Norvic Family Practice

Quality Report

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

Contents

Summary of findings

Overall summary

The Norvic Family Practice provides a range of primary medical services for approximately 8,000 patients from two locations in Smethwick. As each of these locations is registered separately with the CQC, our inspection considered services provided by the Victoria Health Centre only. The other location is a short distance away in Norman Road.

Prior to our inspection we spoke with patients during a listening event held locally and we also spoke with the local area team from NHS England, the local clinical commission group (CCG) and the local medical committee. During our inspection we spoke with staff and patients attending the practice that day.

We found that the practice was effective, caring, responsive and well-led. However, we found that the practice should improve some of its safety review arrangements. The practice was committed to learning from when things went wrong and engaged in significant event and clinical audit. Clinical audit is a way of finding out if healthcare has been provided in line with recommended standards.

Patients we spoke with at the practice reported that the practice was caring and that they were treated with respect. The majority of patients reported satisfaction with the care they received from the practice but there were concerns expressed regarding difficulty in getting appointments. This has been an area on which the practice has been working over a period of time and has implemented actions to improve access.

The practice was proactive in identifying the needs of the practice population and had analysed data and implemented changes to how services are delivered as a result. The practice offered services to include provision of health care to all population groups.

There was a specific GP with an interest in care of older people and mental health, and patients with long term conditions are managed appropriately. The practice offered facilities for young children and mothers for support and advice and opportunity to take up national screening programmes for immunisation and cervical screening. The practice had systems in place to identify vulnerable people and those with mental health problems who may need additional support and referral to more specialised services.

The practice had extended opening hours and online appointments to provide improved access to services for those patients who work.

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.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice was mostly safe although the systems in place to ensure monitoring of safe practice and arrangements for addressing any issues which may present risks to patients or staff should be reviewed, as we found one example where a piece of single use equipment had passed its use by date. The significant event analysis (SEA) process was embedded within the practice demonstrating commitment to learning from when things went wrong. Staff were trained in safeguarding procedures and demonstrated an understanding of the safeguarding policy and their responsibilities within the practice. There were sufficient staff with the appropriate skills to carry out their roles and who were trained to deal with unforeseeable emergencies.

Are services effective?

The practice was effective. The practice demonstrated commitment to best practice standards and had systems in place to ensure that these were adopted by all staff. Regular clinical audit was carried out to review care and improve standards of care for patients as a result. There was sufficient, well maintained equipment and facilities within the practice to enable all staff to carry out their roles effectively. There was evidence of joint working with other agencies and communication internally and externally to enhance patient care.

Are services caring?

The practice was caring. We observed positive interactions between staff and patients and we spoke with patients who reported that they were treated with kindness, respect and dignity. They reported positive experiences during consultations with clinicians and felt listened to. Consent was always sought prior to procedures and patients felt involved and informed regarding their care and treatment.

Are services responsive to people's needs?

The practice was responsive. There was evidence of genuine commitment to the comments and views via the patient survey and comment cards. There was regular analysis and review of the appointments system, which the practice had accepted from patient feedback, was the issue that mattered most to patients. The practice had a clear system for dealing with complaints and implemented it accordingly.

Summary of findings

Are services well-led?

The practice was well led. There was commitment to staff training and development through appraisal and one to one discussions, and an open and honest culture was evident throughout the practice. Staff reported that they knew who to contact if they needed help with concerns or issues occurring in the practice.

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
The practice had a proactive approach to meeting the needs of older people. Within the practice services had been developed to promote and improve care for elderly patients. They had a systematic method of identifying patients with specific conditions and adapted care according to patients' personal needs. Patients over the age of 75 years had a named GP.

People with long-term conditions
The practice had a clear and structured procedure when identifying patients and managing patients with long term conditions. Clinics were held to ensure patients had access to annual review and opportunity to discuss their condition when patient education and change of care management was necessary. The practice and community nurses offered on-going support to patients with long term conditions; good communication between practitioners was evident.

Mothers, babies, children and young people
Midwives attended the practice weekly to offer advice and care for women during pregnancy. Health Visitors were based in the building and had a close working relationship with the practice and other health professionals. Smoking cessation advice and education regarding pregnancy and childbirth were provided during this time. The practice offered child health clinics to provide medical checks, immunisation and development review for babies with the GP and health visitor as well as advice and support for new mothers.

The working-age population and those recently retired
The practice offered extended appointments up to 8pm one evening per week to allow patients who work broader access to health care. There were also facilities to allow patients telephone appointments if they had difficulty attending appointments at the practice. Online booking and repeat prescription requests were also available.

People in vulnerable circumstances who may have poor access to primary care
The practice had a system for identifying patients with learning disabilities and offered annual physical health checks. The practice worked closely with carers, particularly young carers, to support and signpost to alternative support agencies where necessary.

Summary of findings

The practice offer care for those patients with no fixed address and provide immediate necessary treatment where appropriate. Advice and signposting was also available and provided as required.	
People experiencing poor mental health The practice had a GP, with a special interest in mental health, who worked with other services to provide a holistic approach to care involving specialists. The practice also directly employed two counsellors to help patients with mental health issues, such as depression. This allowed patients direct access to additional support without being referred to outside agencies.	

Summary of findings

What people who use the service say

We spoke with six patients during our inspection and viewed eight comment cards completed by patients in the four weeks prior to our inspection. We also spoke with patients who attended a listening event held by a local group.

Almost all patients we spoke with expressed satisfaction with the care they received at the practice. They reported that they were treated with respect and kindness. However, they did tell us that sometimes it was difficult getting an appointment.

Seven of the comment cards we received included positive comments about how the caring and thoughtful the staff were at the practice. Two cards contained comments about problems getting an appointment.

Overall the majority of comments were very positive expressing satisfaction with the service, with the exception of the ability to book appointments.

Areas for improvement

Action the service MUST take to improve

The provider should review arrangements for checking equipment, in particular the system in place to make sure all single use equipment used in the practice is within date.

Action the service SHOULD take to improve

- The provider should review the secure storage arrangements for patient records.
- The provider should review arrangements for checking equipment, in particular the system in place to make sure all single use equipment used in the practice is within date.
- The practice should ensure concerns reported to the NHS property team are routinely followed up, to ensure they are completed.

Norvic Family Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector and a GP with a practice business manager and an additional CQC Inspector.

Background to Norvic Family Practice

The Norvic Family Practice is located in Smethwick, West Midlands and is made up of two practice locations based in Suffrage Street and Norman Road. The practice provides primary medical services for approximately 4,500 patients. The practice based in Norman Road was not part of this inspection.

Norvic Family Practice has four GP partners and a salaried GP. They employ three practice nurses, a health care assistant. The clinical team is supported by a practice manager, a deputy practice manager, a secretary and three administration and reception staff.

The practice service for out of hours care is via the NHS 111 service.

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward.

How we carried out this inspection

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?

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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Prior to the inspection, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. A listening event was held prior to inspection and we reviewed comment cards where patients and members of the public shared their views and experiences of the service.

We carried out an announced inspection on 08 August 2014 between 9.30am and 5.30pm.

During our inspection we spoke with a range of staff including GPs, practice nurse, community nurses and

Detailed findings

reception staff and spoke with patients who used the service. We observed how patients were dealt with and talked with carers and family members. We also reviewed policies and procedures in use throughout the practice.

Are services safe?

Our findings

Safe Track Record

The practice had designated lead GPs for particular roles across the practice, for example, safeguarding, diabetes and elderly care. Staff we spoke with were aware of whom to go to if they had concerns regarding safety issues.

There were arrangements to report, record and learn from safety incidents, concerns or near misses. The practice had a significant event analysis (SEA) template which provided staff with guidance on how to report, respond to, review and learn from incidents and significant events. Significant event analysis is a technique to reflect on and learn from individual cases to improve quality of care overall. Staff we spoke with demonstrated an understanding of the importance of carrying out SEA reviews. However, the practice manager told us there had been no SEAs reported in the past few years.

The practice manager showed us the reporting system, which consisted of an internal e-mail alert system to the GPs, clinical staff and others as relevant. For example, national prescribing alerts were disseminated to all GPs and nurses. Prescribing alerts inform clinicians when there is an immediate concern with a medicine. The practice manager maintained an electronic record of all the alerts received.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring events which impacted on performance. There was a system to respond to Medicines and Healthcare Products Regulatory Agency (MHRA) and other safety alerts. The MHRA is responsible for regulating all medicines and medical devices in the UK by ensuring they work and are acceptably safe. The practice held regular and routine staff and clinical meetings. We saw notes from these meetings that staff were made aware of any reviews and changes.

Staff told us that an open and transparent approach existed within the practice and they could talk with any of the GPs or manager. The practice had a commitment to learning and shared improvements and changes as a result with an understanding of the importance of review.

Reliable safety systems and processes including safeguarding

There were operating procedures to safely maintain the services provided. There were policies and procedures related to medicine management, prescriptions and repeat prescriptions, use of equipment and its maintenance. Arrangements for the maintenance of medical gases that were used at the practice were covered by a comprehensive policy and procedure document.

We saw that patient paper medical records were stored in an open plan office, which was shared by another GP Practice. We asked about the safety and security of the storage arrangements and were told that the building, including the area where the records were stored, was the responsibility of the local NHS trust from whom the practice rented the premises. We were told that, at the end of the day, the building caretaker activated the alarm system ensuring the safety of the premises and its content.

We found that system had the potential to be insecure, as unauthorised people from the other practice had opportunity to access the records. There were no stand-alone security systems in place to protect the records independent of the overall building security system operated by the caretaker.

The practice had a nominated lead GP for safeguarding and we saw from staff files that appropriate training in safeguarding had been provided. The nominated lead GP had level 3 Safeguarding training. Safeguarding level 3 learning provides advanced level knowledge of child protection issues and concerns. We spoke with staff regarding safeguarding of vulnerable adults and children. The staff we spoke with demonstrated an understanding of their role and responsibility regarding reporting arrangements. Staff told us that when patients were at risk or if a child is known to social services an alert was placed on the system to indicate to the staff member that the patient may need additional support or that communication with other agencies may be necessary.

Monitoring Safety & Responding to Risk

The practice undertook various reviews and audits to monitor and identify any risks that affected patient care. For example, the practice undertook regular checks on the temperature for the medicines refrigerator; and we saw evidence of a cancer audit to determine the outcome of

potential cancer referrals. The practice had analysed the outcome of the audit, in order to review practice and consider if services could be changed to provide improved care.

We spoke with staff who told us that they could contact a GP if they had concerns regarding patient care. Clinical meetings involved the multidisciplinary team who had opportunities to share information regarding treatment and highlight any potential risks for patients. The staff were aware of specific lead roles of GPs within the practice, whom they could approach if necessary.

When we reviewed the emergency medical equipment we saw that it was checked regularly and that the checks were recorded as having taken place. However, we also found that the date of use for one of the single use needles had expired in the month before our inspection. Due to the timing of the monthly equipment checks it was possible for a piece of equipment to be in date at the time of checking, but to expire at the end of the month. The timing of the routine monthly checks meant there was a risk of using out-of-date single use equipment. The practice must to review the coordination of the equipment checks

Medicines Management

The practice had a GP with lead responsibility for the management of medicines. We found that there were systems in place for storing and administering medicines, with regular checks in place to monitor the usage and expiry dates. Medicines we looked at were in date and stored appropriately. We also looked at the records for the refrigerator temperatures and found that they had been recorded and maintained correctly.

Staff explained how the practice managed the process for repeat prescriptions We saw that patients could order a repeat prescription from the practice, by post or online.

Cleanliness & Infection Control

The practice was visibly clean throughout. Arrangements were in place which ensured the practice was cleaned to a satisfactory standard. Cleaning was undertaken by the local NHS trust. We saw that reviews of the cleaning was undertaken and staff told us that any shortfalls in the quality of cleaning were reported immediately and that cleaning staff would be sent to the practice as appropriate.

Appropriate infection control policies and procedures were in place. These provided staff with guidance about the standards of hygiene they were expected to follow. Training records confirmed staff had received infection control training. This was also confirmed by the staff we spoke with.

We looked at all clinical areas and consultation rooms. Protective paper covers for consultation couches, personal protective equipment and materials, and bins for clinical and sharps waste, were available in each consultation room we visited. Waste, including clinical waste, was disposed through an arrangement with the local NHS trust. Privacy curtains within consultation rooms were disposable and were date marked with the replacement date. All of the patients we spoke with told us they though the practice was clean.

In one consultation room we found the laminate covering on a work surface had peeled away which exposed the bare chipboard making it an infection control risk. In another room we found the hand wash sink had several chips and the splash guard was cracked. The practice manager told us that these concerns had been reported to the local NHS trust, that provided the maintenance of the premises, and that they awaited a repair. The practice should follow up on these repairs with the local NHS trust to determine when they will be made.

Staffing & Recruitment

The practice manager told us that staff levels were reviewed regularly, with staffing rotas created in advance based on the clinics which were running the following week. During times of staff sickness the practice called other members of the team who were off duty, before requesting locum cover. They told us that patients were always given a choice whether they wished to be seen by another GP.

Dealing with Emergencies

Systems were in place to identify and manage foreseeable risks. The practice's business continuity plan set out the alternative arrangements that would be put in place if the normal service provision failed. This included arrangements on how to access doctors in the event of their unplanned absence. There were arrangements with the out of hours service provider to respond to service demands when the practice was closed. The practice held regular fire alarm drills to test the understanding of the

Are services safe?

emergency procedure. Other aspects of business continuity, such as provision of Information Technology (IT), were part of a service level agreement with the NHS trust.

Equipment

The practice had a comprehensive and complete equipment log. Equipment was maintained and serviced by an external contractor and we saw records which confirmed that this took place at appropriate intervals. The practice manager told us that as well as routine maintenance the contractor could be contacted at any time to address any urgent issues with equipment.

Staff we spoke with told us they had sufficient appropriate equipment to carry out their role and we saw that equipment was available for staff.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

The practice demonstrated commitment to monitoring and improving services for patients. They reviewed the needs of the practice population and addressed these. We saw, for example, the diagnosis and ongoing treatment of diabetes had been reviewed in line with guidelines issued by the National Institute for Health and Care Excellence (NICE). NICE provides national guidance and advice to improve health and social care.

Staff told us that the practice discussed changes to the treatment of patients with complex conditions at the practice and staff meetings. We saw minutes of the meetings to confirm this.

We spoke with staff regarding safeguarding children and vulnerable adults who demonstrated awareness and understanding of the Children Act and their role. Staff we spoke with also had an awareness of the Mental Capacity Act and Gillick competence which is used to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge

The GP we spoke with told us that many people whose first language is not English choose to communicate using a family member. We also saw that many of the staff at the practice spoke additional languages. However, patients were also offered the facility of a translator when required, which was arranged when necessary and co-ordinated with an appointment.

Management, monitoring and improving outcomes for people

Discussions with clinical staff confirmed that the practice had systems in place to ensure that current national and the local clinical commissioning groups (CCG) recommendations and guidance was followed.

On a practical level we saw that staff listened, learned and took action to make improvements. The focus on promoting and achieving clinical excellence in the quality of care was based on the Quality and Outcomes Framework (QOF), which is a system for the performance management and payment of GPs in NHS England, Wales, Scotland and Northern Ireland.

We saw that the practice had a system in place for completing clinical audit cycles. Clinical audit is a process that is designed to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. The GPs we spoke with were able to describe audits undertaken at the practice relevant to the care offered to patients. The results of the audits were discussed and changes made where necessary.

Examples of audits included a review of repeat prescriptions issued. We saw earlier examples from 2012 where a concern regarding patients who did not attend for appointments had caused significant problems for the management of resources at the practice. Following a review of booking arrangements changes were implemented which were evaluated in 2013/2014 and identified a reduction in the number of missed appointments. The practice had experienced a high number of missed appointments, where patients did not attend for their booked appointment. The practice introduced a book on the day system to reduce the number of missed appointments.

Effective Staffing, equipment and facilities

The practice had a well-documented recruitment policy, which set out the processes to be followed. The staff files we reviewed demonstrated that the policy and procedure had been followed appropriately. We saw that staff had received a Disclosure and Barring Service (DBS) check. The DBS carries out criminal record checks for specific positions, professions, employment, offices, works and licences included in the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975. The practice obtained personal and professional references for staff prior to commencement of employment. For clinicians we saw that the procedure included checks with appropriate registration bodies. Staff we spoke with verified that they had DBS checks and had undertaken a comprehensive induction at the start of their employment.

Although the practice had not conducted a formal training needs analysis, we saw that training was discussed as part of staff appraisals. Staff were appropriately trained and competent to carry out their role. We spoke with staff and the practice manager and looked at records. The practice had a clear policy and procedures to ensure staff received an effective induction programme, for example, we saw

Are services effective?

(for example, treatment is effective)

that new starters were supported and appraised at three and six monthly intervals. Nurses were clinically supervised and appraised by the GPs and the health care assistant was supervised by the nurse.

We also saw that non-clinical staff were trained to enable them to be effective; this included training in safeguarding and health and safety. The practice was supportive of staff who wished to attend training and continue their personal and professional learning and development. Staff were provided with opportunities to continuously learn and improve. They told us they were provided with enough opportunities for continuous learning which enabled them to retain their professional registration.

Staff told us their personal development was encouraged and supported. Nursing staff told us that they were able to complete the necessary training to keep their knowledge and skills up-to-date.

Protected time education, usually organised by the local CCG, took place on a regular basis. The practice had recently started providing opportunities for training GPs to complete their training at the practice.

There was evidence of staff appraisals and staff reported that they felt this was a relevant and supportive process. Staff told us that their personal development needs and performance were discussed during their annual appraisal meeting with their line manager. Practice nurses reported that they were also supported through practice nurse meetings which were held monthly.

We saw that there was a system in place for managing poor or variable performance which focused on providing support and development.

All medical staff had undertaken the appraisal process in preparation for revalidation which is the process by which GPs are required to demonstrate on a regular basis that they are up to date and fit to practise.

The practice manager had a system in place to review the on going professional registration arrangements for the clinical staff.

Working with other services

The practice had made arrangements to promote multidisciplinary working with other services. District nurses and health visitors had an office at the practice. We spoke with two district nurses who told us that they had a good working relationship with the GPs and practice clinical staff which helped them in providing appropriate care to the patient. For example they told us that as part of end of life care, they communicated with the GPs out of hours or at weekends and ensured continuity of care.

Multi-disciplinary team meetings took place monthly where all members of the team were invited. We saw minutes of meetings where the health visitor had attended to discuss patient care.

The practice also communicated daily with the out of hours service to determine if patients had been seen or were likely to require help or treatment out of hours. They told us that all urgent results were communicated by letter or phone call.

Health Promotion & Prevention

We found a broad range of information leaflets and posters in the reception area and throughout the practice regarding health promotion and prevention of ill health. Leaflets dealing with smoking cessation and depression and diabetes were available and there were also large visual displays about healthy lifestyles.

Patients in need of extra support were identified and their needs addressed. For example, patients who required end of life care were 'flagged' on the clinical system, had individual care plans and were discussed at weekly clinical meetings to ensure their changing needs were met. Information was provided by the community nurses and palliative care service to ensure improved outcomes for patients through good communication. The practice offered clinics for patients with long term conditions regularly throughout the year. At the clinics their condition was reviewed and treatment and medication changed as required. Influenza vaccination was offered to all patients with long term conditions where appropriate. The practice also provided insulin initiation and work with the community diabetic team, with specialist nurses and a consultant

Patients who had caring responsibilities were also identified on the clinical system and an alert created to allow signposting to local support services to be offered where appropriate.

All new patients were offered routine health checks, where their medical history was taken. Where appropriate, patients were offered advice and support regarding lifestyle changes, exercise programmes, or weight control.

Are services effective?

(for example, treatment is effective)

The practice had organised a rolling programme to deal with the high level of influenza vaccines required at certain times of year. They told us that this involved staff at all levels and included opening Saturdays to promote the service, ensure optimal attendance and prevent excessive workload during normal hours.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Patients were treated with dignity and respect. This was confirmed by all of the patients we spoke with.

Consultations took place in private with the doors to consultation rooms being closed during patient-doctor consultations. Privacy curtains were available in all the consultation rooms.

Reception staff were courteous and spoke respectfully to patients at all times. They listened to patients and responded appropriately. For example, we saw that a member of the reception staff asked a patient, whose first language was not English, if they required an interpreter for their appointment with the GP.

The practice had a chaperone policy, and the staff who acted as chaperones had been trained and were aware of the policy and appropriate procedures. We spoke with staff and they demonstrated how to offer patients the option of having a chaperone to be present during their consultation. The practice had signs promoting the availability of the service in the reception area and consultation rooms. A chaperone is a person who serves as a witness, for both a patient and a medical practitioner, as a safeguard during a medical examination or procedure and is a witness to continuing consent of the procedure. Family members or friend may be present but they cannot act as a formal chaperone.

During the inspection we saw how the staff responded to patients and dealt with their questions and concerns. We saw that staff treated patients with kindness and respect and maintained their dignity. Staff members were helpful and sympathetic to patients experiencing discomfort on arrival and attempted to comfort them appropriately. There was a hearing induction loop to assist patients with hearing impairment.

The general open plan nature of the waiting area meant that, on occasions, it may be possible for personal information to be overheard from the reception window. However, we saw that staff were aware of this possibility and were discrete in their dealings with patients. The practice made use of available office and consultation rooms should a patient ask for a discussion about sensitive matters.

Patients were provided with the support they need to cope emotionally with their care and treatment. The practice made appropriate referrals, for example to organisations that provided care and support to people who have been affected by a death or to help patients with mental health needs. Staff told us that families who had experienced bereavement could receive a follow up contact to establish the need for support and signpost accordingly. In addition, counselling was available from the counsellors employed at the practice and patients were referred as appropriate.

Involvement in decisions and consent

Each of the six patients who spoke with us on the day of inspection told us they felt involved in making decisions about their care and treatment. This was supported by the comments we received from patients who had completed comment cards prior to our inspection.

Patients told us that they were provided with information regarding their treatment and had opportunity to ask questions. We saw that the practice had a policy regarding consent. Staff we spoke with told us that they always sought patients consent and ensured their understanding before carrying out procedures. They confirmed that this was documented in patient notes where written consent was necessary.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

As we spoke to the staff at the practice we found that they worked hard to understand the needs of their patients. One of the GPs had undertaken a training course dealing with patient engagement.

We saw that the GPs had taken lead responsibility for specific areas of care. For example, we saw that housebound patients were provided with regular, planned visits coordinated by the health care assistant. The GPs also provided support and care for chronic conditions during extended home visits for those patients who were unable to attend the practice. The practice also worked closely with the district nurse team to reduce unplanned admission to hospital, as these patients may benefit from increased GP intervention.

We saw that the practice also talked with patients about their caring responsibilities and was actively seeking to identify 'hidden carers'; that is patients who had not formally registered as carers but who had caring responsibilities.

The practice had a safeguarding policy for dealing with vulnerable adults and worked with the health visitors and learning disability nurses to assess and meet the needs of these patients. Patients with a learning disability were invited in for an annual health check as part of the enhanced services provision.

Following reviews about the availability of appointments and concerns within the practice about the high number of patients who did not attend their appointments, the practice amended and extended its opening hours. This was to allow easier access to those groups of people who find it difficult to attend for appointments during the daytime hours.

Facilities at the practice included appropriate waiting room area, with the consulting and treatment rooms all on ground level to ensure ease of access for all patients'.

The practice provided a weekly clinic giving weight management and lifestyle advice. The services of an in-house counsellor were also available, with referrals made after an appointment with a GP.

Access to the service

The practice offered patients different ways of accessing appointments. Patients were able to book appointments up to four weeks in advance and could do this through a web booking system available 24 hours a day, by telephone during surgery hours and in person at the surgery. Patients we spoke with told us they could normally see the GP of their choice within two days, but could always consult with a doctor or nurse on the same day if the matter was urgent.

When available consultation slots for a day had been exhausted the practice referred the call to a GP who made a clinical decision about the care of that patient. The practice also operated a telephone consultation system, for example after care following discharge from a hospital.

Extended access to appointments was available each Wednesday until 8pm. A number of appointment slots were reserved each day for patients that needed to see a GP urgently. When we inspected we spent time at the reception desk and found that the appointment system worked well for the patients and no pressures were evident in allocating appointments.

The practice supported patients to receive a timely and accurate diagnosis, either directly from the practice or by referral to a specialist. Arrangements had been made which helped to ensure that test results were followed up in a timely manner.

The appointment system allowed patients to see a doctor of their choice. Some patients told us they would rather wait a little longer to see the preferred GP of their choice. Patients told us that had no problems getting appointments and were usually seen at the given time.

The practice leaflet provided information about the range of services offered and how patients could obtain medical support outside of surgery hours. Health promotion literature, and information about services at the practice, was available in the reception area and in other areas accessed by the patient, for example outside the practice nurse's room. The practice website provided patients with information about opening hours, how to obtain repeat prescriptions, and what to do in an emergency.

Concerns & Complaints

The practice had a clear and easy to follow complaints leaflet for patients. The leaflet had information about how to make a complaint, with details of the NHS England complaints team and the Parliamentary Health Services

Are services responsive to people's needs?

(for example, to feedback?)

Ombudsman (PHSO), should onward referral be required. The PHSO investigate complaints from members of the public about unfair treatment or if they have received poor service from government departments and other public organisations and the NHS in England. The leaflet was available to patients in the reception area.

We saw examples of some of the complaints from patients and the response from the practice. Complaints were dealt with in accordance with the policy and procedures. The practice complaints policy included actions to ensure complaints were dealt with in a timely fashion. The outcomes of complaints were discussed at staff and practice meetings.

The practice had a comments box in the reception area, for patients to leave their views about the service. However, we found no comments in the box. The practice may wish to review how comments from the patients might be more effectively gathered.

At the time of the inspection the practice did not have a Patient Participation Group (PPG), although the practice manager told us the practice had plans to establish a group in the future. A PPG is a group of patients, registered with the practice, who have an interest in the services provided. The aim of the PPG is to represent patients' views and to work together to improve services and to promote health and improved quality of care.

Are services well-led?

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

Our findings

Leadership & Culture

The practice had a statement of purpose setting out their aims and objectives for delivering services. It contained a description of the range services offered, including partnership working with other professionals to deliver care and ensure a better experience and improved outcomes for patients.

The staff we spoke with demonstrated a clear understanding of the ethos of the practice and a strong commitment to their work was evident. They told us that they were supported by the management team at the practice to deliver services to patients to improve their health outcomes. All staff told us they felt involved and valued and contributed to the development of the practice.

We saw that the GPs met regularly to discuss priorities for the practice and identify action required to be taken in order to meet the needs of the practice and patients'. We saw notes from different meetings that took place within the practice. Staff confirmed that relevant information was made available to them from meetings which they did not attend.

Governance Arrangements

There was an open culture within the practice, for example, with staff able to seek support and advice from colleagues as required. The practice actively sought feedback from staff during appraisals and 1:1 meetings and encouraged their involvement in improving the services provided to patients.

The practice had policies and procedures in place to support quality and performance. The practice had identified lead GPs for specific areas of the practice, for example safeguarding, care of the elderly, changes in NICE guidance. Staff were aware of their responsibilities within their role and were able to explain who they would go to should they have concerns regarding anything in the practice.

Systems to monitor and improve quality & improvement

We saw that patients' complaints were reviewed and findings reported to practice staff. The results of a patients survey, carried out earlier in the year, had also been analysed and the outcomes published in the newsletter and displayed on the notice board.

We did not see any formal written management arrangements or reporting structures for the practice. The absence of formal practice management structures is an area where the practice may wish to review, as this would allow effective coordination of activities including with the local NHS trust.

For example, we saw that the practice had membership of the 'Building User Group' and that concerns about repairs to fixtures and fittings were reported to NHS Property Services, who had responsibility for the upkeep of the premises. However, when arrangements for repair work were delayed or did not meet requirements, we did not see any procedures for escalation or reporting the ongoing concerns within the practice.

Patient Experience & Involvement

Patients we spoke with told us that they felt involved with their care and that staff at the practice listened to their needs and concerns.

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

In the absence of a Patient Participation Group the practice used the patient survey and feedback received from the practice box in reception to understand the views of patients. A PPG is a group of patients, registered with the practice, who have an interest in the services provided. The aim of the PPG is to represent patients' views and to work together to improve services and to promote health and improved quality of care.

We did see evidence of where the practice had taken steps to review and undertake action to improve the patient experience, particularly in respect of the appointments system and expansion of opening hours.

Comments were fed into practice meetings and any outcomes were communicated to staff and actions undertaken or referred to practice team meetings to discuss future actions.

The practice manager told us that outline plans were in hand to consider the introduction of a Patient Participation Group (PPG) in the future.. At the time of our inspection no formal time line for implementation had been agreed.

The staff were aware of the whistleblowing policy, which contained relevant information to support staff with allocated staff members identified to whom concerned could be addressed.

Are services well-led?

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

The practice held a range of meetings for staff. The whole primary care team met twice a year. Staff meetings were held every four months, with notes of discussion taken. Staff had the opportunity to contribute and to raise issues at these meetings. The GP partners met twice monthly to discuss business issues that affected the practice. The nursing team met monthly for clinical discussion.

Management lead through learning & improvement

The practice had an ethos of supporting the staff learning and development process, with training and ongoing support and appraisal. We saw evidence of staff appraisal and staff we spoke with confirmed that they had an opportunity to express their own learning and development needs through the process. The nursing staff reported that their appraiser listened to them and felt this was a valuable process.

The practice had carried out a review of their performance, with comparison of data and information to establish benchmarking of their performance and to measure improvements.

Identification & Management of Risk

The practice worked to identify and manage potential risk by communication with staff through meetings and review processes such as clinical audit. The staff demonstrated an awareness of what they would do in the event of an adverse situation, with health and safety, safeguarding and whistleblowing examples identified.

A service continuity plan and risk assessment defined how the practice considered and managed risk to the delivery of services. Risks had been considered and clear processes were in place for delegated responsibility in the case of an emergency situation. Contact details for all relevant staff were included in the plan, which was reviewed and updated on an annual basis.

We saw that high level emergency planning had been considered to manage response to external threats.

Clear roles and responsibilities for staff members during an emergency incident had been identified. We saw that links had been identified with partner agencies and organisations, which could provide assistance in different ways, to make sure core provision of services could be maintained.

The risks already considered by the practice included loss of usage of the main premises, loss of computer or telephone system and general utilities, We also saw that consideration had been given to succession planning in the event of the unexpected incapacity or death of senior partners.

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

The practice had identified the needs of this group of people and developed services specifically to address these. Each patient over 75 had a named GP and many of these patients received a personal care plan, coordinated by the health care assistant.

The practice had a named GP with a special interest in the elderly. The practice provided home visits for patients too ill to attend the surgery, and worked closely with the district nursing team to offer joint working.

Home visits were provided for elderly housebound patients for influenza vaccination and advice on general health promotion was also given at that time.

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

The practice offered a number of chronic disease clinics, including asthma, chronic obstructive pulmonary disease and diabetes. The practice had a systematic approach for identifying and managing patients with long term conditions. The community nurses liaised with lead GPs and specialist nurses to provide holistic care for patients with long term conditions. Patients who were house bound were visited at home and support, advice and education on how to manage their condition offered as necessary.

If patients with long term conditions and those who had a physical disability arrived at the surgery without an appointment they were made comfortable and accommodated when an appointment became available.

There was a lead GP for dementia, which further enhanced the care of patients and provided continuity of care, quicker response to patients and improved communication with GPs regarding a patient's condition.

The practice offered clinics for patients with long term conditions regularly throughout the year. At the clinics their condition was reviewed and treatment and medication changed as required. Influenza vaccination was offered to all patients with long term conditions where appropriate. The practice also provided insulin initiation and work with the community diabetic team, with specialist nurses and a consultant.

If patients could not attend during clinic times, arrangements could be made to see patients during extended hours appointments. All patients with long term conditions were recalled and reviewed at least annually.

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

Midwives arranged weekly clinics at the practice and liaised about their patients with the GPs regularly. The practice was housed in the same building as the health visiting team and had a close working relationship with them.

The practice nursing team held weekly immunisation clinics. If parents were unable to attend the practice at clinic times arrangements were made to see patients at other more convenient hours. The practice had systems in place to make sure that all babies who missed immunisations appointments were discussed with the health visitor so that the parent could be encouraged to attend.

The GPs completed six-week checks and parents were called for these appointments. Eight week immunisation appointments were booked in to the nurse immunisation clinic, with information about immunisation displayed on the notice boards around the practice. Further literature was available from the practice nurses.

At new patient registrations for children under five years of age, the parents were given a specific questionnaire, that was shared with the health visitor so that any concerns might be appropriately followed up.

Young people asking for an appointment without an adult present were able to book appointments. GPs completed a Gillick competence test. Gillick competence is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. Confidentiality of young patients was respected and the practice had an alert system in place on the medical record to ensure any information that the young person wished to keep confidential was not shared with parents.

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

Patients of working age who were not able to make appointments on the day were able to make appointments in advance and were also offered telephone appointments.

Patients were able to book appointments online and request repeat medication. The practice offered extended opening hours one evening a week until 8pm. Appointments could be accessed via the practice website, at reception or by telephone. The late opening was advertised in the practice leaflet and on the website.

Repeat prescriptions were available online for those unable to access the surgery during normal working hours.

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 had safeguarding policies in place for dealing with vulnerable adults.

There were a number of services to which the practice could refer patients they were concerned about, including the health visitors and learning disability nurses. The practice offered annual health checks to patient with learning disabilities.

The practice booked interpreters for patients when required. Practice staff were able to translate for patients that speak French, Spanish, Urdu, Hindi and Punjabi.

The practice worked closely with carers, especially young carers, to ensure that they were well supported. The practice had a system to identify carers on their data system, this alerted staff that additional support may be required.

People with no fixed address were seen as temporary residents and given necessary treatment when they attended the practice.

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

The practice had a GP with lead responsibility for mental health issues. We saw that the practice directly employed two councillors to help patients with mental health issues such as depression or bereavement.

The practice referred into the community psychiatric service where appropriate and had links with a crisis team and the children and adolescent mental health service.

Patients who experienced a mental health issue were seen the same day and were often added onto the end of lists by the reception team. The practice recalled its patients annually for a care planning appointment.

The drug and alcohol service run clinics in the practice every week.