Dr PF Mullen's Practice

Quality Report

7 Smithdown Place
Liverpool
L15 9EH
Tel: 0151 733 2800
Website: www.pennylanesurgery.nhs.uk

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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 PF Mullen's practice. Dr PF Mullen's practice is registered with the Care Quality Commission to provide primary care services.

We undertook a planned, comprehensive inspection on the 15 October 2014 at the practice location Dr PF Mullen's practice (also known as Penny Lane Health Centre). We reviewed information we held about the practice and spoke with patients, representatives of the patient participation group, GPs, staff, and the local Clinical Commissioning Group pharmacy lead involved with the practice.

The practice was rated as Good overall. There were some elements of the practice that could be improved but the practice provided good care to the population it served.

Our key findings were as follows:

- There were systems in place to mitigate safety risks. 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 the practice staff were kind, caring and helpful.
- The practice was responsive. The practice operated an open access clinic for patients three days a week and currently provided some evening appointments for patients who had difficulty attending because of their employment.
- The practice was well led. The practice worked well together as a team and had regular staff meetings and training.

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

Summary of findings

The provider should:

- Consider having oxygen available for medical emergencies.
- Ensure all policies and procedures are up to date.
- Ensure there is a written record for all staff appraisals including nurses and Health Care Assistants.
- Risk assess whether clinical staff currently employed require Disclosure and Barring Service checks.

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. Information from NHS England and the local Clinical Commissioning Group (CCG) indicated that the practice had a good track record for maintaining patient safety. The practice had systems in place for monitoring safety and learning from incidents and safety alerts to prevent reoccurrences. For example the practice carried out significant event audits to help GP's individual and practice based learning.

All staff were aware of the safeguarding vulnerable adults and children policies in place and who to contact for further guidance. The practice had a GP lead for safeguarding who liaised with other agencies when necessary.

There were systems in place to ensure medicines including vaccines, were safely stored and in date.

The practice was clean and tidy. All equipment was regularly maintained to ensure it was safe to use.

The practice had emergency medication available and a defibrillator. The practice had responded successfully to medical emergencies in the past both at the practice and in the immediate vicinity. The practice did not have oxygen and the GPs we discussed this with advised us they would look into this matter.

Are services effective?

Good

The practice is rated as good for effective. 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 had systems in place to promote good health. All staff had received training suitable for their role and some had received appraisals. The practice worked with other local multidisciplinary teams including mental health and pharmacy teams.

Are services caring?

Good

The practice is rated as good for caring. Information from surveys and comment cards and patients from the patient participation

Summary of findings

group we spoke with indicated that staff were helpful and caring. The practice provided accessible information to ensure patients understood treatment. We observed that patients were treated with kindness and respect.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. We found that the practice had sought ways to improve their service for their local population. For example, the practice operated an open access system three days a week but in response to patient feedback, then offered a patient when they arrived, a time slot to come back which was convenient to them.

The practice also offered pre-bookable appointments up to two weeks in advance and patients could contact the practice early in the morning to arrange urgent same day appointments. Children were always offered same day appointments for urgent care. 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 had a clear ethos of being a traditional family practice providing quality care and treatment. The practice staff worked well together as a team and strove to always improve their systems of care by having twice weekly clinicians' meetings and monthly staff meetings. In addition, the practice worked with other practices in the local area to improve services to the immediate population.

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

Part of the practice's contract involved comprehensive geriatric assessments. The practice offered a named GP for those patients who were 75 years and older in line with the new GP regulations. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs.

The practice held monthly 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.

Immunisations such as the flu vaccine were offered to older patients and the practice had been operating a series of Saturday morning clinics specifically for the flu vaccination.

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. The Health Care Assistant helped with blood pressure monitoring of patients.

The practice used the Quality and Outcomes Framework to monitor patient outcomes and worked on local initiatives. The practice was currently involved in improving treatment for diabetic patients.

Families, children and young people

Good

Mothers and babies at six weeks old were routinely checked by the Health Visitor and GP. After this visit, appointments were made for the baby to have immunisations with the Health Visitor at another location.

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. Although the majority of vaccinations were done by Health Visitors, the Practice Nurse would also carry out opportunistic vaccinations when children were not up to date

Summary of findings

with the vaccination programme and had attended for other reasons. Immunisation guidelines were available in the GPs surgeries and the Practice Nurse had attended a training update on immunisations in September 2014.

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 a designated Health Trainer who could spend more time with patients to discuss their current lifestyles and to promote healthy living such as healthy eating and weight loss.

The practice had an open access appointment system which operated three days a week and in addition was running extended hours for the next few months to allow patients who worked more flexible appointment times.

All patients were offered referrals to hospitals of their choice by operating a 'Patient Choose and Book' service and appointments were made by the GP at the time of the patient's consultation.

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. The practice would signpost patients with no fixed abode to any relevant service. The practice had also worked with a local 'safe house' in the area.

The practice used the facilities of a local translation service to ensure patients whose first language was not English could receive GP appointments and also access other local health care services.

People experiencing poor mental health (including people with dementia)

Good

The practice maintained a register of patients who experienced mental health problems. The register was used by clinical staff to offer patients an annual health check and medication review.

The practice was supported by a Primary Care Mental Health Liaison Practitioner who provided advice and support to improve the mental and physical health of patients. The practice had received suicide awareness training. The practice also had links with local counselling services.

Summary of findings

What people who use the service say

As part of our inspection process, we asked for Care Quality Commission (CQC) comment cards for patients to be completed prior to our inspection. We received 22 comment cards and spoke to one patient and two members of the patient participation group (PPG). All comments received were overwhelmingly positive about how different generations within families had received excellent care. Comments highlighted that the GPs and staff were helpful and caring and that they received prompt attention and support when they were seriously ill. Patients also commented that the practice was safe and hygienic.

Our findings were in line with results received from the national GP patient survey and the practice's in-house survey. For example, the latest national GP patient survey results showed that in July 2014, 92% describe their overall experience of this surgery as good (from 120 responses) and 90% were able to get an appointment to see or speak to someone the last time they tried and 86% found it easy to get through to practice by phone.

The practice's in-house surgery results for 2012-2013 (from 42 responses), 98% were very satisfied or satisfied with the customer service provided by receptionists. The national GP patient survey showed that 90% found the receptionists helpful.

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 82% said the last GP they saw or spoke to was good at involving them in decisions about their care.

Areas for improvement

Action the service SHOULD take to improve

- Consider having oxygen available for medical emergencies.
- Ensure all policies and procedures are up to date.
- Ensure there is a written record for all staff appraisals including nurses and Health Care Assistants.
- Risk assess whether clinical staff currently employed require Disclosure and Barring Service checks.

Dr PF Mullen's Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Dr PF Mullen's Practice

Dr PF Mullen's Practice (also known as Penny Lane Surgery) is located in the outskirts of Liverpool City centre. The practice has four GP partners and one salaried GP (two male and three female) a Practice Nurse, a Health Care Assistant and administration staff. The practice is open 8.00am to 6.30pm Monday to Friday. Patients requiring a GP outside of normal working hours are advised to contact an external out of hours provider (Urgent Care 24). The practice had a GMS contract which also included provision for such services as various vaccinations and geriatric assessments. The practice is a training practice and currently works with two part time registrars.

There were approximately 6,200 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 20-65 years of age.

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. The practice had not been previously inspected and was planned 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 service 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
- 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 the practice provided before the inspection day. There were no areas of risk identified across the five key question areas. We carried out an announced visit on 15 October 2014 and spent nine and a half hours at the practice.

Detailed findings

We reviewed all areas of the practice. We spoke with a range of staff including three of the GPs, the Practice Nurse, two reception staff and the Practice Manager on the day.

We also spoke with the pharmacy lead from the local Clinical Commissioning Group for the practice. We sought views from the patient participation group and via comment cards and reviewed survey information.

Good

Are services safe?

Our findings

Safe Track Record

Information from NHS England and the local Clinical Commissioning Group (CCG) indicated that the practice had a good track record for maintaining patient safety. We had received no information of concern from other sources.

The Practice had a system in place for reporting, recording and monitoring significant events and information from complaints. The practice had an incident management procedure and an incident recording form which was accessible to all staff via the practice's computers. The practice carried out an analysis of these events and this also formed part of the GP'S individual revalidation process.

Learning and improvement from safety incidents

We looked at the minutes from the practice's significant event annual review. There were written reports of the events, details of the investigations (root cause analysis) and learning outcomes. There was a clear framework for actions to be taken by designated staff within set time frames with a date for the review of the effectiveness of any action taken. The clinicians and Practice Manager held staff meetings twice a week and minutes from the meetings clearly demonstrated that discussions about any incidents took place. We looked at two incidents that had occurred and found appropriate actions had been taken to reduce the risk of incidents happening again.

One of the GPs acted as a lead for receiving patient safety alerts and the pharmacy lead from the CCG also collected any information with regards to alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). Information was cascaded to the appropriate staff members in team meetings and where necessary patients were contacted to review their medication. For example the latest alert regarding Domperidone medication for adult gastric reflux.

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 contact numbers displayed both in reception and treatment areas. All staff had received training at a level suitable to their role, for example the GP lead had level three training. 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.

A chaperone policy was available on the practice's computer system and in the staff handbook. All staff had received recent training. The Practice Nurse acted as the main chaperone and a notice was in the waiting room to advise patients the service was available.

Medicines Management

The Practice Nurse oversaw the stock checks and controls. The practice had a fridge for the storage of vaccines available in the treatment room. We found all vaccinations to be in date. There was a cold chain policy in place and fridge temperatures were checked daily. Regular stock checks were carried out to ensure that medications were in date and there were enough available for use. The Practice Nurse carried out vaccinations and had recently received immunisation training updates.

Emergency medicines were available and stored securely such as adrenalin for anaphylaxis and stocks of benzyl penicillin for meningitis. Emergency drugs were also available in GP bags for home visits. All the emergency medication was in date.

The practice did use paper prescriptions; these were securely stored and disposed of. Systems were in place to check on patients who had not collected their prescriptions. Patients could order their prescriptions on line and there were clear guidelines available to patients both in the waiting room and on the practice web site about how to order and collect prescriptions. There was a repeat prescriptions policy in place for staff.

The practice worked with pharmacy support from the local Clinical Commissioning Group and a pharmacy lead worker visited the practice and carried out medication audits.

Cleanliness & Infection Control

The practice had infection control leads who had undergone training. All staff had received training on infection control at induction however it was not clear if staff had received any further training regarding infection control updates. There were policies and procedures in place which were easily accessible for all staff.

Good

Are services safe?

The last audit to be carried out in January 2014 carried out by Liverpool Community NHS Trust was very comprehensive and showed a 90% compliance level. The practice had carried out all the practical actions required. However some actions such as replacing older taps with elbow taps (which would reduce the risk of cross infection) had not been completed at the time of our inspection as the practice was in the process of considering an overall refurbishment plan.

The practice contracted an external cleaning company and was clean and tidy. Treatment rooms had the necessary hand washing facilities and personal protective equipment such as gloves was available. Sharps bins were appropriately stored and information clearly displayed in each treatment room about sharps injuries. Clinical waste disposal contracts were in place. The practice had a spillage kit containing guidance for use.

Equipment

All electrical equipment had received a portable appliance check to ensure the equipment was safe to use. The practice had a record of all the clinical equipment in use which was checked weekly by the Practice Manager to ensure it was working properly.

Staffing & Recruitment

The practice had five GPs and one Practice Nurse who worked four days a week. In addition there was a Health Care Assistant, Clinical Psychologist and a Health Trainer who attended for one session a week. The clinical service was assisted by seven part time reception and administration staff. The GPs would provide cover for each other if one of them was absent and the practice very rarely used locum staff. On the occasions locums had been used, GPs we spoke with told us the locum's referrals and prescriptions were monitored to ensure safe and best practice for their patients. The GPs and Practice Nurse had been at the practice for many years and the practice had a low turnover of staff. The staff rota was done three months in advance and staff covered for each other when necessary.

The practice had a recruitment policy in place and information about Disclosure and Barring Scheme (DBS) checks which clearly stated that reception staff did not require DBS checks. We looked at staff recruitment and training documentation and found the files were not indexed which therefore made it difficult to track what training had been received and what recruitment checks had been completed.

The Practice Nurse had worked for the practice for many years and there were no DBS checks in place for them. Similarly, for the Health Care Assistant, the practice had no documentation to show that DBS checks had been sought but had relied on the information that they worked elsewhere. Whilst there was no requirement for these staff to have DBS checks at the time of their recruitment, we did not see any evidence that the practice had carried out any further risk assessments to assure themselves that these members of staff were suitable to work alone with patients. The practice had checked the General Medical Council Licence for the salaried GP to practice prior to employment.

Monitoring Safety & Responding to Risk

There were procedures in place for monitoring and managing risks to patient safety. There was a Health and Safety policy and all staff were given information on health and safety at induction. There were weekly checks and assessments of the building carried out by the Practice Manager. There was a fire procedures policy and a fire risk assessment that had been carried out by an external company.

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.

All staff received basic life support training and there were emergency drugs available in the practice and in GP bags such as adrenalin. There also was a suitably stocked first aid box available.

There was a defibrillator available on the premises and the Practice Manager told us all staff had been trained on the use of the defibrillator by the ambulance service. There was an emergencies policy in place and discussions with the GPs clearly demonstrated how they would all respond to a medical emergency. They gave us examples of how they had successfully dealt with medical emergencies in the practice and had also responded to medical emergencies

Good

Are services safe?

within the immediate vicinity of the practice. The practice did have pulse oximeters but no oxygen. We discussed this with the GPs at the practice who told us they used to have oxygen and would look into the need for this.

The practice had a 'Disaster Recovery Plan' in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice had a system of registers for patients who had greater needs for example learning disabilities register. This helped the practice identify patients who required specific appointments such as annual health checks or medication reviews. In addition, the GPs held meetings twice a week and minutes from these meetings demonstrated that individual clinical cases were discussed to ensure the best treatment for the patient.

We spoke with three 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. The registrar we spoke with also had access to NICE guidelines.

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. Practice performance was discussed at clinician's meetings held on a weekly basis.

The practice was also supported by the local Clinical Commissioning Group (CCG) and was taking part in the Primary Care Quality Framework designed to help support practices deliver high quality primary care services. GPs and practice managers met with other practices in the area (Neighbourhood meetings) to regularly discuss improvements.

The practice had systems in place to monitor and improve outcomes for people with long term conditions such as diabetes.

The practice also carried out clinical audits. Medicines management audits and work focusing on prescribing trends for antibiotics were carried out in conjunction with the CCG. We looked at one audit in more detail for patient referrals and could see a full audit cycle had been completed.

Effective staffing

New staff received an induction programme that covered such topics as fire safety, health and safety and confidentiality and security procedures. The registrar we spoke with also confirmed they received a two week induction programme and was fully supervised and supported. For example, all the referrals made by the registrar were discussed with the trainer.

Staff received a training needs assessment to identify their individual training needs when first starting employment at the practice. All new staff had a 'buddy' to mentor them in the first six months of employment.

Prior to our inspection we were sent a spread sheet listing training that had been completed this year for all members of staff. Training included: - basic life support, computer training, chaperoning in general practice, confidentiality and practice management training. The practice had an on-line system for information governance training and safeguarding training and we were told staff were at different levels.

Non clinical staff were supported by appraisals from the Practice Manager. The Practice Manager received their appraisal from the GP. We looked at the staff file for the Practice Nurse and could not find any written documentation to support a recent annual appraisal being completed.

Working with colleagues and other services

The practice had access to patients' blood tests and X-ray results from local hospitals and had a system in place for recording information on to patients' medical records. Cases which required immediate follow up where flagged up on the practice's computer system for the GP to action. Letters were divided between GPs and placed in their letter in tray in the reception area. Each GP could access their patients' follow up requirements and we saw GPs dealt with hospital letters and test results so that actions were taken in a timely manner. Patients were contacted as soon as possible if they required further treatment or tests.

Information Sharing

Systems were in place to ensure information regarding patients was shared with the appropriate members of staff. For example, there was a secure white board used to record patients who may be at risk from abuse that relevant staff involved in the patient's care could access. There were other communication tools in place such as a message and visit book to record home visits.

Good

Are services effective?

(for example, treatment is effective)

Information about individual clinical cases was shared at twice weekly clinician's meetings. The Practice Manager also attended these meetings so that any relevant information could be shared with any relevant staff. The practice had an e-mail system for cascading any information.

The practice held monthly multidisciplinary Gold Standard Framework meetings for patients who were receiving palliative care and minutes of these meetings were available to all staff.

Consent to care and treatment

We spoke with one GP about mental capacity who provided us with an example of their understanding around consent and mental capacity issues. The GP was aware of Gillick guidelines for children. (These help clinicians to identify children aged under 16 years of age who have the legal capacity to consent to medical examination and treatment).

Health Promotion & Prevention of ill health

Once patients were registered with the practice, the Health Care Assistant or Practice Nurse carried out a full health check and referred the patient to the GP or other clinic within the practice when necessary. Routine health checks were available for patients between 45-65 years age.

There were health promotion and prevention advice leaflets available in the waiting room including information on bowel cancer screening programme. Information from the CCG in September 2014 for the practice development framework indicated that the practice had exceeded the targets for cancer screening rates by at least 10%.

We observed there were adverts to patients to ensure they received their flu jabs and were offering Saturday morning appointments for the vaccination.

The practice had a Health Trainer who attended the practice once a week. The Health Trainer gave advice on: losing weight and eating a healthy diet, becoming more active, stopping smoking and consuming alcohol sensibly. The appointments were longer and the trainer had links to signpost patients to any additional local services.

The practice worked with the Primary Care Mental Health Liaison Practitioner to ensure that all those patients listed on their register with mental health issues received an annual physical health check.

Information from the local Clinical Commissioning Group outlined that the practice was only 1.5% away from achieving child immunisation targets. Although the majority of vaccinations were done by Health Visitors, the Practice Nurse would also carry out opportunistic vaccinations when children were not up to date with the vaccination programme and had attended for other reasons.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

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

Patient's feedback from comment cards and discussions with the patient participation group was overwhelmingly positive. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect.

We saw that at all times the practice strove to maintain patients' dignity. For example, we could see screens were available in the waiting room and we were told by one of the GPs that this had been used during a medical emergency to protect the dignity of the patient.

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 well in these areas. For example, according to the latest GP patient national survey in June 2014, 73% of patients said the last GP they saw or spoke to was good at involving them in decisions about their care and 75% said the nurse was also good at involving them in decisions about their care.

All patients were offered referrals to hospitals of their choice by operating a 'Patient Choose and Book' service and appointments were made by the GP at the time of the patient's consultation.

Patient/carer support to cope emotionally with care and treatment

Reception staff knew that when patients wanted to discuss sensitive issues or appeared distressed that they would offer them a private room to discuss their needs. GPs told us that in cases of bereavement at least one GP would telephone the patient to ensure their needs were being met.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had an established patient participation group (PPG) that had been running for over five years. The numbers of patients attending meetings had fluctuated over the years and the group were currently looking for more participants. Adverts encouraging patients to join the PPG were available in the waiting room, in the practice information leaflet and on the practice's website.

We looked at a previous patient survey carried out by the PPG in 2012. From the survey an action plan was put into place and we could see that suggestions put forward by the PPG had been implemented in the practice. For example, the action plan called for the introduction of being able to order repeat prescriptions on line and this service was now in place.

Tackling inequity and promoting equality

The practice used interpreter services and worked closely with link workers from the community to strive to improve equal access to health care and health promotion services in the area. Staff were aware of the interpreter services available and how to access them.

The practice had an equality policy and anti-discrimination policy to tackle bullying or harassment.

Access to the service

The practice is open 8.00am to 6.30pm Monday to Friday. The practice operated an open access system three days a week. In response to patient feedback, then offered a patient when they arrived, a time slot to come back which was convenient to them. The practice recognised that after bank holidays they would obviously be busier and therefore always operated an open access clinic the day after.

The practice also offered pre-bookable appointments up to two weeks in advance and patients could contact the practice early in the morning to arrange urgent same day appointments. Children were always offered same day appointments for urgent care. 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 both in the waiting room and within the practice leaflet and website. 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 complaints received by the practice from September 2013 to October 2014. Complaints were broken down into whether they were complaints about administration or clinical work in order to identify any trends. The review outlined that patients when necessary were invited to attend the practice to discuss their complaint and offered an apology and highlighted whether the patient was happy with the outcome of the complaints process. We were told by the practice manager that complaints would be discussed at staff meetings. However minutes from staff meetings we viewed were very brief and did not always identify what actions would be taken and by whom.

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

In discussions with one of the GPs and Practice Manager, we were informed that the practice strove to provide a really good traditional service from the 'cradle to the grave'. When they didn't, they stopped listened and reflected on what they could do better. Discussions with members of the patient participation group echoed these values and confirmed that patients received a traditional family doctor approach.

All staff were engaged in producing a high quality service and each member of staff had a clear role within the structure of the practice. For example, there were leads for safeguarding and infection control.

The practice was engaged with the local Clinical Commissioning Group (CCG) and had completed a practice development plan. We also saw proposals for funding for 'winter pressure' planning to ensure the practice could cope with the possible extra seasonal demand. The plan incorporated extra appointments for patients and was within realistic limits.

Governance Arrangements

The main GP partner was the designated lead for Clinical Governance for the practice. The practice had policies and procedures to support governance arrangements which were available to all staff on the practice's computer system and in a staff handbook available at the reception. However some of the policies we reviewed were not in date. We discussed this with the Practice Manager who was aware the timeline for renewal of some policies had slipped and was seeking to remedy this during October 2014. We did see evidence to support that the repeat prescriptions policy was in the process of being reviewed.

Leadership, openness and transparency

We discussed one incident that had happened at the practice and how the GP had been open and honest about what had happened and had led by example to install a no blame learning culture. The GP had involved the patient throughout in order to be transparent about the event. The practice worked well together as a team holding regular meetings. Information from meetings and any decision making processes were cascaded to staff via e-mail on the practice's computer system.

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

We looked at a previous patient survey carried out by the patient participation group PPG in 2012. From the survey an action plan was put into place and we could see that suggestions put forward by the PPG had been implemented in the practice. For example, the action plan called for the introduction of being able to order repeat prescriptions on line and this service was now in place.

We saw there was a suggestion box available on the front of the reception desk which was checked by the practice manager. The practice had acted on any suggestions for example they had moved the prescription box and patients asked for it to be returned to its original place which the practice duly did.

Management lead through learning & improvement

All staff were given induction training. The Practice Manager undertook a training needs assessment for staff to identify their individual training needs.

Non clinical staff had annual appraisals overseen by the Practice Manager where they could discuss their future roles and how they could improve on their performance. GP partners were all involved in revalidation, appraisal schemes and continuing professional development.

The GPs and Practice Manager attended meetings (Neighbourhood meetings) with other practices every three months where they discussed local CCG plans and benchmarked each other against target performance such as vaccination programmes. Learning points were discussed and could be cascaded to each practice. The CCG confirmed the practice attended all the neighbourhood meetings and CCG training events.

The GPs and clinicians held informal meetings every Monday and a further formal meeting on a Friday where issues such as any significant events were discussed in more detail.

The practice held monthly staff meetings which involved the practice manager and reception/administration staff. The meetings incorporated staff training. We saw minutes from the monthly meetings which only briefly outlined discussions held and did not go into any detail about any actions needed.