Dr Morris, Oliver, Ferguson & Gozzelino

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

This is the report from our inspection of Dr Morris, Oliver, Ferguson & Gozzelino at the location the Strand Medical Centre which is registered with the Care Quality Commission to provide primary care services.

We undertook a planned, comprehensive inspection on the 11 November 2014 at the Strand Medical Centre. We reviewed information we held about the services including patients' comments and spoke with GPs, staff and patients.

Dr Morris, Oliver, Ferguson & Gozzelino are rated as good overall.

Our key findings were as follows:

- The premises were clean and tidy. Systems were in place to ensure medication including vaccines were appropriately stored and in date.
- The practice was effective. Patients had their needs assessed in line with current guidance and the practice promoted health education to empower patients to live healthier lives.
- The practice was caring. Feedback from patients and observations throughout our inspection highlighted that the staff were kind, caring and helpful. Patients we spoke with felt involved in treatment decisions.
- The practice was responsive and acted on patient complaints and feedback.
- The staff worked exceptionally well together as a team.

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

The provider should:

- Put systems in place to monitor the use of prescriptions in line with national guidance to prevent inappropriate use of prescription forms.
- Document any staff meetings to ensure good communications between staff, for example, regarding learning points from incidents or complaints.
- Carry out a Legionella risk assessment.

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.

The practice had systems in place for reporting, monitoring and learning from incidents and safety alerts to prevent reoccurrences. For example the practice carried out significant event audits. However, significant event reviews and clinical meetings whereby significant events could be formally discussed and enable key learning points to be cascaded to staff had lapsed.

The practice had a GP lead for safeguarding who liaised with other agencies when necessary. There were safeguarding policies available for vulnerable adults and children. Clinical staff we spoke with were aware of their responsibilities for safeguarding and had received training suitable for their role. There were enough staff to keep people safe.

There were systems in place to ensure medication including vaccines, were safely stored and in date. The practice also had emergency medication and equipment available and emergency protocols in place.

The practice appeared to be clean and tidy .Clinical equipment was regularly maintained to ensure it was safe to use.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed that the practice was performing reasonably in line with other local practices and took National Institute for Health and Care Excellence (NICE) guidelines into consideration. This included assessments of capacity and systems in place to promote good health. Staff had received training suitable for their role and had received appraisals. The practice worked with other local multidisciplinary teams including pharmacy teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Information from surveys and comment cards indicated that staff were helpful and caring. There was accessible information to ensure patients understood the services available. We observed that patients were treated with kindness and respect.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. We found that the practice had sought ways to improve their service for their local population and had acted on suggestions made by patients. For example patients were unhappy with telephone access and new phone systems were being installed in January 2015.

There were no problems in accessing the practice for urgent on the day appointments but patients did complain about long waits for routine appointments. The practice carried out telephone consultations and home visits when necessary.

Are services well-led?

Good

The practice is rated as good for well led. The practice staff worked well together as a team. However formal staff meetings had lapsed but the practice did hold informal meetings when possible. The practice had not had a full time practice manager in post for some time but had recruited a new practice manager who was due to start in January 2015.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice was responsive to the needs of older people, including offering home visits. GPs from the practice also carried out visits to care homes in the area.

The practice had a register for patients who had dementia and also for patients requiring palliative care. The practice held Gold Standard Framework meetings to discuss patients who required palliative care with other health care professionals to ensure patients received 'joined up' care appropriate to their needs. In addition the practice participated in a local initiative called a 'Virtual Ward' which aimed to treat elderly patients at home with the help of other healthcare professionals such as district nurses to avoid admission to hospital.

The practice proactively encouraged older people to receive immunisations such as the flu and shingles vaccines.

People with long term conditions

Good

There were registers of patients with long term conditions which enabled the practice to monitor and arrange appropriate medication reviews. The Practice Nurse supported patients with a variety of long term conditions such as chronic obstructive pulmonary disease. Health care assistants took bloods to avoid patients attending hospital for routine checks.

The practice worked with the local Clinical Commissioning Group (CCG) on local initiatives.

Families, children and young people

Good

Mothers and babies at 6 weeks old were routinely checked by the Health Visitor and GP. After this consultation, appointments were made for the baby to have immunisations with the Practice Nurse.

The practice had a system in place for flagging up those children who had not received their vaccinations and the practice was encouraging follow up visits. The Practice Nurse had recently received refresher training on immunisations.

The practice had a system for ensuring that children requiring prompt care were seen as a priority.

Working age people (including those recently retired and students)

Good

The practice had offered extended opening hours one evening per alternate week from 6.30 pm - 8.00 pm and alternate Saturday

Summary of findings

mornings 9.00 am - 11.30 am for pre-booked appointments. These appointments were to improve access for patients who found it difficult to attend weekday appointments due to work or other commitments.

People whose circumstances may make them vulnerable

Good

The practice kept a list of patients with learning disabilities and arranged support and an annual health check. GPs from the practice carried out visits to a local care home that had a unit for younger stroke patients.

One GP took the lead responsibility for looking after patients with drug and alcohol addiction problems. They liaised with the local drugs and alcohol team and reviewed patients regularly.

An advisor from The Citizen's Advice Bureau also held sessions at the surgery once a week to help more vulnerable people, for example, with understanding their benefits.

People experiencing poor mental health (including people with dementia)

Good

The practice maintained a register of patients who experienced poor mental health. The register was used by clinical staff to offer patients an annual physical health check and medication review. Patients had a comprehensive care plan agreed with the patient or family/ carer where appropriate.

The practice had a nominated GP to act as lead for mental health patients and had carried out an audit of mental health referrals to ensure they were appropriate and in line with other practices locally. The practice liaised with local services for example, Inclusion Matters. Patients where necessary were referred to this service and patients were followed up on the outcomes of their treatment.

Summary of findings

What people who use the service say

The latest national GP patient survey results from July 2014 showed that, 82% of patients described their overall experience of this surgery as good (from 118 responses); 63% were able to get an appointment to see or speak to someone the last time they tried and only 46% found it easy to get through to practice by phone.

Results from the national GP patient survey also showed that 88% said the last GP they saw or spoke to was good at explaining tests and treatments and 85% said the last GP they saw or spoke to was good at involving them in decisions about their care. 90% said the last GP they saw or spoke to was good at treating them with care and concern. 78% found the receptionists helpful.

The practice's in-house survey results for 2014 indicated that patients found staff and GPs very good and caring but there were on-going problems trying to access appointments and arranging pre-bookable appointments.

We also asked for comment cards for patients to be completed prior to our inspection. We received 20 comment cards. We also spoke with four patients and representatives from the Patient Representative Group (PRG). All comments received from patients overwhelmingly indicated that patients found the reception staff helpful, caring and polite and that the GPs provided excellent care and treated them with dignity. We were told palliative care was exceptional and that the staff worked brilliantly as a team. Several patients however complained of not being able to get through to the practice by telephone easily and although patients could receive urgent appointments on the day, they would have to often have to wait a long time for a non-urgent appointment.

Areas for improvement

Action the service SHOULD take to improve

- The provider should put systems in place to monitor the use of prescriptions in line with national guidance to prevent inappropriate use of prescription forms.
- Document any staff meetings to ensure good communications between staff regarding learning points from incidents or complaints.
- Carry out a Legionella risk assessment.

Dr Morris, Oliver, Ferguson & Gozzelino

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC inspector and the team included a GP specialist advisor, a practice manager specialist advisor and an expert by experience.

Background to Dr Morris, Oliver, Ferguson & Gozzelino

The Strand Medical Centre is located near the main shopping area of Bootle, Liverpool. The practice is in a deprived area of the country with a high level of unemployment.

The practice's lead partner retired as a partner earlier in 2014 but still works at the practice. The practice now has three GP partners (one male and two female), one salaried GP, two GP registrars, two Practice Nurses, two Healthcare Assistants, reception and administration staff. The practice is open 08.00 to 18.00 Monday to Friday. The practice also offered extended opening hours for pre-bookable appointments one evening every alternate week and is also open alternate Saturday mornings.

The practice has a PMS contract and also offers enhanced services for example; avoiding unplanned admissions. The practice is a training practice.

There were approximately 7,200 patients registered at the practice at the time of our inspection. The practice treated all age groups but the majority of the patients seen at the practice were between 20-55 years of age.

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 planned inspections 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

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

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

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

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

Detailed findings

- People experiencing poor mental health (including people with dementia)

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 provided by the practice before the inspection day. We carried out an announced visit on 11 November 2014 and spent nine hours at the practice.

We spoke with a range of staff including three of the GPs, a practice nurse and health care assistant, administration and reception staff. We sought views from patients and representatives of the Patient Representative Group and reviewed comment cards and survey information.

Good

Are services safe?

Our findings

Safe Track Record

The Practice had a policy in place for reporting, monitoring and learning from incidents. Staff we spoke with were clear about the process of reporting incidents. There was an incident recording form which was accessible to all staff and an incident log book was kept at reception.

Learning and improvement from safety incidents

The Practice had a policy in place for reporting, monitoring and learning from incidents. We looked at documentation provided for some of the practice's significant events for 2014. There were details of the investigations (root cause analysis) and learning outcomes documented. Minutes from previous clinicians' meetings much earlier in the year demonstrated that discussions about any incidents had previously taken place. We looked at one incident that had occurred and found appropriate actions had been taken and new procedures and policies had been implemented to reduce the risk of the same type of incident happening again. However, there had been no formal review in more recent cases as directed by the practice policy. Formal clinicians' meetings to discuss significant events or other safety issues arising had lapsed over recent months. There were therefore missed opportunities for reflection. Although we were told by GPs and the rest of the staff team that they held daily discussions, there was a risk that important communications to other staff members could be missed and hence a risk of reoccurrence of incidents.

The practice collected any information with regards to national patient safety alerts. The practice also acted on alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). The pharmacy lead from the local Clinical Commissioning Group (CCG) alerted the practice via e-mail if there were any alerts. The lead GP partner for the practice was also the lead for medicines management for the CCG and they also cascaded any further information to other members of staff within the practice. For example, the practice had worked to reduce the number of Diclofenac prescriptions (a strong pain killer which can have side effects for certain patients) following a MHRA alert.

Reliable safety systems and processes including safeguarding

The practice had safeguarding vulnerable adults and children policies in place which were available to all staff both in hard copy and on a shared file on the practice's computer system. There were safeguarding flowcharts with guidance on what to do regarding reporting safeguarding and contact numbers of local safeguarding teams on display in the consulting and treatment rooms for staff to follow.

The practice had a computer system for patients' notes and there were alerts on a patient's record if they were at risk or subject to protection. In addition the practice kept a list of children who were at risk and reviewed this list monthly. We spoke with the GPs, one of the practice nurses and members of the reception and administration team who were all aware of their safeguarding responsibilities and discussed various examples of cases of safeguarding both for children and vulnerable adults and what action they had taken. The GP lead and other GPs had attended training about child safeguarding arranged by the CCG and had attained level 3.

A chaperone policy was available both in the waiting room and on the website for patients to read. We were told reception staff would act as chaperones.

Medicines Management

The practice had two fridges for the storage of vaccines available in the treatment room. The practice nurses took responsibility for the stock controls and fridge temperatures. We found vaccinations to be in date. There was a cold chain policy in place and fridge temperatures were checked twice a day. Regular stock checks were carried out to ensure that medications were in date and there were enough available for use. One of the practice nurses carried out vaccinations and told us they had recently received immunisation training updates.

Emergency medicines such as adrenalin for anaphylaxis and benzyl penicillin for meningitis were available. One of the health care assistants had overall responsibility for ensuring emergency medication was in date and carried out monthly checks. All the emergency medication was in date.

Prescription pads were securely stored however there were no systems in place to monitor who had used the prescriptions which went against national guidance for prescription security. There was a repeat prescribing policy in place and systems were in place to check on patients

who had not collected their prescriptions. There were clear guidelines available to patients both in the practice information leaflets and the practice web site on how to order and collect prescriptions.

The practice worked with pharmacy support from the local CCG to complete medication audits. The practice attended quarterly meetings with the CCG and there were clear action plans in place. The practice had access to the local antibiotic prescribing policy and the lead GP partner was the prescribing lead for the CCG.

Cleanliness & Infection Control

There was an infection control policy and decontamination policy in place and the designated member of staff for infection control was one of the practice nurses. The lead for infection control had received training suitable for their role but was not aware of any local meetings with the infection control team to be able to cascade best practice guidelines to other staff.

No Legionella (a bacteria found in water supplies) risk assessment had been carried out. We were told an infection control audit had been carried out by the local infection control team over a year ago. There was no documentation available at the time of our inspection but we were subsequently sent an audit from 2013.

Reception staff had received training in how to handle samples and there were gloves and spillage kits located behind reception. Reception staff also knew how to deal with patients who presented with signs of infectious diseases.

Patients we spoke with confirmed the practice was clean and we found the practice appeared to be clean. The practice employed a cleaner who came in once a day. Treatment rooms had the necessary hand washing facilities and personal protective equipment (such as gloves) was available. Sharps bins were appropriately stored. There was information displayed in the treatment room about safely disposing of sharps to prevent injuries. Clinical waste disposal contracts were in place.

Equipment

We saw evidence to support that all clinical equipment in use had received an annual calibration check for example blood pressure monitors, to ensure the equipment was in working order. Staff we spoke with told us they had no concerns about the condition or availability of clinical equipment they had to work with.

The practice had oxygen and a defibrillator for use in medical emergencies. We saw logs of checks to confirm the equipment was tested weekly.

Staffing & Recruitment

The practice had a recruitment policy but this did not reflect the introduction of the new Disclosure and Barring Scheme (these checks provide employers with an individual's full criminal record and other information to assess the individual's suitability for the post) but did refer to previous schemes. After our visit the practice advised us the policy had been updated. We reviewed three staff files and found that clinicians either had DBS or Criminal Records Bureau (CRB) checks. Staff files contained evidence to suggest that all relevant checks had been carried out at the time of recruitment. Records indicated that all staff received induction training suitable for their role.

The clinicians were supported by reception and administration staff led by an acting Practice Manager a Reception Supervisor and Deputy Manager. We saw a staff rota for two weeks and staff covered for each other when necessary.

Monitoring Safety & Responding to Risk

The acting Practice Manager told us all new employees working in the building were given induction information for the building which covered health and safety and fire safety.

We saw there were log sheets of some repairs carried out earlier in the year. There was a fire risk assessment in place which had been carried out a few years ago. After our inspection, the practice advised us that this was to be updated within the next three months. Fire equipment was checked annually by an outside company and fire safety information was clearly displayed throughout the building.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. The lead GP partner gave us examples of when the practice had successfully dealt with medical emergencies over the years both in and outside of the practice. The practice had a medical emergency procedure in place and staff we spoke with were aware of the procedures to follow.

Good

Are services safe?

All staff received annual basic life support training and there were emergency drugs available in the practice such as adrenalin. The practice had pulse oximeters, oxygen and a defibrillator.

The practice had a business continuity plan in place for major incidents such as power failure or building damage. Emergency contact numbers were readily accessible for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Once patients were registered with the practice, one of the practice nurses carried out a full health check. We looked at the information covered in a routine health check and found it to be very comprehensive including information about the patient's individual lifestyle as well as their medical conditions. The Practice Nurse referred the patient to the GP or other clinic within the practice when necessary.

The practice had a system of registers for patients who had greater needs for example a learning disabilities register. This helped the practice identify patients who required specific appointments such as annual health checks or medication reviews. The prescribing nurse undertook annual medication reviews for patients with long term conditions.

The practice used a risk stratification tool to ensure that patients had their needs assessed to proactively manage their care and avoid unplanned admissions to hospital. The tool was also used to identify patients who would benefit from care under the virtual ward scheme.

The practice had a register of patients who were carers and these patients were offered flu vaccinations and where necessary signposted for extra support from a local centre.

We spoke with GPs who were aware of their professional responsibilities for keeping up to date with guidance for best practice such as National Institute for Health and Care Excellence (NICE) guidance. GPs within the practice had specific clinical interests and acted as leads for particular diseases for example there was a lead for mental health.

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. GPs from the practice met monthly with the local Clinical Commissioning Group (CCG) to discuss performance. QOF data from 2012-2013 indicated the practice performed in line and above for certain indicators compared with the national average. However it was not clear what mechanisms were used by the practice to monitor their performance against public health information.

The GPs we spoke with did carry out their own individual audits for revalidation purposes but also utilised the results for the practice and patients' benefit. For example, we saw an audit for prescribing Cephalosporin antibiotics within the practice. The learning outcomes of this audit had reduced the prescribing of this drug. Audits were also carried out in conjunction with the pharmacy lead for the local Clinical Commissioning Group.

The practice was striving to reduce benzodiazepine (a powerful potentially addictive medicine) prescribing to patients and was engaging patients to be part of a benzodiazepine reduction programme. The practice had developed information leaflets for patients. There was a practice policy regarding the prescribing of benzodiazepines but this needed updating.

Effective staffing

There was an induction programme for newly appointed members of staff that covered such topics as fire awareness and health and safety.

Staff attended local Clinical Commissioning Group training days including training about safeguarding vulnerable adults and children. There was a record of a skills and training matrix. This included induction, fire safety, information governance, basic life support, safeguarding, infection control and other clinical courses. The matrix also documented if DBS checks and appraisals had been completed.

The practice had an appraisal system in place and GPs were part of revalidation and appraisal schemes. The staff had access to a supporting library in their staff room which included books and journals for further reading. One of the practice nurses told us they attended monthly learning events with nurses from other practices locally.

Working with colleagues and other services

The practice had a system for recording information from hospital letters on to patients' medical records. All letters were initially passed onto the GP to read and action as necessary. Letters and any notes made by the GP were then scanned on to patients' electronic records. If the GP was absent, then the letters would be shared among the other GPs. Patients were contacted as soon as possible if they required further treatment or tests.

Results from blood tests were reviewed by the prescribing nurse every morning and the GP alerted if there were any concerns.

Good

Are services effective?

(for example, treatment is effective)

Some GPs referred patients to hospital using the 'Patient Choose and Book' system. There was a cross checking system in place to ensure that those patients requiring urgent referrals under the two week rule, for example, patients with a suspected diagnosis of cancer, received their appointments.

Information Sharing

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. All members of staff were fully trained on the system, and could demonstrate how information was shared.

The practice shared information with the out of hours care provider for example; the practice would share any anticipatory care documents for patients on end of life care.

The reception area had a noticeboard with a list of all the clinics and hospitals available locally that a patient could be referred to. The list was coded to match an open filing system for referral forms which were stored below the noticeboard.

Consent to care and treatment

We spoke with GPs about their understanding of the Mental Capacity Act 2005. They provided us with examples of their understanding around consent and mental capacity issues. One GP gave us more detailed information about a best interests meeting held with other health care professionals to determine the best options for a patient and whether they had capacity to make a particular decision.

The GPs were aware of Gillick guidelines for children. 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.

The practice carried out occasional minor surgical procedures and we saw consent forms in place which were completed prior to patients being treated. The practice had an up to date consent policy in place.

Health Promotion & Prevention of ill health

The Practice Nurse looked after patients with long term conditions such as diabetes. A member of the administration team managed the lists of patients who had chronic diseases such as diabetes, heart disease, asthma, hypertension and chronic obstructive pulmonary disease to ensure patients were given appropriate recall appointments or treatment.

The Practice Nurse carried out children's vaccinations and there were systems in place to ensure that any children who may have missed a scheduled vaccination were recalled.

Patients we spoke with confirmed that the practice had ensured they had received their flu and shingles vaccinations.

There were health promotion and prevention advice leaflets available in the waiting rooms including information on alcohol awareness, smoking cessation and mental health awareness.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone.

Comment cards we received all indicated that they found staff to be helpful, caring, and polite and that they were treated with dignity. Results from the national GP survey showed that 90% of patients said the last GP they saw or spoke to was good at treating them with care and concern and 78% found the receptionists helpful.

We noted that consultation and treatment room doors were closed during consultations to ensure patient's privacy. Results from the GP national survey showed that only 53% of patients were satisfied with the level of privacy when speaking to receptionists at the surgery. There was a notice at reception which advised patients there was a room available if they wanted to discuss matters in private and a notice explaining to patients why receptionists required certain detailed information. Patients we spoke with were aware they could talk in private to staff if they needed to. The practice did have a confidentiality policy in place.

Care planning and involvement in decisions about care and treatment

Patients we spoke with confirmed they felt involved in decisions about treatment and were supported to make decisions and given information they required. Results from the national GP patient survey also showed that 88% said the last GP they saw or spoke to was good at explaining tests and treatments and 85% said the last GP they saw or spoke to was good at involving them in decisions about their care.

66% of respondents said the last nurse they saw or spoke to was good at involving them in decisions about their care. The Practice Nurse showed us how they printed off health information leaflets for patients for example those patients newly diagnosed with diabetes so that the treatments and services available could be explained to them.

Patient/carer support to cope emotionally with care and treatment

The practice had a system for alerting staff that certain patients may require extra care such as patients suffering with cancer or patients who had bereavement issues. Patients with emotional issues could be sign posted to various bereavement counsellors and support organisations to ensure their needs were being met. In addition, the practice always sent a condolence card to bereaved families or telephoned them to let them know they could come to the practice for support. Patients we spoke with confirmed that they had been extremely well supported by the practice.

Palliative care patients had access to their individual GP's mobile telephone numbers and there were a variety of information leaflets available in the waiting room for various support groups.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had a patient participation group which was called a patient reference group (PRG). The PRG had run a survey in March 2014 and had received 81 responses. We saw the PRG briefing report which outlined how the detailed survey had been carried out, the number of responses and action plans as a result of the findings.

From the survey, the practice had identified three priorities: telephone access, availability of GP appointments and customer care skills. The report contained a plan to respond and to measure the level of success by carrying out the survey in March 2015. There was a notice board within the waiting room with information regarding the outcomes of the survey and what actions were being taken so as to make patients more aware that the practice knew there were problems and was taking action to improve.

Tackling inequity and promoting equality

There was limited access for wheelchairs and pushchairs but the practice did have facilities for disabled patients and also had hearing loops available.

The practice had access to interpreter services and this service was advertised on the practice's website. Patients were told to make arrangements with the practice before their appointments. The practice also worked closely with link workers from the community to strive to improve equal access to health care and health promotion services in the area.

The practice had an equality policy. Staff had recently received training about Equality and Diversity. The practice also respected the rights of its staff and operated a zero tolerance policy which was displayed in the waiting room.

Access to the service

The Strand Medical Centre has an electronic booking in system in place but receptionists helped patients if they had difficulty using this.

The Strand medical centre is open 8.00am to 6.00pm Monday to Friday and also offers extended evening and Saturday morning pre-bookable appointments on alternate weeks.

The practice was aware of some complaints regarding the appointment systems. Although patients could get urgent appointments on the same day, occasionally it could be a long wait (up to two weeks plus) to receive a non- urgent bookable appointment. The practice had developed a 'primary care access plan' in September 2014 but there had been changes in staffing since then and the plan needed updating to address access and appointment issues.

The practice carried out telephone consultations and home visits when necessary.

Listening and learning from concerns & complaints

The practice had a complaints policy in place and information about how to make a complaint was available in the waiting room and the practice's website. Reception staff we spoke with were aware of how to manage a complaint. 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.

We looked at a review of an annual summary of formal complaints received by the practice from July 2013 to September 2014. Complaints were not broken down into different categories such as whether the complaint was a clinical issue or about administration in order to identify any trends. Complaints were supposed to be discussed at GP partner's meetings but the formal arrangements for meetings had lapsed.

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 Strand Medical Centre had the following mission statement: 'We seek to provide our patients with high quality care and advice that is delivered by professional and friendly staff. We are committed to always improving the service we provide.' Staff we spoke with were aware of the values and vision of the practice.

Comments received from patients demonstrated the practice was meeting its vision statement. Patients we spoke with and comments we received were overwhelmingly positive (we received no negative comments) about the quality of care received and how friendly and helpful all staff were.

The practice was engaged with the local Clinical Commissioning Group (CCG) to ensure services met the local population needs.

Governance Arrangements

There were clear formal documented governance structures in place and policies and procedures available. However, the practice had not had a full time practice manager in place for several months and was waiting for someone new to start in January 2015. There had been some slippage in systems for governance partly as a result of the lack of a full time practice manager to oversee the daily running of the practice. In particular formal staff meetings had not taken place for some months relying instead on informal discussions either at lunch times or after work. There were some handwritten notes available but no typed sheets and there was no documentation stored centrally for all to see. We did see evidence that the GP partners held monthly governance meetings earlier on in the year with set agendas that covered performance, significant events, staffing and clinical governance and policies. There was an agenda for formal weekly partners meetings to be held throughout the year but these had lapsed. Reception staff we spoke with indicated that they had not had any staff meetings or training since July 2014. Without formal documentation in place it was difficult to assess how the team cascaded information or learning points as a result of any incidents or complaints.

Policies and procedures were accessible for all staff in a 'Practice Protocols' file and also on a shared drive on the practice's computer system. All policies in the hardcopy file had been updated in October 2014 and were well organised and referred to policies and procedures for patients, administration, management and clinical procedures.

Leadership, openness and transparency

The practice was overseen by a lead GP partner and there was also nominated clinicians within the practice to act as leads for example, safeguarding and infection control.

Staff we spoke with told us they were well supported and knew who to go to in the practice with any concerns. Patients and staff told us the staff worked together brilliantly as a team. It was clear from discussions with staff that the practice operated an 'open door policy' to allow staff to discuss any issues. The practice operated a 'no blame culture' to allow staff to feel confident to raise concerns about poor performance.

Practice seeks and acts on feedback from users, public and staff

The practice had an active patient reference group which had been in place since March 2014 and consisted of a balanced mix of the patient population group. The PRG had a dedicated well highlighted notice board in the waiting room advertising for new members and also to display results of latest surveys and what actions were planned for the future of the practice. For example, from results of the last survey conducted, new telephone systems were to be implemented in January 2015 to reduce the problems of patients being able to get through to the practice to make an appointment. The PRG was also advertised on the practice's web site. The PRG held quarterly meetings and an annual meeting and surveys were distributed to patients before any meetings. In addition there was a suggestions box in the waiting room. Two of the GPs were also carrying out their own surveys.

Staff told us that they could always raise any concerns with any member of staff and they could discuss any problems on an informal basis.

Management lead through learning & improvement

GPs were all involved in revalidation, appraisal schemes and continuing professional development. The practice had an appraisal system for all staff which was up to date.

Are services well-led?

Good

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

The lead GP partner told us they had worked hard to become a training practice and had supported one of the practice nurses to complete an advanced prescribing course. The practice had developed a training matrix to support both clinical and non-clinical staff. The lead GP partner had roles working with the local CCG and was able to cascade information to the practice team. The practice held regular team events outside of working hours to encourage team building. Formalised staff meetings and significant event reviews had lapsed over the past few months leading to a risk that important information may not be cascaded to the whole practice team.

Some staff told us they had previously attended training sessions provided by the local commissioning group (CCG) and one of the GPs attended local Clinical Commissioning Group meetings on a monthly basis.