Westbrook Medical Centre

Quality Report

301-302 Westbrook Centre
Westbrook
Warrington
Cheshire
WA5 8UF
Tel: 01925 654152
Website: http://www.westbrookmedicalcentre.co.uk

Date of inspection visit: 12 May 2015
Date of publication: 25/06/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Westbrook Medical Centre on 12 May 2015. Overall the practice is rated as good.

Westbrook Medical Centre provided safe, effective, responsive care that addressed the needs of the population it served. Improvements were needed to ensure governance arrangements were effective.

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

- Systems were in place to ensure incidents and significant events were identified, investigated and reported. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Lessons learnt from the investigation of safety incidents were disseminated to staff. Infection risks and medicines were managed safely.
- Patients care needs were assessed and care and treatment was being considered in line with best practice national guidelines. Patients experienced clinical outcomes that were in line with or above the national average. Staff were proactive in promoting good health
- Patients spoke highly of the practice. They said they were treated with care, compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice provided care to its population that was responsive to their health needs. Patients were listened to and feedback was acted upon. Complaints were managed appropriately.
- There was an evident leadership structure, staff enjoyed working for the practice and felt well supported and valued. However improvements were needed to ensure audit and governance systems were effective and that systems were in place to identify, assess and mitigate risks.

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

Summary of findings

The provider must:

- Implement effective audit and risk management systems and processes to ensure assessment, monitoring, mitigation of risks and improvements are made in the quality and safety of the services provided, including the quality of the experience of patients using the service.

In addition the provider should:

- Ensure its recruitment arrangements are in line with Schedule 3 of the Health and Social Care Act 2008 to ensure necessary employment checks are in place for all staff and the required information in respect of workers is held. This should include obtaining information about any physical or mental health conditions which are relevant to the person's role and photographic identification.
- Ensure that non-clinical staff are up to date with their appraisals and training in essential knowledge and skills for their role such as basic life support, infection control and safeguarding.
- Implement a system to ensure blank prescription forms are handled in accordance with national guidance and tracked through the practice.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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 learnt and communicated to all staff to support improvement. Child and adult safeguarding policies and procedures were in place. Clinical staff were appropriately trained and staff demonstrated an awareness of safeguarding vulnerable patients. Medicines and infection control risks were managed safely. There were enough staff to keep patients safe. However, improvements were needed to ensure full required information is held in respect of workers and prescription pads were handled in accordance with national guidance.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were around average for the locality, including the Quality and Outcomes Framework (QOF). The Quality and Outcomes Framework (QOF) is a system for the performance management and payment of GPs in the NHS. It was intended to improve the quality of general practice and the QOF rewards GPs for implementing "good practice" in their surgeries. The practice had achieved a score of 91.4% for QOF last year (this was slightly below average overall with some indicators above national and local average). Staff referred to and used guidance from National Institute for Health and Care Excellence (NICE). The practice had identified the specific needs of their patients and was proactive in assessing and planning care particularly for families, children and working age patients, older, vulnerable patients and those with long term and mental health conditions. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health.

Are services caring?

Good

The practice is rated as good for providing caring services. Results from the national GP patient survey, patients we spoke with and those who completed the CQC comment cards in the two weeks prior to the inspection were complimentary and positive about the service and the care and treatment they received. Patients said they were treated with care, compassion, dignity and respect and they were involved in decisions about their care and treatment. Staff we spoke with were aware of the importance of providing patients with privacy and of confidentiality. We also observed that staff treated patients with dignity and respect.

Summary of findings

Are services responsive to people's needs?

Good 

The practice is rated as good for providing responsive services. The practice had identified and reviewed the needs of their local population and provided tailored services accordingly. They engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Access to the service was monitored to ensure it met the needs of patients. Information about how to complain was available and evidence showed that the practice responded appropriately to complaints.

Are services well-led?

Requires improvement 

The practice is rated as requires improvement for being well-led. The practice had a mission statement and clear values were articulated by all staff. There was a leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular clinical and team meetings. However, governance arrangements did not include effective audit or risk management systems and processes to ensure that quality and performance were monitored, risks were identified and managed.

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. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. For example the Quality and Outcomes Framework (QOF) information indicated that last year 90% of patients aged 75 or over with a fragility fracture on or after 1 April 2012, who are currently treated with an appropriate bone sparing agent. This was higher than the national average. 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, avoiding unplanned admissions, seasonal flu vaccinations and in dementia and end of life care. It was responsive to the needs of older people, and offered home visits to deliver care to those older patients who were not able to attend the surgery. It was proactive in providing weekly ward rounds for patients living in local care homes.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The practice had a lower than national average number of patients with long standing health conditions (49.4% of its population). Patients with long term conditions were supported by a healthcare team that cared for them using good practice guidelines and were attentive to their changing needs. There was proactive intervention for patients with long term conditions. Patients had health reviews at regular intervals depending on their health needs and condition. For example 100% of patients with rheumatoid arthritis had received an annual review.

The practice maintained and monitored registers of patients with long term conditions for example cardiovascular disease, diabetes, chronic obstructive pulmonary disease and heart failure. These registers enabled the practice to monitor and review patients with long term conditions effectively. The Quality and Outcomes Framework (QOF) information indicated that patients with long term health conditions received care and treatment as expected and above the national average. For example, 100% of patients with asthma had received a review in the last 12 months, regular and clinical risk groups (at risk due to long term conditions) had good uptake rates for seasonal flu vaccinations.

Clinical staff (both GPs and practice nurses) managed chronic long term conditions and diseases. Patients at risk of hospital admission

Summary of findings

were identified, care plans developed and reviewed regularly. Longer appointments and home visits were available when needed. Patients had a named GP and a structured annual review to check that their health and medication needs were being met.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children who were at risk, for example, the practice maintained a register of children who had a child protection plan. Immunisation uptake rates were above average for standard childhood immunisations. We received positive feedback regarding care and treatment at the practice for this group. Patients we spoke with told us they were confident with the care and treatment provided to their families. Appointments were available outside of school hours and the premises were suitable for children and babies including the provision of breast feeding and baby changing rooms. We saw good examples of joint working with midwives and health visitors. For example there were weekly baby clinics held on site and a 'Bosom Buddies' group which supported breastfeeding mothers. The practice responded to the needs of this group and children or young people were always given a same day appointment or urgent appointment as necessary.

Working age people (including those recently retired and students)

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, flexible and offered continuity of care. The practice offered flexibility in appointments and a range of services such as health promotion and screening that reflected the needs for this age group. For example smoking cessation and travel advice. Routine health checks were available to patients aged over 45. Online booking, cancellation of appointments and ordering of repeat medications facilities were available. Extended hours appointments were available with appointments available from 7am most days and one day per week appointments were available until 7.30pm.

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 including children and adults at risk of abuse, patients with dementia,

terminally ill and those with a learning disability. It had carried out annual health checks for people with a learning disability and it offered longer appointments and home visits for vulnerable patients.

The practice worked with multi-disciplinary teams in the case management of vulnerable people. It was able to signpost vulnerable patients and their carers to various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies.

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). For example 78% of those diagnosed with dementia had received a review of their care in the preceding 12 months. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

One of the GPs led on dementia care. The practice worked closely with the mental health services in Warrington. The practice provided an onsite weekly counselling service to patients suffering with poor mental health and was able to signpost patients experiencing poor mental health to access various support groups and voluntary organisations including MIND. Patients with poor mental health were accommodated, where possible, with same day appointments with a preferred clinician.

Summary of findings

What people who use the service say

We spoke with five patients on the day of our inspection including members of the patient participation group (PPG). We received 40 CQC comment cards that were completed in the two weeks prior to the inspection. Patients whom we spoke with varied in age and population group.

All patients were positive about the practice, the staff and the service they received. They told us staff were caring and compassionate and that they were always treated well with dignity and respect. Eighty five percent of respondents to the national GP patient survey said they would recommend the practice to someone new in the area with 92% describing their overall experience of the practice as good. These results were higher than the local CCG average.

Patients had confidence in the staff and the GPs who cared for and treated them. The results of the national GP patient survey published in July 2014 demonstrated they performed well with 100% of respondents saying they had confidence and trust in the last GP they saw or spoke with. Eighty nine percent said the last GP they saw or spoke to was good at treating them with care and concern, 95% of respondents said the last nurse they saw or spoke to was good at treating them with care and concern. Ninety six percent said the last GP they spoke to or saw was good at listening to them, whilst 85% said the GP was good at explaining treatment and tests. The data demonstrated the practice was performing above average for the majority of questions asked.

A minority of patients that we spoke with and comments received expressed concern regarding accessing appointments. They commented it was sometimes difficult to get an appointment. This was corroborated by the national GP patient survey (2014) which said the practice could improve on access to getting an appointment to see or speak to someone. Only 77% of respondents said they were able to get an appointment to see or speak with someone the last time they tried, compared to the local CCG average of 84%. Sixty eight percent described their experience of making an appointment as good, with 92% saying the last appointment they got was convenient. Only 58% of respondents with a preferred GP usually got to see or speak to that GP (this was below the local CCG average). Patients we spoke with told us they had to wait for up to two to three weeks to get an appointment with a preferred GP, however they all said they were able to get a more timely appointment if they didn't mind which GP they saw and this was acceptable to them. Members of the PPG and patients we spoke with on the day told us they felt access to appointments had improved recently since the practice had taken on another GP.

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

Areas for improvement

Action the service MUST take to improve

- The practice must implement effective audit and risk management systems and processes to ensure assessment, monitoring, mitigation of risks and improvements are made in the quality and safety of the services provided, including the quality of the experience of patients using the service.

Action the service SHOULD take to improve

- Ensure its recruitment arrangements are in line with Schedule 3 of the Health and Social Care Act 2008 to ensure necessary employment checks are in place for all staff and the required information in respect of workers is held. This should include obtaining information about any physical or mental health conditions which are relevant to the person's role and photographic identification.

Summary of findings

- Ensure that non-clinical staff are up to date with their appraisals and training in essential knowledge and skills for their role such as basic life support, infection control and safeguarding.
- Implement a system to ensure blank prescription forms are handled in accordance with national guidance and tracked through the practice.

Westbrook Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Lead Inspector and included a GP specialist advisor and a practice manager specialist advisor.

Background to Westbrook Medical Centre

Westbrook Medical Centre is registered with the Care Quality Commission to provide primary care services. It provides GP services for approximately 10500 patients living in Warrington. The practice is situated in a new modern purpose built health centre which houses other health care clinics such as podiatry, audiology and paediatric optometry. The practice has seven GPs (four male and three female), a practice management team, three practice nurses, and administration and reception staff. Westbrook Medical Centre holds a Primary Medical Services (PMS) contract with NHS England.

The practice is open during the week, between 8.30am and 6.00pm. Extended hours appointments are available in the mornings and one evening per week. They are closed one afternoon per month for staff training and development. Patients can book appointments in person, via the telephone or online. The practice provides telephone consultations, pre bookable consultations, urgent consultations and home visits. The practice treats patients of all ages and provides a range of primary medical services.

The practice is part of Warrington Clinical Commissioning Group (CCG).The practice is situated in an affluent area. The practice population is made up of a slightly higher than national average working age population. Forty nine percent of the patient population has a long standing health condition, whilst 52% have health related problems in daily life. There is a slightly lower than national average number of unemployed patients.

The practice does not provide out of hours services. For out of hours medical care patients are advised to ring NHS 111 helpline. Out of hours GP services are provided locally by the local NHS Trust.

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 (Regulated Activities) and Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, 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.

How we carried out this inspection

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

- Is it safe?

Detailed findings

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

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

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

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

We reviewed the practice's policies, procedures and other information the practice provided before the inspection. The information reviewed did not highlight any significant areas of risk across the five key question areas.

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

We spoke with the practice manager, office manager, GPs, practice nurses, administrative and reception staff on duty. We spoke with patients who were using the service on the day of the inspection.

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

Good

Are services safe?

Our findings

Safe track record

Warrington Clinical Commissioning Group and NHS England reported no concerns to us about the safety of the service. 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, concerns and near misses. GPs and nurses told us they completed incident reports and carried out significant event analysis routinely and as part of their on-going professional development.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. Staff told us there was an open and 'no blame' culture at the practice that encouraged staff to report adverse events and incidents.

Learning and improvement from safety incidents

We reviewed the records of significant events that had occurred during the previous 12 months. There was evidence that appropriate learning had taken place and that findings were disseminated to relevant staff through face to face discussions and meetings. Staff, including receptionists, administration and nursing staff, knew how to raise an issue for consideration at meetings and they felt encouraged to do so. We noted that the practice did not carry out an overview of significant events regularly in order to identify themes or trends. All staff were involved in feedback and lessons learnt from incidents and complaints by attending regular meetings at which these were discussed.

The practice showed us the system they used to manage and monitor incidents. We saw evidence of documented action taken as a result and implementation of learning. Where patients had been affected by something that had gone wrong, they were given an apology and informed of the actions taken.

National patient safety alerts were logged, monitored and disseminated by the practice manager to relevant staff. Staff we spoke with were able to give an example of recent alerts/guidance that were relevant to the care they were responsible for. For example the recent guidance on Ebola (Ebola is a contagious viral infection causing severe symptoms and caused an epidemic in West Africa). They also told us that alerts were discussed at meetings or disseminated via email 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 in place to safeguard vulnerable children, young people and adults. The practice had up to date safeguarding child and adult policies and procedures in place. They provided staff with information about identifying, reporting and dealing with suspected abuse and at risk patients. The policies were available to staff on the practice computer system. Staff had access to contact details for both child protection and adult safeguarding teams. We saw these contact details displayed in clinical and non-clinical areas.

We found that all clinical staff had received training in safeguarding at a level appropriate to their role (level three). This training was updated regularly and we saw evidence of update training having taken place this year. However we noted that non clinical staff did not have training in safeguarding nor relevant regular update training. Non clinical staff we spoke with were able to demonstrate knowledge around the types of abuse and how to raise concerns or report incidents.

The practice had a dedicated GP lead in safeguarding. They had attended appropriate training to support them in carrying out their work, as recommended by their professional registration safeguarding guidance. The safeguarding lead did not always attend safeguarding case conferences; however they completed all requested reports for child protection and serious case review meetings. All staff we spoke to were aware that the practice had a safeguarding lead and knew who to speak to in the practice if they had a safeguarding concern. There was a system to highlight vulnerable patients on the practice's electronic records. This system included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. Codes and alerts were applied on the electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were flagged. However we noted

that the highlighting system in place was not clearly identifiable on opening a patient record and did not immediately flag patient's vulnerability or special needs to clinical and non-clinical staff.

The practice had a current chaperone policy. (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). A chaperone policy notice was displayed in the reception area and in all treatment and consultation rooms.

Medicines management

We checked medicines stored in the treatment rooms and fridges. We found that they were stored appropriately. There was a current policy and procedures in place for medicines management including cold storage of vaccinations and temperature sensitive medicines. We saw the checklist that was completed daily to ensure the fridge remained at a safe temperature and spoke to staff who managed the vaccines. They all had a clear understanding of the actions they needed to take to keep vaccines safe. A cold chain policy (cold chain refers to the process used to maintain optimal conditions during the transport, storage, and handling of vaccines) was in place for the safe management of vaccines. We noted that the fridges used to store vaccines and other medicines were not hard wired and did not have warning notices displayed to alert people not to inadvertently unplug them. We found one fridge in the administrative area (that was currently not in use) had no safety checks recorded such as electrical testing, temperature recording or calibration and servicing. When discussed with the practice we were told this would be removed.

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

Repeat prescriptions were held securely. Reception staff we spoke with were aware of the necessary checks required when giving out prescriptions to patients who attended the practice to collect them. Prescriptions were monitored to check they had been picked up by patients. Blank prescription forms were logged however they were not handled in full accordance with national guidance as these were not tracked through the practice and signed for by GPs when taken for use.

Medicines for use in medical emergencies were kept securely in the treatment room and on the emergency trolley. We saw evidence that stock levels and expiry dates were checked and recorded on a regular basis.

The practice staff and GPs were supported by the medicines management team of the Clinical Commissioning Group (CCG) in keeping up to date with medication and prescribing trends.

Cleanliness and infection control

The patients we spoke with commented that the practice was clean and appeared hygienic. We found the premises to be clean, tidy and well maintained. The treatment rooms, waiting areas and toilets were in good condition. Staff had access to gloves and aprons and there were appropriate segregated waste disposal systems for clinical and non-clinical waste. We observed good hand washing facilities to promote good standards of hygiene. Instructions about hand hygiene were available throughout the practice with hand gels in clinical rooms, couches were washable and clean.

The practice had a nurse lead for infection control. Infection control training and annual updates were undertaken by all nursing staff. However we noted that infection control training had not been undertaken by non-clinical staff except for hand washing technique demonstration and handling of specimens. This had been delivered by the practice nurses. Procedures for the safe storage and disposal of needles and waste products were evident in order to protect the staff and patients from harm.

The practice had an infection control audit carried out by the community infection control team in 2015. We saw the completed report and evidence of an on-going action plan to address the issues found. Cleaning was carried out by the practice cleaning staff. The cleaning standards and schedule were monitored.

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.

Regular testing and investigation of legionella was not undertaken (a bacterium found in the environment which

can contaminate water systems in buildings). We were told about the procedure in place to mitigate the risk by regular running of the water systems. However a formal risk assessment was not evident.

Equipment

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

All equipment was tested and maintained regularly and we saw equipment maintenance logs, contracts and other records that confirmed this. There were contracts in place for regular checks of fire extinguishers. We noted that portable electrical equipment was not regularly checked and tested; however the practice told us they had plans in place for the qualified handyman to undertake this shortly. We saw that annual calibration and servicing of medical equipment was up to date, for example weighing scales, spirometers and blood pressure measuring devices.

Emergency equipment was stored in the office. This included nebulisers and oxygen. An automated external defibrillator (used to attempt to restart a person's heart in an emergency) was available within the practice also. These were maintained and checked regularly.

Staffing and recruitment

There was a recruitment policy in place with associated policies and procedures for reference requesting, and recruitment qualification checking. However the policy was not in line with current guidance and regulations, for example it did not include the requirement to undertake obtaining photographic evidence of identification or Disclosure and Barring Service (DBS) checks (these checks provide employers with an individual's full criminal record and other information to assess the individual's suitability for the post).

We looked at five staff files including clinical and non-clinical staff. We found generally these were satisfactory however some files did not contain all the required information relating to workers. For example we found that information about any physical or mental health conditions which may be relevant to the person's role at the practice and photographic identification was not held on file.

We found that a Disclosure and Barring Service (DBS) check had been undertaken for all clinical staff at a suitable level for their roles. Non-clinical staff had not had these checks undertaken however there were DBS risk assessments for all staff to assess the level of risk for these staff. Some reception and administrative staff acted as chaperones. We saw evidence that a DBS check had been applied for these staff and we were told they would not be acting as chaperones until suitable checks had been received.

Records demonstrated clinical staff's professional registration with the General Medical Council (GMC) and the Nursing Midwifery Council (NMC) were monitored and checked regularly. GPs were checked to ensure they were suitable to work in their role and that they were on the NHS England Performers List. This included checking any locum GPs used.

Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness. The staff worked well as a team and as such supported each other in times of absence and unexpected increased activity and demand.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor some risks to patients, staff and visitors to the practice. These included regular cleanliness checks of the premises, medicines management, staffing and dealing with emergencies and equipment. The practice had a health and safety policy in place. Health and safety information was displayed for staff to see. However we found that risk assessments were not in place for general environmental risks and Control of Substances Hazardous to Health (COSHH).

The practice used electronic record systems that were protected by passwords and smart cards on the computer system. Historic paper records were stored securely on site.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example: ill children and young people were usually given an appointment the same day or directed to appropriate health services where needed.

Arrangements to deal with emergencies and major incidents

Good

Are services safe?

A business continuity planning and recovery plan was in place. The plan covered business continuity, staffing, records, electronic systems, clinical and environmental events. The document contained relevant contact details for staff to refer to.

The practice had arrangements in place to manage emergencies. Staff could describe how they would alert others to emergency situations via the electronic systems. Clinical staff had evidence of updated cardio pulmonary resuscitation training; however we found that non-clinical staff were not up to date with this training. There was emergency equipment and medicines available including an automated external defibrillator and oxygen. Suitable emergency medicines were available in the practice and staff knew of their location.

Records showed that fire fighting equipment and fire safety equipment (such as the fire alarm) were routinely checked and maintained under contract. We saw that a recent planned fire drill had taken place.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The clinicians were familiar with, and used current best practice. The staff we spoke with and evidence we reviewed confirmed that care and treatment was aimed at ensuring each patient was given support to achieve the best health outcomes for them. We found from our discussions that staff completed, in line with The National Institute for Health and Clinical Excellence (NICE) and local commissioners' guidelines, assessments and care plans of patients' needs and these were reviewed appropriately.

The GPs and practice nurses told us that they discussed new clinical protocols, reviewed complex patient needs and kept up to date with best practice guidelines and relevant legislation. The practice nurses supported each other and were well supported by the GPs in clinical decision making. Clinical meeting minutes demonstrated that staff discussed patient treatments and care and this supported staff to continually review and discuss new best practice guidelines.

The GPs specialised and led in clinical areas such as safeguarding and minor surgery. They also specialised and took the lead with different patient groups and conditions such as cardiology, rheumatology, dermatology and mental health patients. The practice nurses also managed specialist clinical areas such as family planning, diabetes, immunisations, heart disease and asthma. This meant that the clinicians were able to focus on specific conditions and provide patients with regular support based on up to date information.

The practice provided a service for all age groups. They provided services for patients in the local community with diverse needs, working age patients, patients with learning disabilities, patients living in care homes and patients experiencing poor mental health. The GPs provided a weekly ward round to a large number of patients living in three local care homes. They visited with administrative support to assess, plan, implement and review care and treatments to these patients to provide proactive care and help prevent avoidable admissions to hospital. We found that staff were familiar with the needs of patients and the impact of the socio-economic environment. Services provided were tailored to meet these needs.

The GPs used national standards for the referral of patients for tests for health conditions, for example patients with suspected cancers were referred to hospital and the referrals were monitored to ensure an appointment was provided within two weeks.

Management, monitoring and improving outcomes for people

The Quality and Outcomes Framework (QOF) is a system for the performance management and payment of GPs in the NHS. It was intended to improve the quality of general practice and the QOF rewards GPs for implementing "good practice" in their surgeries. This practice had achieved a score for QOF of 91.4% last year which was slightly lower than the national average; however some indicators were above the national and local average. QOF information indicated that working age patients, families, children and younger patients, those with long term health conditions, vulnerable patients and those with poor mental health all received care and treatment as expected and around or above the national average. For example patients with diabetes had regular screening and monitoring and clinical risk groups (at risk due to long term conditions) had good uptake rates for seasonal flu vaccinations. Child immunisations rates were higher than the local average. Uptake of cervical cancer screening was also around average with the practice achieving 82% of patients having had a cervical smear in the last 5 years (where relevant).

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, managing clinical registers and medicines management. The practice had systems in place which supported GPs and other clinical staff to improve clinical outcomes for patients for example the practice kept up to date disease registers for patients who were vulnerable, terminally ill and for those with long term conditions such as diabetes, asthma and **chronic obstructive pulmonary disease** (**COPD**). These registers were used to identify and monitor patients' health needs and to arrange annual health reviews.

The practice did not have a programme in place for completing clinical audits. Nor could they demonstrate that those audits they had undertaken were complete cycles and demonstrated improved outcomes for patients. (Clinical Audit is a process or cycle of events that help ensure patients receive the right care and the right treatment. This is done by measuring the care and services

provided against evidence based standards, changes are implemented to narrow the gap between existing practice and what is known to be best practice. Ideally, a clinical audit is a continuous cycle that is continuously measured with improvements made after each cycle).

Examples of audits that the GPs had participated in included the recent national cancer network audit, medication audits such as hypnotics and allopurinol prescribing. GPs told of us their plans to undertake an audit on the treatment of atrial fibrillation; this had been decided upon following a learning event on treatment methods for this condition. The practice had identified they had a high level of benzodiazepine and hypnotic medicines use, however we did not see audits or substantive evidence of the work they said they had done to address this.

Data collection and reviews were undertaken of enhanced service provision, locality and national performance indicators and QOF. For example, the practice monitored and reviewed unplanned hospital admissions. The medicines management support team from the local Clinical Commissioning Group (CCG) also undertook regular frequent audits of medications and prescribing trends such as tranquillisers.

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 monitored that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used.

The practice had a palliative care register and regularly discussed the care and support needs of patients and their families. The patient's care plan and any other relevant information were shared with the out of hour's services to inform them of any particular needs of patients who were nearing the end of their lives.

Effective staffing

There was an induction procedure in place which identified the essential knowledge and skills needed for new employees. We saw a completed induction checklist for a recent new employee.

We reviewed staff training and found there was no training policy or plan in place which identified core essential training which should be undertaken by all staff and periodically updated appropriate to role. We found that non-clinical staff had not received regular update training in infection control, cardio pulmonary resuscitation, health and safety or safeguarding of vulnerable adults and children. Clinical staff had received core essential training and could demonstrate they were up to date, for example in cardio pulmonary resuscitation, safeguarding and in role relevant skills such as immunisations and cervical smears. Non clinical staff had evidence of training in role specific topics such as information governance and customer contact.

Practice staffing included medical, nursing, managerial and administrative staff. We noted a good skill mix among the doctors with each having special interests in different fields of general practice. GPs undertook continuing professional development for their roles for example, minor surgical procedures, dermatology and dementia. Practice nurses were part of a local practice nurse forum called 'Practice Makes Perfect' which provided them with peer support.

Clinical staff had annual appraisals; however we noted non-clinical staff were out of date having not had an appraisal in the last 12 months. We were told of and shown plans to introduce a new appraisal process and documentation shortly. We spoke to staff who told us the practice was supportive of their learning and development needs. All GPs were up to date with their yearly continuing professional development requirements and they had either been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

The practice nurses and GPs had completed accredited training around checking patients' physical health and around the management of the various specific diseases and long term conditions. Additional role specific training had been undertaken by clinical staff to support them in these roles. 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 (for example seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease) were also able to demonstrate that they had appropriate training to fulfil these roles.

Good

Are services effective?

(for example, treatment is effective)

The practice closed one half day per month and used this time for practice team meetings and for learning and development.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those patients with complex needs. We were shown how the practice provided the 'out of hour's' service with information, to support, for example, end of life care. The practice received blood test results, X ray results, and letters from the local hospital including discharge summaries and out-of-hours GP services both electronically and by post and we saw that this information was read and actioned by the GPs in a timely manner. Information was also scanned onto electronic patient records in a timely manner.

The practice worked closely with other health and social care providers in the local area. They told us how they worked with the community mental health team, social workers and health visitors to support patients and promote their welfare. However they told us that since the district nurses had been relocated out of the practice building, communication with district nurses was more difficult and they did not meet as frequently to discuss patients and care.

Information sharing

The practice used electronic systems to communicate with other providers. They shared information with out of hour's services regarding patients with special needs. They communicated and shared information regularly between themselves, other practices and community health and social care staff.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. This software enabled scanned paper communications, such as those from hospital, to be saved in the computer system for future reference. All members of staff were trained on the system, and could demonstrate how information was shared. Electronic systems were in place for making referrals, and the practice made most of its 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 found that there was a backlog of summarising of new patients records due to a recent admission of a large number of new patients to the practice. GPs told us the process in place to mitigate the risk of inappropriate care and treatment. When a patient new to the practice presented for an appointment the GP would read all the patient paper historical records to ensure full information was reviewed regarding the patient if the clinical summarising had not yet been done.

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. They were able to discuss consent issues with us and demonstrated their understanding around consent and mental capacity issues. They were aware of the circumstances in which best interest decisions may need to be made in line with the Mental Capacity Act when someone may lack capacity to make their own decisions. Clinical staff demonstrated an 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).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures a patient's written consent was obtained and documented in the patient notes. Implied consent was obtained for child immunisations with recorded explanation and consent held in their records.

Health promotion and prevention

The practice supported patients to manage their health and well-being. The practice offered national screening programmes, vaccination programmes, children's immunisations, long term condition reviews and provided health promotion information to patients. They provided information to patients via their website and in leaflets and posters in the waiting area about the services available. This included smoking cessation, blood pressure monitoring and travel advice.

The practice offered NHS Health Checks to all its patients aged over 40. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for children's immunisations was

Good

Are services effective?

(for example, treatment is effective)

slightly higher than national average. Seasonal flu immunisation rates for the over 65 group were around average for the CCG. There was a process for following up non-attenders by the named practice nurse.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. The practice kept up to date disease registers for patients with long term conditions such as diabetes, asthma and chronic heart disease which were used to arrange annual health reviews. The practice also kept registers of vulnerable patients such as those with mental health needs and learning disabilities and used these to plan annual health checks. For example, the practice kept a register of all patients with dementia and records showed 85% had received a face to face review in the last 12 months. The practice had also identified the smoking status of patients over the age of 16 and actively offered smoking cessation advice to these patients.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Staff we spoke with were aware of the importance of providing patients with privacy and of the importance of confidentiality. The computers at reception were shielded from view for confidentiality. We noted phone calls were taken away from the reception desk and this afforded confidentiality to patients. Patients were offered a separate area where they could speak confidentially with staff if necessary.

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

We looked at 40 CQC comment cards that patients had completed prior to the inspection and spoke with three patients. Patients were positive about the care they received from the practice. They commented that they were treated with respect and dignity, felt they had confidence in the staff caring for them and that their health needs were addressed. Patients we spoke with told us they had enough time to discuss things fully with the GP, treatments were explained and that they felt listened to.

The National GP Patient Survey 2014 found that 89% of patients at the practice stated that the last time they saw or spoke to a GP; the GP was good or very good at treating them with care and concern. Ninety five percent of respondents said that the nurses were also good at treating them with care and concern. Ninety two percent of patients who responded to this survey described the overall experience of their GP surgery as good or very good.

The practice offered patients a chaperone prior to any examination or procedure. Information about having a chaperone was seen displayed in the reception area and all treatment and consultation rooms. Patients confirmed with us that chaperones were offered regularly and they had the choice of male or female doctors to examine them. There was a notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

Patients who we spoke with and who made comments via the CQC comments cards, told us they felt involved in decisions about their own treatment, they received explanations about diagnosis and treatments and staff listened to them and gave them time to think about decisions. This was reflected in the patient survey results.

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 rated the practice well in these areas. For example, data from the National GP Patient Survey 2014 demonstrated 84% of patients said the GPs were good at involving them in decisions about their care and 85% said the GP was good at explaining tests and treatments. These results were around average when compared to CCG area and nationally. Eighty seven percent of respondents said the last nurse they saw or spoke to was good at involving them in decisions about their care.

Patients we spoke with told us that health issues were discussed with them, treatments were explained, and they felt involved in decision making about the care and treatment they received. They also 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.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with on the day of our inspection and the comment cards we received told us that staff were caring and compassionate.

Patients told us they had enough time to discuss things fully with the GP, they felt listened to and felt clinicians were empathetic and compassionate. Results from the National GP Patient Survey told us that 87% of patients said the last GP they saw or spoke to was good at giving them enough time, 96% said the GP was good at listening to them and 85% said they were good at explaining tests and treatment.

The practice cared for patients with terminal illness and those coming towards the end of their life. They had a palliative care register and regularly discussed the care

Good

Are services caring?

plans and support needs of patients and their families. Patient care plans and supportive information informed out of hours services of any particular needs of patients who were coming towards the end of their lives.

Staff spoken with told us that bereaved relatives known to the practice were offered support. The practice signposted carers to support led by community 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. The needs of the practice's population were understood and systems were in place to address identified needs in the way services were delivered. The practice held information and registers about the prevalence of specific diseases within their patient population and patient demographics. This information was reflected in the services provided, for example screening programmes, vaccination programmes, specific services and reviews for elderly patients, those in care homes, those patients with long term conditions and mental health conditions.

We were told the practice engaged with the NHS England Area Team, Clinical Commissioning Group (CCG) and other practices to discuss local needs and service improvements that needed to be prioritised.

The practice was responsive to the needs of families and working age patients, older patients, those with long term conditions and mental health conditions and vulnerable patients. They offered extended hours appointments, child health services, home visits, care home ward rounds and extended appointments for those with enhanced needs. Patients received annual health checks and had care plans in place.

Patients with dementia, learning disabilities and enduring mental health conditions were reviewed annually. They were encouraged to bring carers with them to these reviews. The practice had implemented the 'named GP' for patients over 75 to support continuity of care. The practice was proactive in contacting patients who failed to attend vaccination and screening programmes.

The practice had an active patient participation group (PPG). We met with members of this group who told us they were valued and listened to by the practice who acted, where possible, on suggestions made by patient representatives.

Tackling inequity and promoting equality

The practice was situated in a purpose built health centre and provided disabled access in all areas. There was disabled car parking available and good, large car parking facilities available nearby. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities and a room available for breast feeding mothers.

The practice analysed its activity and monitored patient population groups. This enabled them to direct appropriate support and information to the different groups of patients. The practice had a majority population of English speaking patients though it could cater for other languages as it had access to translation services. They had tailored services and support around the populations' needs and provided a good service to all patient population groups.

The practice did not routinely provide equality and diversity training for its staff.

Access to the service

The practice was open Monday to Friday 8.00am until 6.00pm. Extended hours appointments were available earlier in the morning and one day per week in the evening. They were closed one half day every month for training and development. Information was available to patients about appointments on the practice website and in the practice information leaflet. This included who to contact for advice and appointments out of normal working hours when the practice was closed such as contact details for the NHS 111 service. The practice offered pre bookable, on the day appointments and home visits. Appointments could be made in person, online or by phone. Priority was given to children; babies and vulnerable patients identified as at risk due to their condition. Patients confirmed that they were always given an appointment on the same day if their condition was assessed as needing urgent attention.

Appointments were tailored to meet the needs of patients, for example those with long term conditions and those with learning disabilities were given longer appointments. Home visits were made to older patients, vulnerable housebound patients and patients living in local care homes. Patients told us that if they wished to see the GP of their choice then usually there was a wait of two to three weeks. However patients told us they always got a timely appointment with a GP if they did not have a preference. This was confirmed by the patient survey results which told us that 58% of patients with a preferred GP usually got to see that GP (this was lower than the local CCG average).

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patients we spoke with, comment cards and patient survey results told us patients were generally satisfied with the appointment system. Some patients said there was difficulty getting through to the practice on the telephone and getting an appointment. The national GP patient survey told us that only 64% of patients said they found it easy to through to the practice by phone (around the local average). The practice had introduced online booking of appointments and repeat prescribing requests. The practice told us they were looking at ways to improve the appointment system and access to GPs and practice nurses. Patients told us they felt that access to appointments and the appointment system had improved recently.

Listening and learning from concerns and complaints

The practice had a policy, procedure and system in place for handling complaints and concerns. The practice manager and clinical staff managed the complaints and they liaised with all relevant staff in dealing with the complaints on an individual basis.

We looked at the complaints log for the last 12 months and found that complaints had been dealt with and responded to appropriately. The practice took action in response to complaints to help improve the service. We noted the practice did not review complaints quarterly, six monthly or annually in order to detect themes or trends.

We saw that information was available to help patients understand the complaints system in a patient leaflet and on the website. Patients we spoke with were not aware of the complaints procedure, however they told us what they would do if they needed to make a complaint and none of the patients we spoke with had ever had cause to complain.

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 had a mission statement and vision to provide quality healthcare to their patients. Staff could articulate the practice ethos however not all staff were aware of a formal mission statement and this was not displayed in the practice.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the computer shared drive and in hard copy. Policies and procedures were dated, reviewed and appropriate. Staff were familiar with the policies and procedures and confirmed they were aware of how to access them.

The practice had named members of staff in lead roles. For example, there was a lead for infection control, safeguarding, palliative care, learning disability and mental health. We spoke with staff in different roles and they were all clear about their own roles and responsibilities. They all told us there was a friendly, open culture within the practice and they felt very much part of a team.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing around the national average. For 2013/14 the practice obtained 91.4%. We saw that QOF data was monitored and discussed between the team and actions taken to maintain or improve outcomes.

The practice did not have a programme in place for completing clinical audits. Nor could they demonstrate that those audits they had undertaken were complete cycles and demonstrated improved outcomes for patients. Clinical reviews and data collections were undertaken by medical staff and were not widely shared with other staff for learning and improvement. We looked at a selection of these. Those audits GPs had undertaken were generally basic in detail and did not demonstrate cycles of audits or patient outcome improvements.

The practice did not have arrangements in place for identifying and managing some of the potential risks to the practice, patients and staff. There were no general environmental health and safety risk assessments in place. There was no evidence of portable appliance testing having been undertaken. Recent fire safety training had not been undertaken by practice staff; however there was evidence of a fire evacuation drill having been carried out last year. There was no evidence of regular testing and investigation of legionella (a bacterium found in the environment which can contaminate water systems in buildings). We were told about the procedure in place to mitigate the risk by regular running of the water systems. However a formal risk assessment was not evident. Non clinical staff had not received appropriate essential skills training or regular appraisals. This had not been identified as a risk and appropriate action plans to address the training needs were not in place.

The practice held regular meetings, these were documented. We looked at a sample of minutes and found that clinical issues, significant events and complaints had been discussed.

Leadership, openness and transparency

Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings and with the practice management team.

Staff felt confident in the senior team's ability to deal with any issues, including serious incidents and concerns regarding clinical practice. All the staff we spoke with told us they felt they were valued and well supported.

The two senior GP partners at the practice had recently retired and the practice had undergone some instability with difficulty recruiting to the posts. One new partner had been recruited and the leadership team was settling in to new roles and responsibilities within the practice and the business. GPs demonstrated they were considering future service provision and succession planning.

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

We looked at complaints and found they were dealt with appropriately. The practice investigated and responded to them in a timely manner, and complaints were discussed with staff to ensure staff learned from the event.

The practice had an active patient participation group (PPG). They told us they were valued and listened to by the practice team. GPs and the practice staff attended the PPG

Are services well-led?

Requires improvement

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

meetings and a two way communication took place. Suggestions were acted upon such as considering piped music in the reception/waiting areas as a means of preventing the overhearing of confidential conversations.

The practice had gathered feedback from patients through patient surveys, friends and family test comments and complaints. Information was promoted in reception to patients encouraging them to access and participate in the NHS friends and family test. The NHS friends and family test (FFT) is an opportunity for patients to provide feedback on the services that provide their care and treatment. It was available in GP practices from 1 December 2014. We saw the results of the latest tests which were positive with the majority of patients recommending the practice to others. For example the results of the friends and family test for February 2015 demonstrated that when asked "would you recommend this service to friends and family", all 25 respondents said extremely likely or likely to recommend the practice.

The practice gathered feedback from staff through formal and informal 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. Regular informal discussions and meetings were held at which staff had the opportunity and were happy to raise any suggestions or concerns they had.

Management lead through learning and improvement

The practice could not demonstrate that a training and development policy and plan were in place to ensure that staff were trained and developed appropriately to their role. Clinical staff were mostly up to date with essential core training such as cardiopulmonary resuscitation, infection control, and safeguarding. However non- clinical staff were not as it was not felt necessary for their role. Staff had the opportunity to attend learning events delivered by the CCG during their half day closures.

Clinical staff had annual appraisals and were up to date with these. Non clinical staff were due to have their appraisals and a new methodology was seen that was shortly to be implemented.

The practice had completed reviews of significant events, complaints and other incidents. The results were discussed at practice meetings. However there was no overarching regular review of significant events or complaints at which trends and themes were identified and addressed.

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 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** There was not an effective auditing system in place to ensure assessment, monitoring and driving of improvements in the quality and safety of care and treatment provided. There was not an effective risk management system or process in place to assess, monitor and mitigate risks relating to the health, safety and welfare of people using the services and others. This included general environmental and health and safety risk assessments. **Regulation 17 (2) (a), 17 (2) (b)**

This section is primarily information for the provider

Enforcement actions

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.