The Hedges Medical Centre - SA Bailey

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.

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Summary of findings

Overall summary

We carried out an announced inspection of The Hedges Medical Practice on 10 July 2014. This was a comprehensive inspection under Section 60 of the Health and Social Care Act (2008) as part of our regulatory functions.

Our key findings were as follows;

- Patients reported good access to the practice. Appointments, including those required out of normal working hours or in an emergency were available.
- Systems were in place to identify and respond to concerns about the safeguarding of adults and children. All staff demonstrated a good awareness of the processes.
- Systems were in place to maintain the appropriate standards of cleanliness and protect people from the risks of infection. The practice was clean.
- We saw patients receiving respectful treatment from staff. Patients felt that their privacy and dignity was respected by staff.

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

The provider should:

- Ensure that reasonable adjustments are made for patients with a disability so that they can access all the practice accommodation.
- Ensure that telephone access is improved for patients so that they can always get through to the practice via the telephone.

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?

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 people safe.

Are services effective?

Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely. People'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 have been identified and planned for. The practice could identify all appraisals and the personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

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 making 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 their confidentiality.

Are services responsive to people's needs?

The practice reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG), to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. However, patients said that they had some difficulty in getting through on the telephone.

The practice was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand. Records we viewed showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Summary of findings

The practice acknowledged that there were some building issues which were not of the practices making, and that the practice was trying to rectify these.

Are services well-led?

The practice 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

What people who use the service say

During our inspection, we spoke with four patients, reviewed four comment cards left by patients and spoke with five representatives of the patient participation group (PPG). The PPG is a group of patients who work with the practice to discuss and develop the services provided. Patients told us that the care they received at the practice was very good. They said they felt staff were respectful and friendly. They told us the practice was accessible and they were able to get the appointments they wanted.

The results of the local patient survey completed in October 2013 showed that 77.4% of the patients were able to see the GP on the day that they wanted to. 56.1% of the patients were able to see the doctor they prefer most or some of the time. With 87.4% of the patients being satisfied with the overall care that they received from the surgery and a similar percentage who had recommended the surgery to a friend. Access by telephone remained an issue despite extra support being provided at peak times.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that reasonable adjustments are made for patients with a disability so that they can access all the practice accommodation.
- Ensure that telephone access is improved for patients so that they can always get through to the practice via the telephone.

The Hedges Medical Centre - SA Bailey

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, a GP and a practice manager acting as specialist advisers and an Expert By Experience.

Background to The Hedges Medical Centre - SA Bailey

The Hedges Medical Centre, Pasley Road, Eyres Monsell, Leicester. LE2 9BU. The practice provides a range of primary medical services. It is a teaching practice. The practice serves a population of 5,316. The area served has a higher than average deprivation rate compared to England as a whole. The practice serves a higher than average population between the ages of 45 and 79 and a lower than average population between the ages of 15 and 39. In addition the percentage of British Ethnic and Minority (BME) patients is much lower than the average population. The full clinical staff team includes six GP partners, one trainee GP, two practice nurses and one healthcare assistant / phlebotomist. A phlebotomist is a person who takes blood samples for the practice. The team is supported by a practice manager, a medical secretary, an office manager and five reception staff. A health visitor and midwife also work with the practice from the community.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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

This provider had not been inspected before and that was why we included them.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

Before our inspection visit, we reviewed a range of information we held about the practice and asked other organisations to share what they knew about the practice. We carried out an announced inspection visit on 10 July 2014.

During our inspection we spoke with a range of staff including the GP partners, GP trainees, nurses, one

Detailed findings

phlebotomist, the reception and dispensary teams and the practice manager. We spoke with four patients and representatives of the patient participation group. The PPG is a group of patients who work with the practice to discuss and develop the services provided.

We observed how staff interacted with patients. We reviewed the practice's own patient survey and four CQC comment cards left for us by patients to share their views and experiences of the practice with us.

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

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

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health.

Are services safe?

Our findings

Safe track record

The staff we spoke with demonstrated an understanding of their roles in reporting incidents and significant events and were clear on the reporting process used at the practice. The senior staff understood their roles in discussing, analysing and reviewing reported incidents and events. We saw that the relevant guidance was available to all staff.

The practice's weekly meeting was used for staff to review and take action on all reported incidents, events and complaints. We looked at minutes of the meetings that demonstrated this happened as and when required. Details of any discussions and decisions made in those meetings were made available to all staff through a range of meetings. In addition the patient participation group (PPG) were very active and held meetings and also developed action plans that acted upon feedback from the patients, incidents and complaints.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. Significant event analysis is used by practices to reflect on individual cases and where necessary, make changes to improve the quality and safety of care. We looked at examples of how staff had used the procedure to report incidents and significant events relating to clinical practice and/or staff issues. The minutes of the partners' meetings available at the practice demonstrated that all incidents and near misses were discussed. The meetings included discussion on how the incidents could be learned from, and any action necessary to reduce the risk of recurrence. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff.

Safety alerts were reviewed by and distributed to the relevant staff by the practice manager. The staff we spoke with demonstrated an awareness of how safety alerts were communicated and told us they were receiving those relevant to their roles regularly. They were able to give examples of recent alerts relevant to the care they were responsible for.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. 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 share information, record safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role . All staff we spoke to knew who to speak to in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. All nursing staff, including health care assistants, had been trained to be a chaperone. If they were not available to act as a chaperone, all receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans, were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults, and records demonstrated good liaison with partner agencies such as the police and social services.

Medicines management

The risks to patients from the unsafe use and management of medicines were minimised and controlled. A system was in place to order and check all medicines, and receive and store vaccinations at the required temperature. The checks included daily monitoring of the fridge temperature at which the vaccines were stored. All of the staff we spoke

with were aware of the system in place and how to use it. We checked the medicines and vaccines and found them to be stored securely at the appropriate temperature and within their expiry dates.

All prescriptions were reviewed and signed by a GP before they were given to patients. We saw the protocol for weekly prescribing for vulnerable patients and staff we spoke with understood the need for this and how it worked.

Practice staff undertook regular audits of controlled drug prescribing to look for unusual products, quantities, dose, formulations and strength. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

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. The infection control policy was displayed on the notice board in the lobby on the ground floor for all to see. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The records we looked at showed that staff were trained in and had access to a policy on infection control. The patients we spoke with, or who completed a comment card for us were positive about the standards of cleanliness at the practice. The practice had a nominated lead for infection control. The staff we spoke with were aware of their responsibilities and those of the lead.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place.

Staffing and recruitment

Records we looked at contained evidence that 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 of staff 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.

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. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. There were emergency processes in place for patients with long-term conditions. Staff gave us examples of referrals made for patients whose health deteriorated suddenly.The practice monitored repeat prescribing for all patients and a protocol of weekly prescribing for vulnerable patients.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. The notes of significant event meetings showed that staff had discussed a medical emergency concerning a patient and that the practice had learned from this..

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included

Are services safe?

those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. 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. These included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company if the heating system failed, and details of the relocation of the surgery to a named neighbouring practice.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Risks associated with the service and staffing changes (both planned and unplanned) were included in the continuity plan. These also included how to assess the capacity of staff to travel to the alternative location.

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 saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed.. We found from our discussions with the GPs and nurses we found that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they each led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for, and providing colleagues with advice and support. For example, GPs told us this supported all staff to continually review and discuss latest best practice guidelines for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need, and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The practice showed us a clinical audit that had been undertaken in the last year. This was a completed audit where the practice was able to demonstrate the changes resulting since the initial audit. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. Other examples included audits to confirm that the GPs who undertook minor surgical procedures, were doing so in line with their registration and NICE guidance.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 85% of patients with learning disabilities had an annual review, and the practice met all the minimum standards for QOF in diabetes. However, the practice was an outlier for QOF (or other national) clinical targets in asthma and Chronic Obstructive Pulmonary Disease (COPD) admissions.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year. We heard during the practice meeting how the practice was actively planning to increase the percentage of health check for patients.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question

Are services effective?

(for example, treatment is effective)

and, where they continued to prescribe it, outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had a palliative care register and had regular internal as well as monthly multidisciplinary meetings to discuss the care and support needs of patients and their families. Staff we spoke with demonstrated a good understanding of end of life care and the consent issues linked with such care.

Effective staffing

Systems were in place to ensure that people received care from appropriately qualified staff. The staff we spoke with said they could recall that the practice had completed a series of recruitment checks including criminal records checks, references from previous employers and checks on their professional registration. The staff files we looked at confirmed what staff had told us. Criminal records checks were available for clinical staff, and a risk assessment was completed as to whether non-clinical staff required it. Where applicable, the professional registrations and revalidations of staff at the service were up-to-date.

The practice had systems in place to ensure that its staff remained competent and effective in their roles. From speaking with staff and our review of documentation we found that staff received an appropriate induction when joining the service. Staff referred to the induction process as thorough.

There were systems in place to ensure patients received care from competent and effective staff. All of the staff we spoke with said they received an annual appraisal of their performance and competencies. We looked at some examples of these and saw that there was also an opportunity for staff to discuss any training requirements. Staff told us that the training provision at the practice was good, and they accessed much of their training during protected learning time. This is time when GP's have no patients to see and use the time for learning and training. The various certificates we looked at demonstrated staff had access to and attended a wide range of training, especially relating to clinical skills.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Staff received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hour's GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The 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 monthly multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. Staff felt this system worked well and remarked on the usefulness of the meetings as a means of sharing important information.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hour's provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made an average of 75% of referrals last year through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

The practice had systems in place to provide staff with the information they needed. An electronic patient record (SystmOne) was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care

Are services effective?

(for example, treatment is effective)

plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. The practice kept records and showed us 85% care plans for people with a learning disability had been reviewed in last year. When interviewed, staff gave examples of how a patient's best interests were taken into account if they did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

Health promotion and prevention

We saw that the practice operated patient registers and nurse led clinics for a range of long term conditions (chronic diseases) and there was a nominated GP lead for each of these. There were clinics for diet and exercise, smoking cessation, Open Mind, Alcohol and Drugs Team, Midwifery, sexual health and chlamydia screening. Chlamydia screening packs, including contraception were also available for patients to take away.

The practice maintained a register of all patients with learning disabilities and all 58 were offered an annual health check in 2014.

We found that the practice offered a number of services designed to promote patients' health and wellbeing and prevent the onset of illness. We saw various health related information was available for patients in the waiting area. In addition the practice leaflet was also available and included information on a variety of topics to aid patients through their individual care pathway.

The practice had participated in targeted vaccination programmes for older people and those with long term conditions. These included the shingles vaccine for those aged 70 to 79 and the flu vaccine for people with long term conditions and those over 65. The childhood immunisation programme had reached an average 95.7% take up rate.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the patient survey 2013/2014, a survey of 230 patients undertaken by the practice's patient participation group (PPG) and patient satisfaction questionnaires sent out to patients by each of the practice's partners. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was also 'very satisfied' for its satisfaction scores on consultations with doctors and nurses.

Four patients completed CQC comment cards to tell us what they thought about the practice, and were positive about the service they experienced. 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 also spoke with four patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. However, some patients had commented in the patient's survey that confidentiality was not always maintained, at the reception area due to the closeness of the waiting area. The concern in regard of patient confidentiality and other concerns from the patient survey have been discussed by the PPG and GP partners and an action plan has been agreed.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff. We were shown an example of a report on a recent incident that showed the actions taken had been robust.

The practice's leaflet clearly stated the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The practice had made suitable arrangements to ensure that patients were involved in, and able to participate in decisions about their care. All of the four patients we spoke with said they felt listened to and had a good relationship with the GPs and nurses. They said their questions were answered by the clinical staff and any concerns they had were discussed.

The results of the General Practice Assessment Questionnaire for 2013/2014 showed that 87.4% of the respondents felt satisfied with the overall care that they received and would recommend the surgery to a friend.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff, and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The patients we spoke to on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and patient website also told people how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written

Are services caring?

information available for carers to ensure they understood the various avenues of support available to them. Carer's packs were also available at the reception. The packs helped inform carers of what services were available in the community to help, should they be needed.

Staff told us that if families had suffered a bereavement, their usual GP contacted them. The practice sent condolence cards to all those carer's of patients who had died. Patients we spoke to who had had a bereavement confirmed they had received this type of support and said they had found it helpful. Six out of seven deaths that have taken place recently where at a place of patient preference.

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 people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices, to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. The practice also carried out risk stratification. This process involved looking at patients whose health suggests they are at risk of hospital admission. The practice worked closely with other agencies to provide health and social care to avoid admission.

Feedback from local care homes was very positive. The practice tried to send the same GP to the care home to maintain continuity of care. Staff at the care home were confident that the practice would support them and felt at ease to ask questions about the patients care needs.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services, in response to feedback from the patient participation group (PPG) in the 2012/2013 survey. The practice had actioned the following; two extra duty doctor appointments were made available for advanced booking. Updated customer care training has been provided for administration and reception staff GP's changed the way that they booked their own appointments, so that earlier morning appointments have been freed up for receptionists to book in patients in advance, two GP clinics have been arranged to take place later in the afternoon to offer easier access to workers and school children, a costings exercise has been undertaken for patient calling and booking in screens, solutions to phone access had been discussed andon line access had started for repeat prescriptions and booked appointments in advance.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups of patients in the planning of its services. There were a variety of clinics available to meet the health needs of all groups.

From our review of documentation we saw that most of the staff at the practice had completed equality and diversity training. We saw that the access for wheel chair users was a little difficult when trying to get through the entrance doors within the practice. The doors did not provide an electronic opening device, which meant that some people in a wheelchair were not able to easily access the premises.

Appointments were available from 8:30am to 6.30pm on weekdays. Appointments for carers, workers and school children were available up to 10 days in advance. Telephone appointments were available at the end of the morning surgery for advice from a doctor or a nurse.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hour's service was provided to patients.

Longer appointments were also available for people who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to local care homes as needed and by a named GP, and to patients who lived at home.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to, and they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. However, some concerns had been expressed about difficulty in getting though on the telephone. This was in contrast to some patients who said they had not had any difficulty and were pleased to have the GP call them back with advice or an appointment offered that day.

Listening and learning from concerns and complaints

Are services responsive to people's needs?

(for example, to feedback?)

The practice considered that lessons were to be learnt from complaints. It 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. Verbal, written and telephone complaints were all recorded and investigated.

All staff attended the meetings where the complaints were discussed and lessons learnt.

We saw that information was available to help patients understand the complaints system. For example, there were posters displayed and a summary note contained within the practice leaflet available. Patients we spoke with 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.

Are services well-led?

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were well embedded in the culture of the practice. The practice had a Patient Charter and this was clearly displayed on the patient participation notice board in the waiting area. The patient charter detailed the mission statement along with patient rights and the practice rights. The charter was well written and contained useful advice. However, it appeared lost on the notice board and may be more effective for patients, carers and relatives if it could be found a more predominant position in the practice.

The partners held meetings every two months to discuss the practice development strategy. We saw the minutes of these that identified key areas for improvement and leadership.

We spoke with eight members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at 10 of these policies and procedures. All of these had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We spoke with eight 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. QOF is a system used to monitor the quality ofservices in GP practices. QOF consisted of groups of indicators against which practices score points according to their level of achievement.

The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at weekly team meetings and action plans were produced to maintain or improve outcomes.

The practice had arrangements for identifying, recording and managing risks. The practice's weekly meeting was used for staff to review and take action on all reported incidents, events and complaints. We looked at minutes of the meetings that demonstrated this happened as and when required. Details of any discussions and decisions made in those meetings were made available to all staff through a range of staff meetings.

The practice had a system in place for reporting, recording and monitoring significant events. The minutes of the weekly meetings available at the practice demonstrated that all incidents and near misses were discussed. The meetings included discussion on how the incidents could be learned from and any action necessary to reduce the risk of recurrence.

Leadership, openness and transparency

We saw from minutes that team meetings were held weekly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example disciplinary procedures, induction policy, which were in place to support staff.

Seeking and acting on feedback from patients, public and staff

The practice had mechanisms in place to listen to the views of patients and those close to them. The practice had a patient participation group (PPG), which began in 2011 with 12 members. Due to alternative commitments had reduced in membership to seven. The PPG is a group of patients who work with the practice to discuss and develop the services provided. There was also an online virtual patient participation group (vPPG) of three members. The vPPG is an online community of patients who work with the practice to discuss and develop the services provided. Between them, the groups' membership represented mainly white British and one member of dual heritage. We saw that through meetings or emails the groups were able

Are services well-led?

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

to feedback their views on a range of practice issues. We spoke with a member of the PPG. They spoke of the valuable work the group was doing and of their good working relationships with practice staff.

The work of the PPG was described in an annual report. This was accompanied by a plan of improvements the group would work towards achieving. This enabled the patient members to offer support and guidance to other patients at the practice. The report also detailed the group's aims for 2014/2015.

The practice had distributed a patient survey for two weeks in February 2014 and responses were received from 230 patients. The results showed that 87.4% rated their experience of the practice as good to excellent.

The staff we spoke with said the results of the patient survey, patient complaints and other patient feedback were discussed in their meetings so they were clear on what patients thought about their care and treatment. They said the practice away day and their regular meetings were opportunities for them to share their views on the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.

The practice was a GP training practice and had a registrar. The practice employed registrars who are qualified doctors training to be GP's. The registrars at the practice were supervised by one of the partner's who is the GP trainer.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients. For example changes to prescribing and medicines management had been made.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Our findings

Nationally reported data showed that 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, in dementia and end of life care. The practice 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

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Our findings

There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that 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.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

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. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Our findings

The needs of the working age population and those recently retired had been identified. The practice had adjusted the services it offered to ensure these were accessible to provide flexible 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.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Our findings

The practice held a register of patients living in vulnerable circumstances and those with a learning disability. It had carried out annual health checks for people with a learning disability and 85% of these patients had received a follow-up. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Patients whose circumstances may make them vulnerable had been 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

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Our findings

People experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

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