Heatherview Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Heatherview Medical Centre on 24 June 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, responsive, caring and well led services. It also was rated as good for providing services for the following population groups; 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).

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

- There were systems in place to mitigate safety risks including analysing significant events and safeguarding.
- The premises were clean and tidy.
- Systems were in place to ensure medication including vaccines were appropriately stored and in date.
- Patients had their needs assessed in line with current guidance and the practice had a holistic approach to patient care.
- Feedback from patients and observations throughout our inspection showed that staff were kind caring and helpful.
- The practice had systems in place to respond to and act on patient complaints and feedback safety and the quality of the service provided.
- The staff worked well together as a team.
- The practice was part of a Zero Tolerance Scheme that provided care to patients who had been violent or threatened violence towards staff at other practices and had been removed from their lists. There were 70-100 patient contacts per quarter and approximately 60% were discharged from this service after the initial twelve month contract had been completed. These patients were always seen promptly on arrival at the practice.
- The practice were aware of patients who were not able to read and would contact them by telephone or knock on their front door if a matter required urgent

Summary of findings

attention, or a health need required following up, for example those with long term conditions. Receptionists in the practice would assist with form filling when needed.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice highly 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 for patients about the services available was easy to understand and accessible. We saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the Clinical Commissioning Group to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

Summary of findings

The practice ran a Zero Tolerance Scheme which allowed patients who were excluded from other practices to receive healthcare. When needed the practice would support patients who had difficulty reading and writing to complete forms and would visit them to ensure they kept their appointments.

Are services well-led?

Good

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

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. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care.

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 living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency attendances. Immunisation rates were above national averages for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

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 this population group had been identified and the practice had adjusted the services it offered to ensure that services were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

Summary of findings

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 for example, those with a learning disability. It offered longer appointments for people with a learning disability and provided them with an annual health check.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). 90% of people living with dementia had an agreed care plan in their records. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

As part of our inspection process, we asked patients to complete comment cards prior to our inspection. We received five comment cards and spoke with one member of the Patient Participation Group (PPG). We also spoke with six patients. All comments received indicated that patients found the staff helpful, caring and polite and the majority described their care as very good.

These findings were in line with results received from the National GP Patient Survey. For example, the national GP patient survey results for 2013/14 showed that 85.5% of patients described their overall experience of this surgery as fairly good or very good.

Results from the National GP Patient Survey showed that 69.9% of patients find it easy to get through to this surgery by phone, which was below the national average. However, 94.7% of patients stated that the last time they saw or spoke to a nurse, the nurse was good or very good at treating them with care and concern which was higher than the national average.

Heatherview Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Heatherview Medical Centre

Heatherview Medical centre is situated in the Alder Hills area of Poole which has a high level of deprivation. The practice is located in large purpose built premises. At the time of our inspection there were 10,053 patients on the practice list. The practice has five GP partners, three salaried GPs, four practice nurses, a practice manager and a team of administrators and reception staff.

The practice is open 8.30am to 6.30pm Monday to Friday. Telephone lines were open from 8am. Patients requiring a GP outside of normal working hours are advised to contact an external out of hours service that is provided by South Western Ambulance Trust. The number of this service is clearly displayed in the reception area and on the practice website.

The practice has a PMS (Personal Medical Services) contract and offers enhanced services for example; additional immunisations, learning disabilities health check schemes and services for violent patients, which the practice call the Zero Tolerance Scheme.

The main practice is situated at: 2 Alder Park Road, Alder Road, Poole BH12 4AY

The practice has a branch surgery which is: Fernside Surgery, 2a Hennings Park Road, Poole BH15 3QU and was not visited as part of this inspection.

Why we carried out this inspection

We carried out a comprehensive inspection of the services under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We carried out a planned inspection to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to provide a rating for the services under the Care Act 2014.

How we carried out this inspection

Before visiting the practice we reviewed information we held and asked other organisations and key stakeholders to share what they knew about the practice. We also reviewed policies, procedures and other information the practice provided before the inspection day. We carried out an announced visit on 24 June 2015. We only visited the main registered location of Heatherview Medical Centre.

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?

Detailed findings

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)

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example we reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 12 months. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system for reporting and recording significant events. There was a specific form that staff had to complete. Significant events were routinely shared and discussed at regular meetings and learning points were identified. Records we looked at confirmed this. We also found that themes were analysed and actions taken to minimise risk of reoccurrence. Learning was shared with all relevant members of staff, including nursing staff. Information was shared with the clinical commissioning group and other GP practices within the area if required.

Reliable safety systems and processes including safeguarding

The practice had safeguarding vulnerable adults and children policies in place which were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. In addition there were flow charts for guidance and contact numbers displayed within the reception area and treatment areas. There was a lead member of staff for safeguarding.

All staff had received safeguarding children training at a level suitable to their role for child safeguarding, for example all clinicians had level three training. Staff had also received safeguarding vulnerable adults training and understood their role in reporting any safeguarding incidents. GPs attended safeguarding meetings and provided reports where necessary for other agencies. The practice had a large conference room which was often used by social services for their multi-disciplinary safeguarding meetings, which made it easier for GPs to attend in person. The practice had a computer system for patients' notes and there were alerts on patients' records if they were at risk or subject to a protection order.

A chaperone policy was available on the practice's computer system. The practice nurses and reception staff acted as chaperones if required and a notice was in the waiting room to advise patients the service was available should they need it. Staff had received training to carry out this role and all staff had received a Disclosure and Barring Service (DBS) check.

Medicines management

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 checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. Practice staff monitored the refrigerators temperatures and appropriate actions had been taken when the temperatures were outside the recommended ranges.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescriptions for use in printers and those for hand written prescriptions were handled in accordance with national guidance and were tracked through the practice and kept securely at all times.

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying medicines, which included regular monitoring. Appropriate action was taken to manage these medicines if required.

Cleanliness and infection control

We saw all areas in the practice were visibly clean and tidy. Comments we received from patients indicated that they found the practice to be clean.

Treatment and consulting rooms had the necessary hand washing facilities and personal protective equipment, such as gloves available. Hand sanitising gels were available throughout the practice for staff and patients to use. Clinical waste disposal contracts were in place and spillage kits for blood and bodily fluids were available.

Good

Are services safe?

The practice had a designated lead for infection control. There was an infection control policy in place. An audit had been carried out on infection control processes at the practice; areas identified for improvement had been completed, or were in the process of being completed. Regular cleaning audits and checks of treatment rooms were carried out to ensure the risk of infection was minimised. Cleaning records and audits were documented and we saw records which confirmed this.

The practice had a policy in place for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). A legionella risk assessments had been completed and legionella testing had been carried out.

Equipment

Staff said they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. We looked at records for equipment testing and calibration. (Calibration is where pieces of equipment such as weighing scales and thermometers are tested to ensure they provide accurate measurements). We found that all equipment was tested and maintained. All electrical equipment was checked to ensure the equipment was safe to use.

Staffing and recruitment

Staff said there were enough staff to meet the needs of patients and they provided cover for each other in the event of unplanned absences or annual leave. GPs said that they were required to clear their desks and complete all tasks prior to leave and all further tasks would be covered whilst they were on leave, so they would return to a clear desk. The GP responsible for the Zero Tolerance Scheme, where patients had strict criteria for seeing a GP due to their previous behaviours, told us another GP was designated to care for these patients whilst they were on holiday.

The practice had a recruitment policy which set out the standards it followed when recruiting clinical and non-clinical staff. All clinical staff and reception staff who acted as chaperones had a criminal records check carried out via the DBS to ensure they were suitable to carry out their role. The practice used two locum GPs on a regular basis and we saw that all necessary and relevant checks had been carried out. For example, checks on the NHS England GP performers list and medical indemnity insurance.

Monitoring safety and responding to risk

The practice had designated members of staff responsible for ensuring compliance with fire, legionella and other health and safety regulations for the premises.

There were suitable arrangements in place to manage the risk of fire. All staff had received fire safety training and basic life support training.

There were procedures in place for monitoring and managing risks to patient safety. All new employees working in the building were given information for the building which covered health and safety and fire safety as part of the induction process. There was a health and safety policy available for all staff.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records and staff confirmed that they had received basic life support training. Emergency equipment was available including access to oxygen and an automated external defibrillator (a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). Staff were able to tell us where this equipment was located and how to use it, records confirmed that the equipment was checked regularly.

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.

Emergency medicines were held securely in the practice and all staff knew where this was. The medicines included those used for the treatment of cardiac arrest, abnormal heart rhythms and low blood sugar levels. Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

The practice had a disaster handling and business continuity plan in place for major incidents such as power failure or building damage. This document was reviewed on a six monthly basis by the practice manager and partners.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

The practice used a system of coding and alerts within the clinical record system to ensure that patients with specific needs were highlighted to staff on opening the clinical record. For example, patients on the 'at risk' register, learning disabilities register and palliative care register.

The practice took part in the avoiding unplanned admissions scheme. The clinicians reviewed their individual patients and discussed patient needs at formal meetings to ensure care plans were in place and regularly reviewed.

The GPs told us that they lead in specialist clinical areas such as diabetes, sexual health, women's health and heart disease. The practice nurses supported this work and also ran nurse led clinics for long term conditions such as respiratory (breathing) conditions.

The practice offered new patients a full health check which included information on the patient's lifestyle as well as their medical conditions. These checks were carried out by practice nurses or healthcare assistants, who had received training, and when needed patients were referred to a GP or nurse practitioner for further treatment and advice.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework system (QOF). This is a system for the performance management of GPs intended to improve the quality of general practice and reward good practice.

The GPs carried out clinical audits as part of their revalidation process. (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). Examples of audits included a cancer diagnosis audit started in 2015 and new diagnoses of hypertension, which was commenced in 2014 and the second cycle of the audit was due to start in August 2015. We found that GPs did not routinely share the outcomes of their clinical audits with others in the practice.

Doctors at the practice had undertaken minor surgical procedures in line with their registration and NICE guidance. An example of a completed clinical audit related to quality assurance of minor surgical procedures, and covered areas such as whether patients were given sufficient information on the procedure, whether they had sufficient local anaesthetic and whether they considered the practice was the best place to have their procedure. Results showed that improvements were required particularly with regards to ensuring patients had a full explanation of the procedure prior to giving consent. An action plan had been put into place.

The practice also met with the local clinical commissioning group (CCG) and the Bourne Valley Action Group, which is a charity, set up residents of Bourne Valley to improve their neighbourhood and other health professionals to discuss performance and health needs of patients. The practice was part of a federation of eight GP practices who worked together to bid for contracts to provide healthcare. This involvement supported the exchange of best practice and positive information between practices, voluntary agencies and secondary care services in the local area.

Effective staffing

The practice had an induction programme for newly appointed members of staff that covered such topics as fire safety, health and safety and confidentiality.

Staff received training that included safeguarding vulnerable children, equality and diversity and information governance awareness. The practice was closed for half a day a month to accommodate training that was organised by the local CCG.

The practice nurses attended local practice nurse forums and attended a variety of external training events. They told us the practice fully supported them in their role and encouraged further training. The nurse was supported to attend meetings and events.

All GPs were up to date with their yearly continuing professional development requirements and they had been or were in the process of being revalidated. There was an annual appraisal system being set up to ensure all other members of staff received a formal appraisal.

Good

Are services effective?

(for example, treatment is effective)

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received.

The out of hours service (OOH) was able to access summary care records held by the practice. Summary care records consist of important details about a patient, such as known medicine allergies, brief details of their past medical history and whether they had a current care plan in place. The practice sent information to the OOH service via fax and information received from the OOH service was received via email. Regular meetings were held with other health professionals, such as district nurses and health visitors, to discuss patient needs or safeguarding concerns. Patients who were receiving end of life care were discussed at regular meetings with the community care team and risk assessed according to their condition, to make sure effective treatment was provided.

The practice worked with the midwifery team to provide ante and post natal care for pregnant women and new mothers. The practice was able to message the midwifery team with any urgent concerns or GPs would speak with midwives when they were in the building carrying out clinics. The practice also worked with the clinical commissioning group's multidisciplinary team to reduce admissions to hospital and supporting patients in their own homes. The practice had a health visitor's hub on site, and also district nurse's hub.

Accommodation for these health professionals was facilitated by the practice to increase continuity of care and promoted joined up working. GPs Software used by social workers was due to be loaded onto the computer systems to enable social workers to work in the practice and thus provide an integrated care hub. This arrangement allowed health visitors and district nurses to be part of the multidisciplinary team meetings held by the practice.

Information sharing

The practice used several electronic systems to communicate with other providers. We saw evidence of a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services. The practice computer systems were linked between both locations and summary care records were accessible to relevant care providers. The practice was also able to access on line links with the local hospitals to obtain test results.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record 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.

Consent to care and treatment

The practice had a Mental Capacity Act 2005 policy in place to help GPs with determining the mental capacity of patients. We spoke with the GPs about their understanding of the Mental Capacity Act 2005 and Gillick guidelines. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. Gillick competence is used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

GPs told us that there was a nominated psychiatrist who was responsible for carrying out formal mental capacity assessments, for example, when a patient was drawing up a lasting power of attorney. They said that usually a 'best interest' decision was made if there were no formal documents in place and if they had any concerns about a patient's ability to consent. The practice recorded these 'best interest' decisions on their computer and had started to develop a formal template to ensure the information was auditable in the future.

The practice carried out minor surgical procedures and we found appropriate information had been given to patients and consent had been sought from patients prior to the procedure being carried out.

Health promotion and prevention

The practice had a variety of patient information available to help patients manage and improve their health. There were health promotion and prevention advice leaflets

Good

Are services effective?

(for example, treatment is effective)

available in the waiting rooms for the practice including information on dementia. The practice staff sign posted patients to additional services such as lifestyle management and smoking cessation clinics.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous, caring and very helpful to patients both attending at the reception desk and on the telephone. Five CQC comment cards were received and patients we spoke with all indicated that they found staff to be helpful, caring, and polite and that they were treated with dignity.

Results from the national GP patient survey showed that 78.7% of patients said the last GP they saw or spoke to was good at treating them with care and concern this was in line with the national average. The survey also showed that approximately 94.7% of patients said the last nurse they saw or spoke to was good at treating them with care and concern this was higher than the national average.

The practice had a large waiting area which was separate from the reception area and consulting rooms. There was also a privacy room that could be used if a patient wished to discuss their concerns confidentially.

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.

The practice had a confidentiality policy in place and all staff were required to sign to say they would abide to the protocols as part of their employment contract.

Care planning and involvement in decisions about care and treatment

Results from the national GP patient survey showed approximately that 80.8% of patients said the last nurse they saw or spoke to was good or very good at involving them about their care which was comparable to the national average.

The patient survey also showed that approximately 75.7% of patients said that the last time they saw or spoke to a GP the GP was good or very good at involving them in decisions about their care this was in line with the national average.

The practice participated in the avoidance of unplanned admissions scheme. Informal meetings took place to discuss patients on the scheme to ensure all care plans were regularly reviewed.

The service had access to a language service to support those patients where English was not their first language. Staff we spoke with told us they did not need to use this service often but knew how if needed.

Patient/carer support to cope emotionally with care and treatment

The practice had a large waiting area which was separate from the reception area and consulting rooms. There was also a privacy room that could be used if a patient wished to discuss their concerns confidentially. Information for carers was available in the reception and a member of staff was responsible for coordinating a carer's register and provided support to these patients. The practice's computer system had flags placed on them to indicate whether a patient was a carer or being cared for. This enabled GPs and nurses to ensure they were appropriately supported.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, the practice had worked with the patient participation group (PPG) on how appointments were provided and the PPG was supporting the practice in monitoring changes.

The practice met with the Clinical Commissioning Group (CCG) and engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements to better meet the needs of its population. The practice was part of a federation of GP practices who had been formed to bid for contracts to provide appropriate care and treatment for the local population.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities. The majority of the practice population were English speaking patients but access to telephone translation services were available if they were needed. The practice population had a small number of non-English speaking patients. The practice was able to access a translation service if needed. A British sign language interpreter could be arranged if required and the practice said they had previously used this service. The privacy room had a hearing loop installed to assist patients who had a hearing impairment.

The practice had settled Romany gypsy communities and a high number of single parents in their practice area. They had tailored services to meet these patients' needs. GPs said that some patients would attend the practice only when their need was urgent and the practice was continuing to find ways to engage these patients in self-management of their conditions. GPs were aware of patients who were not able to read and would contact them by telephone or knock on their front door if a matter required urgent attention, or a health need required following up, for example those with long term conditions. Receptionists in the practice would assist with form filling when needed, for example benefit applications.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events.

The practice was part of a Zero Tolerance Scheme. For patients who had been violent or threatened violence towards staff at other practices and had been removed from their lists. We spoke with the GP who coordinated this service. They told us that they would carry out an initial consultation and patients were obliged to attend with an advocate present. Subsequent visits could be with or without an advocate present dependent on whether a patient respected and adhered to the strict boundaries on behaviours that were put into place. The GP said that there were between 70-100 patient contacts per quarter and approximately 60% were discharged from this service after the initial twelve month contract had been completed. These patients were always seen promptly on arrival at the practice.

Access to the service

The practice was open between 8:30am and 6:00pm Monday to Friday. The practice offered a number of emergency appointments each day to support those patients who needed to be seen urgently. There were pre-bookable early morning appointments available with the practice nurses. The practice offered patients telephone consultations when appropriate as an alternative to an appointment. Members of the PPG told us that this access system worked well and the practice made every effort to provide a high standard of care.

The service offered home visits to those patients who were housebound or too ill to attend the practice. The patient survey indicated that 72.3% of patients were satisfied with the practice's opening hours which is slightly below the national average.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

The practice had recently had an extension built which increased the number of consulting rooms available. As part of this work care had been taken to ensure patients

Good

Are services responsive to people's needs?

(for example, to feedback?)

with disabilities were able to access the building safely. For example, there was a ramp for wheelchair users and automatic front doors. There was sufficient space for wheelchair users to manoeuvre around the practice which helped them to maintain their independence. Accessible toilet facilities and baby changing facilities were also available.

Listening and learning from concerns and complaints

The practice has a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England.

Information about how to make a complaint was available on the practice's website and in the waiting area. The complaints policy clearly outlined a time framework for when the complaint would be acknowledged and responded to. In addition, the complaints policy outlined who the patient should contact if they were unhappy with the outcome of their complaint.

The practice kept a complaints log book and we noted only written formal complaints had been logged. The practice manager said that when a verbal complaint was received this was recorded in the patient record. Themes from complaints had been identified and regular monitoring occurred to ensure actions taken were effective.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice set out their aims and objectives in a presentation at the start of our inspection. The vision and values included providing high quality primary care and promoting health living. Emphasis was also placed on involving patients in making decisions and involving other health professionals when needed. The statement of purpose underpinned this ethos and included detail on ensuring all staff were trained and competent to meet the vision and values. Staff confirmed they were aware of the vision and values and considered they were support to meet the aims of the practice.

Governance arrangements

The practice had policies and procedures to support governance arrangements which were available to all staff on the practice's computer system. The practice was in discussion with other members of the GP federation to harmonise policies and procedures, for example the human resources policy. The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards.

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

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always take the time to listen to all members of staff. All staff were involved in discussions about how to run the practice and how to develop the practice. The partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice. The practice had a range of meetings which allowed staff the opportunity to comment on service provision and also arranged regular social events for staff and their families.

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

The practice had a stop/start/continue session which covered all aspects of the practice and was an opportunity for staff to comment on activities or tasks they would like to stop, either because it did not work or they did not find it added value to their work; staff were also able to suggest areas where work could start to improve patients experience; or continue with activities that had been implemented because they considered they were effective and would like it to continue. The practice had provided a staff room as a result of their start/stop/continue sessions. The practice also had a whistleblowing policy in place if staff felt they wished to use this route instead of the stop/start/continue sessions.

The practice had a patient participation group (PPG) which met every two to three months. We met with a representative from this group. They showed us the work they were doing to prepare for the annual patient survey. The PPG said that they are actively promoting the formation of a virtual group to engage patients from across the population groups in the running of the practice. We saw this was included on the practice's website. They said they had recently carried out a survey to gather views on the extended hours surgery on Saturday mornings, which had been stopped. As a result of this survey and in response to patients' needs, the practice had commenced the service again.

Management lead through learning and improvement

The practice staff said they worked together as a team and were supported to attend training appropriate to their roles. There were formal meeting systems in place to support shared learning and to drive forward improvements. The GPs were involved all involved in revalidation, appraisal schemes and continuing professional development. There was evidence that all staff had learnt from significant events and complaints received by the practice. The practice was a training practice for doctors who wished to become GPs. There were two GP trainers who worked at the practice who were responsible for supporting and mentoring the trainees.