient comments cards from our Care Quality Commission (CQC) comments box that we had asked to be placed in the practice prior to our inspection. We saw that the majority of comments were positive. Patients said they felt the practice offered a good service, and staff were helpful, caring and professional. However, seven patients made comments that were less positive. These comments all related to the appointment system and access to appointments via the telephone.

We looked at the national patient survey published in January 2015. The survey found that 94% of patients rated Salters Meadow Health Centre as good or very good, which placed them amongst the best practices. The results showed that 81% of patients would recommend the practice to someone new to the area.

Areas for improvement

Action the service MUST take to improve

- Ensure the methods used for review and dissemination of learning from significant events, near misses and complaints are robust.

Action the service SHOULD take to improve

- Ensure the risks to patients and staff from infection control are minimised by completing, recording and acting upon findings from regular infection control audits.
- Introduce regular staff meetings to support and involve all practice staff.
- Ensure that accurate records of meetings are kept.
- Ensure that staff are aware of and identify with the practice vision and values
- Ensure outcomes from the innovative projects the practice is involved are collated as part of quality improvement work.
- Ensure all training is recorded.

Salters Meadow Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) lead inspector. The lead inspector was accompanied by a GP specialist advisor and a practice manager specialist advisor.

Background to Salters Meadow Health Centre

Salters Meadow Health Centre is located in the centre of Chase Terrace, close to Burntwood, Staffordshire. The practice provides services to people living in the surrounding towns and villages.

The practice has six GP partners (four male and two female), one nurse practitioner, three practice nurses, a phlebotomist, practice manager, office manager and reception and administration staff. There are 11809 patients registered with the practice. The practice is open from 8am until 6.30pm Monday to Friday. The practice offered extended hours as part of an enhanced service to cover high demand during the winter. Additional pre bookable appointments were available from 6.30pm to 7.15pm on Thursdays, and 7.30am until 10am on Saturdays. The practice treats patients of all ages and provides a range of medical services.

The practice holds a Personal Medical Services (PMS) contract with NHS England. This is a contract for the practice to deliver enhanced primary care services to the local community over and above the General Medical Services (GMS) contract.

Salters Meadow Health Centre has opted out of providing an out-of-hours service to its patients but has alternative arrangements for patients to be seen when the practice is closed. The out of hours service is provided by Staffordshire Doctors Urgent Care via NHS 111.

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 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.

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.

Detailed findings

How we carried out this inspection

Before the inspection we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We received information from the Clinical Commissioning Group (CCG) and the NHS England Local Area Team.

We carried out an announced visit on 25 February 2015. During our inspection we spoke with four GPs, the advanced nurse practitioner, a practice nurse, the practice manager, deputy practice manager and two reception staff. We spoke with four patients who used the service about their experiences of the care they received. We reviewed 38 patient comment cards sharing their views and experiences of the practice. We also spoke with staff from four local care homes.

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

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

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

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

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. We found procedures were in place for reporting safety incidents, complaints or safeguarding concerns. Staff we spoke with knew it was important to report incidents and significant events to keep patients safe from harm. Clinical staff told us they were encouraged and supported to raise any concerns that they may have and were able to explain and demonstrate the reporting process in place. Non clinical staff were less clear about the procedure and told us they would refer concerns to a more senior member of staff.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. One of the GP partners was the lead for significant events. We were able to view the records for significant events that had occurred over the last three years. We saw that the period of review continued until the issue had been resolved.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They told us about the system used to manage and monitor incidents. Clinical staff told us significant events were discussed at the clinical meetings and a process was in place to review actions from past significant events and complaints. However, the minutes of the meetings did not demonstrate the detail of the discussions including the review of any previous actions, any learning that had taken place, or that findings were shared with relevant staff. We did not see any evidence to support that a log of all significant incidents was maintained or that annual review took place.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with described the action they would take for alerts that were relevant to the care they were responsible for.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review the risks to vulnerable children, young people and adults. Staff told us they had received training in safeguarding vulnerable adults and children. However, the practice did not show us evidence to support this as central training records were not maintained. Most staff spoken with understood about safeguarding or how to recognise signs of abuse in older people, vulnerable adults and children. Clinical staff were aware of their responsibilities and knew 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 a dedicated safeguarding lead for children and vulnerable adults. They told us they had received relevant role specific training on safeguarding. However, the practice did not show us evidence to support this as central training records were not maintained. Nursing staff told us they would discuss any issues with the patient's GP or the lead GP for safeguarding if they had a safeguarding concern. Nursing staff were able to describe circumstances when they had raised safeguarding concerns with the GP lead, who had then taken appropriate action.

There was a system to highlight vulnerable adults and children on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments. For example, children subject to child protection plans or patients with learning disabilities, or on the admission avoidance register.

There was no information available to patients about the availability of chaperones. Staff spoken with were not aware if there was a written chaperone policy. They told us only the nursing staff acted as chaperones.

Patient records were written and managed in a way to help ensure safety. Records were kept on an electronic system, EMIS Web, which collated all communications about a patient including electronic and scanned copies of communications from hospitals.

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. A log of the fridge's temperature ranges had been recorded daily, although maximum and

minimum temperatures were not recorded. Best practice would be to record maximum and minimum temperatures to demonstrate that vaccines were safe to use because they had been stored in line with the manufacturers' guidelines. There was a cold chain policy in place. Nursing staff spoken with were able to describe what action to take if vaccines had not been stored within the appropriate temperature range.

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.

We saw there were signed Patient Group Directions (PGD) in place to support the nursing staff in the administration of vaccines. A PGD is a written instruction from a qualified and registered prescriber, such as a doctor, enabling a nurse to administer a medicine to groups of patients without individual prescriptions. Staff told us they received appropriate training and updates to administer vaccines.

One of the GPs took on the lead role of medicines management. Several members of nursing staff were qualified as independent prescribers and were supervised and appraised annually by the lead GP. The advanced nurse practitioner told us that prescribing patterns were audited, and the nurses' prescribing was in line with the GPs. We saw from the data we reviewed that the

pattern of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice were similar to national prescribing.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. The practice was supported by the Medicines Management Team from the local Clinical Commissioning Group. A member of the team visited every two weeks and advised of any changes in guidance and carried out searches to identity patients on medicines where the guidance had changed. The needs of identified patients were reviewed by the GPs and changes made as required.

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.

Cleanliness and infection control

Several patients commented on the comment cards that the practice was always clean and tidy, and we observed this to be the case. The landlord of the building was responsible for the cleanliness of the building. We saw that there were cleaning schedules in place for the general areas, emptying the bins and cleaning the floors. Nursing staff were responsible for cleaning the equipment, work surfaces and sinks on a daily basis. We saw evidence to support that this took place.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy. We were told that all staff received training about infection control specific to their role. However, the practice did not show us evidence to support this as central training records were not maintained. We saw that a limited infection control audit had been carried out on 11 February 2015. The audit did not cover all areas of potential risk, or policies and procedures. Although required actions had been identified in the audit, there was no evidence of an action plan in place to address these issues.

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.

The practice had taken reasonable steps to protect staff and patients from the risks of health care associated infections. We saw that relevant staff had received appropriate immunisations and support to manage the risks of health care associated infections. There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We saw evidence that their disposal was arranged through a suitable company.

Notices about hand hygiene techniques were displayed around the building. Hand washing sinks with hand soap and hand towel dispensers were available in treatment rooms. Hand gel was available for patients use around the building.

The landlord of the building was responsible 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 a risk assessment had been carried out, and appropriate action taken to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us that generally they had the necessary equipment to enable them to carry out diagnostic examinations, assessments and treatments. However, they told us they were no longer able to diagnose asthmatics, as the practice did not have the required equipment as outlined in the guidance. Staff told us they referred patients with suspected asthma to secondary care for diagnosis.

They told us that all equipment was tested and maintained regularly. The practice had an asset register / inventory of all equipment available. However, it was difficult to cross reference individual items of equipment to the asset register as a description of the equipment was not recorded. All portable electrical equipment was tested annually and stickers were displayed indicating the last testing date. We saw that the last portable appliance testing had been completed on August 2014. We saw evidence to support the calibration of relevant equipment for example weighing scales, blood pressure measuring devices or fridge thermometers.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. However, we saw that this policy was not always followed as all of the checks as outlined in the policy were not obtained. This included Disclosure and Barring Service (DBS) checks (previously known as Criminal Records Bureau checks) and relevant information about physical and mental conditions that relate to their ability to perform regulated activities. Staff told us that DBS checks were only requested for clinical staff, and they did not ask for any health related information. Risk assessments were not in place for those staff that did not have a DBS in place.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. Nursing staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was one full time advanced nurse practitioner and three full time practice nurses. The lead nurse told us that the team was able to cover annual leave, and there was flexibility within the advanced nurse practitioner appointments to review any patients newly diagnosed with a long term condition.

Monitoring safety and responding to risk

The practice had some systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. The practice also had a health and safety policy.

The landlord of the building was responsible for maintaining the building. A number of risk assessments were seen, for example, fire and legionella risk assessments. Risk assessments of the building were not available on site. We did not see any evidence to support that the practice had carried out its own risk assessments. A limited audit of the building had been carried out on 11 February 2015.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Staff told us that they received training in basic life support. Nursing staff also received training on anaphylaxis (severe allergic reaction). We saw that the training for 2015 was booked in the practice diary. However, the practice did not show us evidence to support this as central training records were not maintained. Emergency equipment 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, anaphylactic shock and low blood sugar. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. However, staff were unaware that the oxygen cylinders had an expiry date and we found that one of the cylinders had expired.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. However, the document did not contain

Good

Are services safe?

detailed guidance or relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. A copy of the plan was not kept off site, despite this being part of the plan.

The landlord of the building had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that the system was tested weekly and serviced on a regular basis. Records showed that staff had attended a fire drill during 2014.

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. One of the GP partners was the lead for dissemination of any new guidance. Clinical staff spoken with told us that new guidance was discussed at clinical meetings. We saw minutes of practice meetings where new guidelines were disseminated and required actions agreed. The nursing staff described the recent changes relating the diagnosis of asthma, and the implications for the patients. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The advanced nurse practitioner and practice nurses led in specialist clinical areas such as diabetes, heart disease, asthma, contraception and sexual health and were supported by the GPs where required. This allowed the practice to focus on specific conditions. The advanced nurse practitioner attended the clinical meetings with the GPs, and disseminated any new best practice guidelines for the management of specific conditions to the nursing team. Although regular nursing staff meetings took place, minutes were not recorded. Consequently, the practice was not able to evidence that new protocols and guidance were discussed.

The practice had been identified as the joint lowest performance in the Clinical Commissioning Group locality for identify and recording with the symptoms of dementia. As a consequence the practice had decided to identify and review patients at clinical risk of dementia in line with national guidance.

We saw data from the local Clinical Commissioning Group that supported the practice's performance for antibiotic prescribing, which was comparable to similar practices. Other data seen indicated that the prescribing of hypnotic medication (used to assist sleeping) was below the national average, and prescribing of non-steroidal anti-inflammatory medicines (used to treat pain or inflammation) was in line with the national average.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality Outcome Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. The QOF is an incentive scheme which rewards practices for the provision of 'quality care' and helps to fund further improvements in the delivery of clinical care. We saw there was a robust system in place to frequently review QOF data and recall patients when needed. The practice achieved 94.8% QOF points out a possible 100%, which was slightly above the national average.

The percentage of the practice population with a long term health condition was slightly below the national average. The GPs and the nursing staff provided support for those patients with long term conditions and chronic disease management. Patients were identified on the electronic system and invited for a regular review of their condition. Staff told us that care plans were developed with the patients and these were reviewed during their review. This practice was not an outlier for any QOF clinical targets. However, they were below the national average for dementia prevalence and the percentage of patients aged 65 and older who had received a seasonal flu vaccination.

The practice offered all aspects of the avoiding unplanned admissions enhanced service. The practice had identified the most vulnerable patients and developed care plans to assist with avoiding admission to hospital. Those patients who were admitted to hospital or attended accident and emergency were discussed at the monthly multidisciplinary meetings. The minutes of the meetings demonstrated that additional support was considered and implemented where required.

Individual GPs showed us a number of clinical audits undertaken in recent years. These were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example: the treatment of patients with osteoporosis (thinning of the bones) has been reviewed, a register of patients with this condition created, and the appropriate treatment added.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes. The practice was supported by the

Good

Are services effective?

(for example, treatment is effective)

medicines management team from the local Clinical Commissioning Group, who flagged up relevant medicine alerts and identified patients on this particular medicine. The information was then passed on to the GPs for them to action. We saw evidence to support that any required action had been taken.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. Staff told us they received training appropriate to their role. However, the practice did not show us evidence to support this as central training records were not maintained. 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 nursing staff confirmed that the practice was proactive in providing training and funding for relevant courses. There was protected learning time each month, with each section of clinical staff attending training relevant to their role. Administration and reception staff tended to use this time to catch up on outstanding work.

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, cervical cytology, sexual health and family planning. Those with the extended roles of providing annual health reviews for patients with long term conditions such as asthma, diabetes and heart disease were able to demonstrate that they had appropriate training to fulfil these roles. The advanced nurse practitioner and one of the practice nurses were independent prescribers of medicines and were supervised by one of the GP partners.

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. Information from other services about patients was reviewed by the named GP for each patient. The practice used an electronic system for document management (Docman). This system enabled documents to be scanned onto the electronic system and then allocated to the named clinician. GPs were notified of results that required urgent action via a task on the electronic system. We followed the pathway of results received at the practice. We saw that results remained as a task until they had been actioned.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs unplanned admissions. These meetings were attended by the community matron, social workers and palliative care nurses and decisions about care were discussed and updated. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

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, and the practice made referrals through the Choose and Book system. (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). We saw that the referral patterns were in line with other local practices.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record EMISWeb to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The GPs told us that the electronic system also produced leaflets explaining conditions that could be given to patients. The system automatically recorded when a leaflet had been produced.

Consent to care and treatment

We saw that the practice had policies on consent, the Mental Capacity Act 2005, and the assessment of Gillick competency of children and young adults. All clinical staff demonstrated a clear understanding of Gillick competencies when providing care and treatment to

Good

Are services effective?

(for example, treatment is effective)

children. A Gillick competent child is a child under 16 who has the legal capacity to consent to care and treatment. They are capable of understanding implications of the proposed treatment, including the risks and alternative options.

The GPs and nursing staff had not received training on the Mental Capacity Act 2005, although they understood the principles. Mental capacity is the ability to make an informed decision based on understanding a given situation, the options available and the consequences of the decision. People may lose the capacity to make some decisions through illness or disability. Nursing staff told us if they had any concerns about a person's capacity to make decisions, they would advise the patient's GP. A representative from a local care home told us that the GPs would refer patients to the community mental health team, if they had any concerns about a patient's mental capacity.

One of the GPs was responsible for caring for patients with learning disabilities who lived in a local care home. Patients with a learning disability and those with mental health needs were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually.

Staff told us that GPs had sought the patient's consent to certain decisions, for example, 'do not attempt resuscitation' care plans. They told us the appropriate paperwork was completed and scanned on to the electronic system. The staff representative from one of the care homes told us that GPs discussed all of the 'do not attempt resuscitation' care plans with the patient and their families.

There was a practice policy for documenting consent for specific interventions. For example, for all invasive procedures written consent from the patient was obtained.

Health promotion and prevention

When registered at the practice new patients were required to complete a questionnaire providing details of their medical history. It was practice policy to encourage all new patients to attend for a new patient health check with the practice nurses.

The practice provided a range of support to enable patients to live healthier lives. Examples of this included, travel advice and vaccinations, in house smoking cessation programmes and referrals to the Waist Lines adult weight management programme. We were also told that the practice carried out child immunisations and offered sexual health and family planning advice and support. We noted a culture amongst the nursing staff to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice nurse told us they discussed promoting a healthy lifestyle with patients when they carried out reviews for patients with long term conditions. They had a range of leaflets available to give to patients, and leaflets were also available in the waiting room.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Patients were invited by letter to attend for a health check.

Flu vaccination was offered to all over the age of 65, those in at risk groups, pregnant women and children between the ages of two and four. The percentage of eligible patients receiving the flu vaccination was below the national average for patients over 65 years old. The shingles vaccine was offered according to the national guidance for older people.

The practice offered a full range of immunisations for children. The percentage of children receiving the vaccines was generally in line with the average for the local Clinical Commissioning Group.

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 102 replies to the national patient survey carried out during January-March 2014 and July-September 2014and a survey of 336 patients undertaken by the practice with support from the patient participation group (PPG). PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care. The evidence from both these sources showed patients were generally satisfied with how they were treated. For example, data from the national patient survey showed that 94% of patients rated their overall experience of the practice as good or very good, which was above the Clinical Commissioning Group (CCG) area average. The survey showed that 91% of patients felt that the GP was good at listening to them, with a score of 95% for the nurses. However, the practice survey had highlighted that some patients felt that reception staff were rude. We also received a similar comment on one of the completed comment cards.

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 28 completed cards, the majority of which were positive about the service experienced. Patients said they felt the practice offered a good service, and staff were helpful, caring and professional. Seven patients made comments that were less positive but these all related to the appointment system and access to appointments via the telephone. We spoke with four patients on the day of our inspection. They also told us that it was difficult to access GP appointments, especially as appointments had to be made with their named GP. They said same day appointments were usually available with the advanced nurse practitioner.

We saw that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk which helped to keep patient information private. The seated waiting areas were away from the main reception desk, preventing conversations from being overheard. The practice operated a system which allowed only one patient at a time to approach each receptionist at the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

The practice operated a zero tolerance policy for abusive behaviour. However, there was no information in the practice or in the patient information booklet to inform patients of this.

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection told us that they felt fully informed and involved in the decisions about their care. They told us they felt listened to and supported by staff.

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 89% of practice respondents said the GP involved them in care decisions and 88% felt the GP was good at explaining treatment and results. The results were similar for the nurses, with 95% of practice respondents said the nurse involved them in care decisions and 91% felt the nurse was good at explaining treatment and results.

Staff told us that English was the first language for the majority of patients registered at the practice. Staff spoken with did not know if the practice had access to a translation service. They told us patients whose first language was not English were usually accompanied by a family member who spoke English to support them.

We saw that the practice took a proactive approach to identify patients who were assessed as most vulnerable, or who had additional needs due to their medical condition. For example, long term conditions, those with a learning disability or mental health difficulties, and those requiring

Good

Are services caring?

end of life care. Individual care plans had been developed for these patients. Multi-disciplinary meetings between GPs, palliative care nurses, district nurses and social services were held to review care plans for patients near the end of their life. The practice used special notes to ensure that the out of hours service was also aware of the needs of these patients when the practice was closed. We saw systems were in place to ensure patients with a long term condition received a health review at least annually. This included patients for example with coronary heart disease, diabetes, chronic obstructive pulmonary disease (chronic lung disease) and asthma. The advanced nurse practitioner told us that appointment days and times for patients with long term conditions were flexible to accommodate patients' preferences.

Patient/carer support to cope emotionally with care and treatment

The GP patient survey information we reviewed showed patients were positive about the emotional support provided by the practice. For example, 90% of patients surveyed said the last GP they saw or spoke with was good at treating them with care and concern with a score of 93% for nurses. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information.

Leaflets in the patient waiting rooms and on the website told people how to access a number of support groups and organisations. For example carers groups, voluntary car scheme, weight loss support groups and cancer care. The practice maintained a carers' register, so additional support could be offered as required.

Patients nearing the end of their life had their care and support reviewed at the monthly multidisciplinary meetings which included practice staff, district and palliative care nurses and social services. The practice did not have a set procedure for contacting families who had suffered bereavement. Each GP would decide if contact was required or bereavement counselling should be offered. Leaflets on bereavement were available and patients could access telephone bereavement services.

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 maintain the level of service provided. For example, patients were usually offered same day appointments with the advanced nurse practitioner and telephone advisory service was offered between 12 noon and 2pm by the nursing staff. The practice provided a range of services in house, for example, warfarin clinics (blood thinning medication) and travel vaccinations.

The practice used a range of risk assessment tools to identify vulnerable patients. As part of an enhanced service the practice had identified patients most at risk of unplanned admissions and had developed individual care plans for them. The plans included anticipating the patient's needs and putting measures in place to avoid admission, for example rescue medicines or end of life medicines.

Nurse-led clinics were held for conditions such as diabetes, hypertension, chronic obstructive pulmonary disease (COPD) and asthma. Other weekly clinics at the health centre provided by community based staff included antenatal care with the midwife and well baby clinics with the health visitor.

The practice had a virtual Patient Participation Group (PPG) to help it to engage with a cross section of the practice population and obtain patient views. PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care. The virtual PPG had 96 members in March 2014 with representatives from a wide cross section of the practice population. Information was shared with members electronically twice a year and members were asked to comment on any issues, surveys and proposed actions. The practice had a good working relationship with the PPG. Information about the PPG was available in the practice booklet and on the practice website. However, the information in the practice booklet was incorrect as it referred to the PPG meeting every month. Following the 2013/2014 patient survey, the practice implemented a number of changes. These included promoting the designated 'privacy room', improved signage and liaised with the voluntary drivers scheme to support patients with transport.

We spoke with representatives from four local care homes. Two of the four representatives told us the service varied between the GPs and sometimes the practice was reluctant to accept the request for a home visit. However, one of the representatives told us that the practice had engaged with patients and their families regarding 'do not attempt resuscitation' decisions and ensured that these decisions were reviewed. The other two representatives told us they had no issues with the service provided and the majority of their patients registered at the practice were able to visit the practice for appointments.

Tackling inequity and promoting equality

The practice had recognised the needs of different population groups in the planning and delivery of its services. The GPs maintained individual patient lists as they felt this provided continuity of care. Patients over 75 years of age had a named GP to ensure continuity of care. The practice met monthly with the multidisciplinary team to discuss patients who required palliative care or were identified as part of avoiding unplanned admissions enhanced service. We saw from the minutes that discussions took place as to whether the care provided was appropriate, and whether additional support could be provided.

The practice was located within a health centre. The premises and services were suitable to meet the needs of people with disabilities. The practice was situated on the ground floor of the building. There was a hearing loop system available for patients with a hearing impairment. We saw that the waiting areas were large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. There were automatic doors to the health centre, which made easy access for wheelchairs users and patients with pushchairs. However, the doors to the practice and to the consulting rooms weren't automatic, and the access was more difficult for wheelchair users. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

The majority of the practice population were English speaking patients. Staff were not sure if they had access to interpreter services. There were both male and female GPs that the practice, although each GP maintained their own

Good

Are services responsive to people's needs?

(for example, to feedback?)

patient list, and appointments were made for patients with their own GP. There was no information informing patients that they could request the 'gender of the GP' if they wished to.

Access to the service

The practice booklet and website outlined how patients could book appointments and organise repeat prescriptions online. This included how to arrange urgent appointments and home visits. Patients could also make appointments by telephone or in person to ensure they were able to access the practice at times and in ways that were convenient to them. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. The contact telephone numbers for the out of hours service were in the practice booklet and on the website.

The practice opened from 8am until 6.30pm Monday to Friday. The practice operated a combination of face to face appointments and telephone consultations, carried out by the advanced nurse practitioner. The practice also offered extended hours as part of an enhanced service to high cover demand during the winter. Additional pre bookable appointments were available from 6.30pm to 7.15pm on Thursdays, and 7.30am until 10am on Saturdays.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to local care homes on request. One GP was responsible for the care of patients with learning disabilities who lived in a local care home.

The national GP patient survey results showed patients rated the practice positively in relation to phone access and appointments. For example: 82% of respondents found it easy to get through to the practice by phone; 88% described their experience of making an appointment as good, and 95% of respondents usually get to see or speak to a GP, both of which were above the local Clinical Commissioning Group average.

There were mixed views from patients we spoke with regarding the appointments system. Two out of the four patients spoken with commented that it was difficult to get a GP appointment, and they may wait several days for an appointment to be available. However, two patients told us that they had contacted the practice that morning for an appointment, although these were with the advanced nurse practitioner. Similar comments were made on the completed comment cards. One patient commented about trying to book a next day appointment and ringing at 8am, and no appointments being available. They then had to ring at 8am each morning until an appointment was available. Other patients commented that appointments were generally available.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their 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.

Patients were made aware of how to complain through the practice booklet and information on the website. However, the complaints policy and information in the practice booklet made reference to the Primary Care Trust, which was replaced by the Clinical Commissioning Group in April 2013. None of the patients we spoke with had any concerns about the practice or had needed to use the complaints procedure.

The practice had received 11 complaints during the previous 12 months. We saw that if the complaint was clinical in nature, the GP concerned responded to the complainant. We saw that complaints was a standing agenda item at the practice meeting attended by the GPs, advanced nurse practitioner, practice manager and deputy. We did not see any evidence to support that complaints had been analysed to establish if the situation could have been handled differently, any shared learning or reviewed over time to identify any trends or themes.

We asked reception staff if they knew about the complaints procedure. They told us they would ask patients to put their complaint in writing to the practice manager. We asked staff if they received any feedback from complaints. They said they only received feedback if they were involved in the complaint.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The practice leadership told us the ethos of the practice included providing care when a person was ill and preventing ill health by offering a variety of services provided by a professional team. The statement of purpose encompassed key values such as partnership working with patients and health professionals, delivery of safe and effective care and prevention of ill health. All staff we spoke with were clear that they aimed to provide patients with the best quality care.

However, discussions with staff showed some were not clear about the overall vision of the practice. We found no records to evidence that the leadership had discussed and agreed the practice vision with all staff.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and some were available to staff on the practice's intranet, or as paper copies. Some staff we spoke with told us that the policies and procedures were kept in the practice manager's office and others showed us the electronic copies. The electronic policies and procedures had been reviewed and overwritten in February 2015. It was unclear how frequently policies and procedures were reviewed.

Each GP partner carried out their own clinical audits which it used to monitor quality and systems to identify where action should be taken. However, there was limited evidence to support that the findings were shared with staff and actions and recommendations were recorded.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF is an incentive scheme rewards practices for the provision of 'quality care' and helps to fund further improvements in the delivery of clinical care. The QOF data for this practice showed it was generally performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings, although there was no evidence of action plans to maintain or improve outcomes.

The practice had arrangements for identifying, recording and managing risks. The building in which the practice was located was owned by a landlord. The building administrator showed us their risk assessments for potential issues, such as Control of Substances Hazardous to Health (COSHH), fire safety and prevention of the legionella virus. Risk assessments of the building were not available on site.

Leadership, openness and transparency

We saw from minutes that business meetings and partner meetings were held regularly, at least monthly. Nursing staff told us that they had monthly meetings as a team. However, there were no agendas or minutes of these meetings, therefore staff who were not in attendance were not able to update themselves. There was no evidence to support that staff meetings for administration and reception staff took place, and staff spoken with could not recall the last time a meeting was held.

The practice manager was responsible for human resource policies and procedures. Staff were unaware of the disciplinary and grievance policy, or the whistleblowing policy, although these were included in the electronic staff handbook. It was not clear if all staff were aware of the electronic staff handbook or referred to the policies and procedures for guidance. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through patient surveys and comment cards and complaints. The practice had a virtual Patient Participation Group (PPG) to help it to engage with a cross section of the practice population and obtain patient views. PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care. Following the 2013/2014 patient survey, the practice implemented a number of changes. These included promoting the designated 'privacy room', improved signage and liaised with the voluntary drivers scheme to support patients with transport.

The practice had gathered feedback from clinical staff through staff meetings, although not all meetings were minuted. We found very limited input to the development of practice services by non-clinical staff. For example, there were no regular and planned staff meetings to discuss practice issues, and feedback from staff was not actively sought.

Are services well-led?

Requires improvement

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training. The practice nurse told us they could request for training that was relevant to the needs of the practice population and the practice supported this. Staff spoken with told us they received an annual appraisal and we saw evidence to support this.

The GPs told us that the outcome of clinical audits and reviews of significant events were shared with staff at clinical meetings to ensure the practice improved outcomes for patients. However the minutes of meetings saw did not demonstrate the detail of the discussions or of any learning that had taken place. This meant that staff who were not in attendance were not able to update themselves. We did not see any evidence to support that a log of all significant incidents was maintained or that annual review took place.

The practice had records that demonstrated concerns, near misses, significant events (SE's) and complaints were appropriately logged. However, the records did not record the detail of any investigation or discussion, or any lessons learnt. There were no minutes to demonstrate the sharing of information the nursing team or non-clinical staff.

We found that the practice did not have a system in place to monitor that all staff attended regular training including refresher updates and there was a lack of records to support the proactive planning for staff development and improvement of the service.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **People using the service were not protected against the risks of inappropriate or unsafe care and treatment because of the lack of robust methods for review and dissemination of learning from significant events, near misses and complaints.** This corresponds to Regulation 17(1) (2)(a)(b) of the (Regulated Activities) Regulations 2014