Ashville Medical Practice PMS Practice

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

We carried out an announced comprehensive inspection at Ashville Medical Practice on 16 December 2014. Overall the practice is rated as good.

Specifically we rated the practice as good in providing safe, effective, caring, responsive and well-led care for all of the population groups it serves.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw the following areas of outstanding practice:

- The practice provided good follow up care for the families of bereaved patients. For example; GPs at the practice would contact the patients and the practice sent bereavement cards to acknowledge their sympathy and ensure patients did not feel isolated.
- The practice provided a successful substance misuse service which had been recognised by Public Health as a flagship service.
- Patients registered with the practice who resided at a local care home for people with learning disabilities were able to attend the practice in groups for flu vaccinations to minimise distress caused during their visit to the practice.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

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

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, 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. Nationally reported data showed outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example the housebound local enhanced service. 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 named GP and a structured annual review to check their health and medication needs were being met. For those people with the most complex needs, the named GP 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 A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies.

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 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 including those with a learning disability. There was a dedicated GP lead for patients with learning disabilities.

The practice regularly worked with multidisciplinary teams in the case management of vulnerable people. Patients were told 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). Ninety three percent of people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multidisciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advanced care planning for patients with dementia.

Summary of findings

What people who use the service say

We received 41 completed CQC patient comments cards where patients and the public shared their views and experiences of the service. We also spoke with two patients and 10 members of the patient participation group (PPG) on the day of our visit.

The patients who had completed the CQC comments cards and those spoken with were complimentary about the level of care and treatment they had received.

However, 14 comment cards also gave negative feedback. We looked at these for themes and found they were mainly around accessing appointments, including getting through on the telephone.

The patients we spoke with told us they were always treated with dignity and respect. They felt all the staff at the practice took time to listen to them and involved them in decisions about their care. However, one person told us they did not always feel listened to.

Outstanding practice

- The practice provided good follow up care for the families of bereaved patients. For example; GPs at the practice would contact the patients and the practice sent bereavement cards to acknowledge their sympathy and ensure patients did not feel isolated.
- The practice provided a successful substance misuse service which had been recognised by the Public Health as a flagship service.
- Patients registered with the practice who resided at a local care home for people with learning disabilities were able to attend the practice in groups for flu vaccinations to minimise distress caused during their visit to the practice.

Ashville Medical Practice PMS Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a second CQC inspector and a GP specialist advisor.

Background to Ashville Medical Practice PMS Practice

Ashville Medical Practice is located in the Kendray area of Barnsley. The practice serves a population of approximately 10,761 patients. The practice is located in a purpose built health centre and provides services from the ground floor and first floor.

The service is provided by five partners. Four general practitioner (GP) partners (three female and one male) and a managing business partner.

Working alongside the partners are two salaried GPs (one female and one male), an advanced nurse practitioner, two practice nurses and two phlebotomist/health care assistants. The clinical team are supported by a practice manager and a team of administrative and secretarial staff.

The practice has a Personal Medical Services (PMS) contract. This is the contract between general practices and NHS England for delivering services to the local community.

Ashville Medical Practice offers pre-bookable appointments between 7.25am - 8.30pm on Mondays and 7.25am – 6pm from Tuesday to Friday. In addition to this, the practice also operates a book on the day appointment system.

When the practice is closed, out of hours cover for emergencies is provided by the NHS 111 service.

A wide range of services are available at the practice and these include vaccinations and immunisations, stop smoking and minor surgery.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Please note 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 Care Quality Commission (CQC) at that time.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations, such as NHS England local area team and Barnsley City Clinical Commissioning Group (CCG), to share what they knew.

We carried out an announced inspection at Ashville Medical Practice on 16 December 2014. During our inspection we spoke with staff including two GPs, an advanced nurse practitioner, the practice manager, a receptionist and a member of the administrative team.

We spoke with two patients on the day of our visit and met with 10 members of the patient participation group (PPG). A PPG is a group of patients who work with the practice to improve services provided.

We observed how patients were being spoken with on the telephone and within the reception area. We also reviewed 41 CQC comment cards where patients had shared their views and experiences of the practice.

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

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

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

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

People experiencing poor mental health (including people with dementia)

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, they 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.

We spoke with two GPs, an advanced nurse practitioner, the practice manager, a receptionist and a member of the administrative team who told us incidents and complaints were discussed at monthly practice meetings.

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 systems in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events and complaints and evidence the practice had learned from these. For example, an incident occurred within the practice when a patient suffered from a heart attack and reception staff had difficulty contacting a GP to call them to the scene.

As a result of the incident a speaker system had been installed to the telephone in each room to ensure receptionists could make clinicians aware and seek assistance.

We spoke with the practice manager who told us that every member of staff was responsible for identifying incidents.

We spoke with a receptionist and a member of the administrative team who were able to explain how incidents were reported within practice and give examples of incidents they had identified.

Reliable safety systems and processes including safeguarding

The practice had systems in place to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed staff had received training on safeguarding.

Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to escalate any safeguarding concerns.

The practice had a dedicated clinical lead for safeguarding vulnerable adults and children. The practice manager was also the deputy and responsible for ensuring information was shared appropriately.

All staff we spoke with were aware who the lead was and who to speak to within the practice if they had a safeguarding concern.

The practice had a system in place to highlight any vulnerable patients on the clinical system to ensure clinical staff were aware of any concerns.

The practice had a chaperone policy in place and the patients we spoke with were aware of how to access a chaperone. However, the policy was not visible in the waiting room or the clinical rooms we looked in. 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.

We spoke with the practice manager who told us the nurses acted as chaperone where possible, but this service was also provided by some members of the administration and reception team who had been trained to act as a chaperone.

Medicines management

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

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

Good

Are services safe?

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

We spoke with a receptionist and a member of the administrative team who told us the checks undertaken by the practice prior to dispensing a prescription. They told us they checked the name, address and date of birth.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who was responsible for ensuring all areas of the practice were kept to the appropriate levels of cleanliness. Staff working at the practice had received infection control training.

We saw evidence the lead carried out audits on a regular basis. All of the audits we reviewed were above required standards.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

Equipment

We saw equipment was available to meet the needs of the practice and this included a defibrillator and oxygen, which were readily available for use in a medical emergency. Routine checks had been carried out to ensure they were in working order.

We saw equipment had up to date annual, Portable Appliance Tests (PAT) completed and systems were in place for routine servicing and calibration of medical equipment where required. The sample of portable electrical equipment we inspected had been tested and was in date.

Staffing and recruitment

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

Staff told us about the arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

The practice had systems, processes and policies to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment.

The practice had developed clear lines of accountability for all aspects of patient care and treatment.

There was evidence the practice learned from incidents and responded to identified risk. The practice looked at safety incidents and where concerns had been raised, they looked at how this could have been managed better or avoided.

We saw emergency equipment was available in the surgery which included emergency medicines. All the staff we spoke with were aware of its location.

Arrangements to deal with emergencies and major incidents

Good

Are services safe?

The practice had arrangements in place to manage emergencies. Records showed all staff had received training in basic life support. Emergency equipment was available including access to an automated external defibrillator (used to attempt to restart a person's heart in an emergency).

Emergency medicines were available in a secure area of the practice and all staff knew of their location. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

We found from our discussions with the GPs and advanced nurse practitioner that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs and advanced nurse practitioner told us they led in specialist clinical areas such as diabetes, heart disease and asthma. This allowed them to focus on specific conditions.

Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

The practice held multiple clinics to meet the needs of the practice population. These helped to ensure each patients' condition was monitored and their care was regularly reviewed.

The practice had registers for patients needing palliative care, diabetes, asthma and COPD. This helped to ensure each patient's condition was monitored and their care was regularly reviewed. Additionally, regular palliative care meetings were held and they included other professionals involved in the individual patient's care. For example palliative care nurses and district nursing staff.

Staff at the practice told us they promoted health initiatives during consultations with patients'. We noted health promotion information available in practice waiting areas and on the practice website.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included appropriate use of the two week wait referral service. The two week wait referral service is an urgent cancer referral to secondary care. The practice had also conducted an audit to review the prescribing of Temazepam. Temazepam is a drug which can be used to treat insomnia. The conclusion of both audits were positive and demonstrated the practice were following guidance.

We saw the practice had a system in place for monitoring patients with long term conditions and this included learning disabilities.

We found clinical staff had a good awareness of recognised national guidelines. For instance they used National Institute for Health and Care Excellence (NICE) quality standards and best practice in the management of conditions such as diabetes.

The practice aimed to deliver high quality care and participated in the Quality and Outcomes Framework (QOF) targets and had achieved a total of 99.7% against the clinical outcomes. This was higher than the CCG and NHS England average.

The QOF aimed to improve outcomes for a range of conditions such as diabetes. The practice used information they collected to help monitor outcomes for patients and the quality of services they provided.

GPs in the surgery carried out minor surgical procedures in line with their registration and NICE guidance. The staff were appropriately trained and kept up to date in their skills and knowledge.

Effective staffing

Practice staff included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw staff were up to date with mandatory courses such as annual basic life support.

We spoke with a receptionist and a member of the administration team who told us they had received induction training when starting the job. They told us they felt supported to carry out their role when left unsupervised and always had access to support when necessary.

All staff undertook annual appraisals which identified their learning needs. Our interviews with staff confirmed the practice was proactive in providing training and funding for relevant courses.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries electronically. There were systems in place in relation to receiving, passing on, reading and acting on any issues

Good

Are services effective?

(for example, treatment is effective)

arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held multidisciplinary team meetings every month to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record.

We spoke with staff about the formal arrangements for working with other health services, such as consultants and hospitals. They told us how they referred patients for secondary (hospital) care and tried to book an appointment using the choose and book system.

Information sharing

Staff had access to electronic systems relevant to their role and all staff had access to up to date practice policies and procedures. Staff told us they were kept informed by the practice manager if there had been any changes to policies and procedures.

Staff told us they had regular monthly meetings. They also had ad hoc meetings whenever there were things to be discussed. We were able to review minutes of these meetings and saw they covered a wide range of topics. For example; safeguarding, significant events and complaints.

We saw evidence the practice staff worked with other services and professionals to meet patients' needs and manage complex cases. There were regular meetings with the multi-disciplinary team within the locality. These included palliative care nurses, community matron, and the safeguarding teams.

The electronic system enabled timely transfer of information with the out of hour's providers and this included the local hospitals and community staff. The GP reviewed all information received and actioned where appropriate.

Consent to care and treatment

We found the health care professionals understood the purpose of the Mental Capacity Act (2005) and the Children Act (1989) and (2004). All staff we spoke with understood the principles of gaining consent including issues relating to capacity.

They also spoke with confidence about Gillick competency assessments of children and young people, which were used to check whether these patients had the maturity to make decisions about their treatment.

We spoke with two GPs who told us there was a template on the clinical system to record a patient's mental capacity.

Patients felt they could make an informed decision. They confirmed their consent had been sought and obtained before any examinations and were aware of how to request a chaperone should they require one.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way.

All patients over 75 years had a named GP and received an annual health check. Patients with a long term condition or mental illness had an annual review of their treatment, or more often where appropriate.

A GP and nursing team led on the management of long term conditions (LTCs) of patients in the practice. They proactively gathered information on the types of LTC patients present with and had a clear understanding of the number and prevalence of conditions being managed by the practice.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients completed CQC comment cards to tell us what they thought about the practice. We received 41 completed cards and the majority were positive about the service they experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. However, 14 comment cards also gave negative feedback. We looked at these for themes and found they were mainly around accessing appointments, including getting through on the telephone.

We spoke with 10 members of the patient participation group on the day of our inspection and two patients who were attending the practice for an appointment. They told us they were satisfied with the care provided by the practice and said their privacy and dignity was respected.

Staff were familiar with the steps they needed to take to protect people's dignity. There was an electronic booking system for those who did not wish to announce their name to reception staff. Rooms were available for patients who required a conversation with reception staff in private.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice good in these areas. For example, data from the national patient survey showed 87% of respondents said the GP involved them in care decisions and 94% felt the nurse was good at explaining treatment and results.

The patients we spoke with on the day of our inspection told us health issues were discussed with them in a way they could understand. They felt involved in decision making about their care and treatment. They told us they felt listened to and had enough time during a consultation to make an informed decision about the choice of treatment they wished to receive.

Care plans were in place for patients with specific health needs and these included patients with long term conditions such as asthma. They were adapted to meet the needs of each individual. This information was designed to help patients manage their own health care and wellbeing to maximise their independence and also helped reduce the need for hospital admission.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection told us staff were caring and understanding when they needed help and provided support where required. The CQC patient comments cards also confirmed the practice staff were very supportive to them and their families.

Palliative care meetings with clinical staff and community health professionals were held to discuss patient treatment, care and support. We were told this ensured patients received coordinated care and support.

We spoke with the practice manager who told us how the practice supported patients and their families following a bereavement. For example; GPs at the practice would contact the patients and the practice sent bereavement cards to acknowledge their sympathy and ensure patients and their families did not feel isolated.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The practice was accessible to patients with mobility difficulties. Consulting rooms were located across two floors and were accessible for patients with mobility difficulties via a lift. There were toilets for disabled patients, and mother and baby feeding /nappy changing facilities.

Patients had access to translation services when needed.

The practice had a well established Patient Participation Group (PPG). We were able to review reports from the PPG and saw the practice had made a number of changes in response to suggestions. For example, the group requested the chairs in the first floor waiting room should have arms and this had been implemented. The appointment system had been updated to include online booking.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, home visits were offered for severely disabled people and a substance misuse service was provided at the practice.

Patients registered with the practice who resided at a local care home for people with learning disabilities were able to attend the practice in groups for flu vaccinations to minimise distress caused during their visit to the practice.

The practice had access to telephone translation services and a hearing loop was located on the reception desk.

The premises and services had been designed to meet the needs of patients with disabilities.

The practice was situated on the ground and first floors of the building with most services for patients on the ground floor. There was lift access to the first floor.

We saw the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice, including baby changing facilities.

Access to the service

Information regarding the practice opening times and how to make appointments were available in the reception area, the practice leaflet and on the website. Patients could book appointments by telephone, online or in person at the reception. Some appointments were pre-bookable and some were allocated to be booked on the same day. Home visits were offered for patients who needed it.

The practice offered a range of appointments between 7.25am and 8.30pm on a Monday and between 7.25am and 6pm on Tuesday to Friday.

When the practice was closed, urgent healthcare advice that was not a 999 emergency was provided by telephoning the Out of Hours NHS 111 service. This service is available 365 days a year and is free of charge.

Results from the national patient survey (January 2015), demonstrated patients were happy with most aspects of the service. For example, 86% of respondents were able to get an appointment to see or speak to someone the last time they tried and 87% of respondents say the last appointment they got was convenient.

Listening and learning from concerns and complaints

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

We saw information was available to help patients understand the complaints system. For example, there was information available from reception advising patients of how to complain. This included contact details for the Parliamentary and Health Service Ombudsman and NHS England. Information was also available in the practice leaflet and on their website.

We spoke with two patients on the day of our inspection and met with 10 members of the Patient Participation

Good

Are services responsive to people's needs?

(for example, to feedback?)

Group (PPG) who were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

The PPG told us that complaints were discussed at the meetings and all were responded to.

We reviewed a summary of complaints received by the practice over the last 12 months and saw that these had documented action and learning.

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

There was an established management structure within the practice. The practice manager, GPs and staff were clear about their roles and responsibilities and the vision of the practice. They worked closely with the local CCG and were committed to the delivery of a high standard of service and patient care.

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice's vision and values included supporting the population to achieve good health outcomes and delivering the best possible care.

Staff told us the practice vision and values were embedded within the culture of the practice. They told us the practice was patient focused; they spoke positively about the leadership and felt valued as employees.

Governance arrangements

The practice had management systems in place. They had policies and procedures to govern activity and these were accessible to staff. We saw the policies incorporated national guidance and legislation.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing above CCG and National averages in all clinical domains.

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

The practice used 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.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk assessments which had been carried out in relation to fire and sharps injuries.

Leadership, openness and transparency

The practice was committed to ongoing education, learning and individual and team development of staff. The performance of staff was the subject of monitoring and appraisal at all levels; which reflected the organisational objectives.

There was good communication between staff. The practice had a proactive approach to incident reporting. They discussed if anything, however minor, could have been done differently at the practice.

We were able to review a range of policies including confidentiality, information governance and complaints. These clearly outlined responsibilities and timescales.

Staff we spoke with told us all members of the management team were approachable, supportive and appreciative of their work. Staff also spoke positively about the practice and how they worked collaboratively with colleagues and health care professionals.

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

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. Patient survey results and action plans were available on the practice website.

We saw the practice had acted upon feedback from patients via the national survey and findings from the PPG. For example, the practice had introduced online appointment booking as a result of patient feedback.

The practice had gathered feedback from staff through meetings, appraisals and discussions. Staff told us they felt comfortable in giving feedback or raising any concerns. Staff told us they felt involved and engaged in the practice to improve outcomes for both patients and staff.

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us annual appraisals took place, which included a personal development plan. We looked at two staff files and saw evidence of this.

The practice had completed reviews of significant events and other incidents and shared the information at staff meetings to ensure the practice improved outcomes for

Are services well-led?

Good

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

patients. The incidents reported by the practice included late cancer diagnoses, an unexpected death and a delayed fast track referral. We saw evidence of this in minutes of meetings and logs of events/incidents.