Ambleside Health Centre

Quality Report

Ambleside Group Practice
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Date of inspection visit: 7 May 2014
Date of publication: 10/07/2014

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.

Summary of findings

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Summary of findings

Overall summary

Ambleside Health Centre registered the Rydal Road surgery with CQC, as responsible for providing primary care, which included access to GPs, minor surgery, family planning, ante and post natal care. They also provided a satellite service in Grasmere. We visited both sites. Ambleside provided a weekday service for over 5000 patients in the Windemere area. The Grasmere Surgery was open most weeks for two hours on a Monday, Wednesday and for one hour on a Friday. Ambleside provided extended services so opened at 07:30 most days. It closed at 18:30 most evenings and at least once a week at 21:30. Cumbria Health on Call (CHOC) provided an out of hours service for patients who used the Ambleside Health Centre.

The patients we spoke with and who completed our comment cards were extremely complimentary about the care provided by the clinical staff; the overall friendliness and behaviour of all staff. Patients reported that they felt that all the staff treated them with dignity and respect.

We found that the provider had listened to patient comments and taken action to improve their service.

A range of appointments were available, including telephone and email consultations. People could book appointments either in person, over the phone or on-line.

The building was well-maintained and very clean. Effective systems were in place for the oversight of medication. Clinical decisions followed best practice.

Governance and risk management measures were in place but we found that the overall governance arrangements of these needed strengthening.

We found that the provider needed to take action to meet one of the regulations. They needed to improve the quality assurance systems. The services were safe and effective.

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 service was safe. Effective systems were in place to provide constant oversight of safety of the building and patients. Staff took action to learn from any incidents that occurred within the practice. Staff took action to safeguard patients and when appropriate made safeguarding referrals.

Are services effective?
The service was effective. Care and treatment was being delivered in line with current published best practice. Patients' needs were consistently met and referrals to secondary care were made in a timely manner. Healthcare professionals ensured that patient's consent to treatment was obtained appropriately at all times. The team used clinical audit tools, clinical supervision and staff meetings to assess the performance of the staff and how well they delivered the service.

Are services caring?
The service was caring. All the patients who responded to our comment cards and those we spoke with during our inspection were extremely complimentary about the service. They all found the staff to be kind and compassionate and felt they were treated with respect. The provider had a well-established patient participation group.

Are services responsive to people's needs?
The service was accessible and responsive to patients' needs. The provider had a clear complaints policy and responded appropriately to complaints about the service. Regular patient surveys were conducted, which covered their satisfaction with the service and the provider took action to make suggested improvements.

Are services well-led?
The service was well led but some improvements were needed. Governance and risk management structures were in place but needed strengthening. The leadership team had a clear vision and purpose.

Summary of findings

What people who use the service say

We received four completed patient comment cards and spoke with 19 people on the day of our inspection. We spoke with people from different age groups, including parents and children, patients with different physical and mental health care needs.

Patients we spoke with found that the practice was very person-centred and they were extremely satisfied with availability of appointments. The patients we spoke with were aware that all the GPs were part-time so in more urgent times they may not see their preferred GP but for the management of their longer-term needs could schedule appointments with this GP.

Patients were extremely complimentary about the care provided by the clinical staff. Their overall friendliness and positive attitude of all staff. They all felt the doctors and nurses were extremely competent and knowledgeable about their treatment needs. They felt that the service was exceptionally good and their views were valued by the staff.

We saw during 2013 and the early part of 2014 the practice had completed a patient survey and then published the action plan, which detailed how they had improved the service in response to the comments. The NHS choices website showed that people rated the service as excellent.

Patients reported that they felt that all the staff treated them with dignity and respect.

Areas for improvement

Action the service COULD take to improve

The provider could improve how they gathered and used information to monitor and improve the practice if the provider strengthened the governance processes they used.

Good practice

Our inspection team highlighted the following areas of good practice:

The practice was involved in the 'Productive General Practice' programme, which is delivered by the NHS Institute for Innovation and Improvement. This progamme expected staff and patients to critically review the service and identify how it can be improved.

To increase participation from younger patients in the patient participation group (PPG) the provider had worked with the University student union to identify a couple of people who would be interested in joining the group.

The practice manager and administrative team had developed a quarterly newsletters, which they sent to all the patients. The topics for the articles were suggested by the PPG.

Ambleside Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Ambleside Health Centre

Ambleside Health Centre registered as a company who provide primary medical services and one of the GP's acted as the registered manager, which meant they were legally responsible for making sure the practice met CQC requirements.

The Ambleside provided a weekday service for over 5000 patients in the Ambleside area. The Grasmere Surgery was open most weeks for two hours on a Monday and Wednesday then for one hour on a Friday. Out of hours provision was provided by Cumbria Health On Call (CHOC).

The Ambleside surgery provided extended services so opens at 07:30 most days. It closes at 18:30 most evenings and at least once a week at 21:30. The service was responsible for providing primary care, which included access to GPs, minor surgery, family planning as well as ante and post natal care.

We visited both surgeries as a part of this inspection.

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

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?

Before our inspection we carried out an analysis of the data from our Intelligent Monitoring system. This did not highlight any significant areas of risk across the five key question areas. As part of the inspection process, we contacted a number of key stakeholders and reviewed the information they gave to us.

We carried out an announced inspection on 7 May 2014 and the inspection team spent eight and a half hours inspecting the two surgeries. We reviewed all areas in each surgery including the administrative areas. We sought views from patients both face-to-face and via comment cards. We spoke with the practice manager, registered manager, two GPs, two nurses, three administrative staff, three medicine management staff, the clinical lead for infection control and the receptionists on duty.

Detailed findings

We observed how staff handled patient information received from the Out of hours team and patient rining the service. We reviewed how GPs made clinical decisions. We also talked with carers and family members.

Are services safe?

Summary of findings

The service was safe. Effective systems were in place to provide constant oversight of safety of the building and patients. Staff took action to learn from any incidents that occurred within the practice. Staff took action to safeguard patients and when appropriate made safeguarding referrals.

Our findings

Safe Patient Care

The provider had systems in place to monitor the service and ensure it maintained patient safety. Reports from NHS England indicated that the practice had a good track record for maintaining patient safety. Information from the quality and outcomes framework, which is a national performance measurement tool showed that in 2012-2013 the provider was appropriately identifying and reporting incidents. From our discussions we found that GPs were aware of the latest best practice guidelines and incorporated this into their day-to-day practices. We found that concerns regarding the safeguarding of patients were passed on to the relevant authorities as quickly as possible.

Learning from Incidents

We saw evidence to confirm that, as individuals, staff were actively reflecting on their practice and recognised the benefits of identifying any patient safety incidents and near misses. We found that GPs reviewed their prescribing practices as and when medicines alerts were received. Centrally the medicine management staff monitored the practice to ensure reviews of medication were completed with patients in a timely manner.

The practice was involved in the 'Productive General Practice' programme, which was delivered by the NHS Institute for Innovation and Improvement. We heard that this programme encouraged both staff and the PPG members to openly review the service and determine where they could improve. We heard how following the use of this tool they had recognised the need to encourage people from a wider age range to join the PPG and had worked with the local university student group to identify patient representatives.

GPs and staff we spoke with discussed the recent introduction of weekly clinical meetings. The minutes we reviewed show that significant events, were discussed when they occurred but it was not a standing item on the agenda. This meant they were not seeing the process as an opportunity for learning and identifying themes or where lessons from one incident could be used to improve their practices in other areas.

Are services safe?

We found that changes to national guidelines, practitioners guidance and any medicines alerts were discussed in these meetings. This meant the clinicians were confident that the treatment approaches adopted followed best practice.

Safeguarding

Staff were readily able to discuss what constituted a child and adult safeguarding concern. They told us about incidents when they had either raised safeguarding or child protection alerts and showed us associated alert forms to confirm this had occurred. We reviewed the provider's safeguarding policies and procedures and found that these were comprehensive and fully covered actions the staff needed to take. We found that staff had received appropriate training around dealing with safeguarding adults and child protection issues and reporting this to the relevant authorities.

Monitoring Safety & Responding to Risk

The GPs worked part-time and therefore booking a particular appointment with a specific GP may take a few weeks but the provider has ensured all the GPs can readily understand the needs of each patient. The practice manager had outlined this issue in the newsletters they send to patients. The receptionist staff told us that they will complete a checklist triage with a patient to determine if the person would be better served by seeing the nurse practitioners.

The patients we spoke with told us they were happy to see any GP as they felt all were competent and knowledgeable. The rotas we reviewed showed that sufficient GPs and other clinicians were on duty to cover all the appointments including the extended hours service.

The provider and practice manager regularly reviewed the demands on the practice such as number of patient appointments being used; number of patients who did not attend and whether patients had expressed concerns that they could not see a particular GP or nurse. We could not find information to confirm that this was then used to make changes to the service.

We found that the provider ensured that the clinical staff received regular cardiopulmonary resuscitation (CPR) training and training associated with the treatment of anaplaxyic shock. Staff who would use the defribilator were regularly tested to ensure they remained competent in its use.

Management of medicines

We found that there were up to date medicines management policies in place. The staff we spoke with were familiar with them. Medicines were kept securely and could only be accessed by the clinical staff and Clinical Commissioning Group (CCG) pharmacist. There were appropriately stocked medicine stores and equipment bags ready for doctors to take on home visits. We saw evidence that the bags were regularly checked to ensure that the contents were intact and in date.

Clear records were kept whenever any medicines were used. Arrangements for the storage and recording of controlled drugs or medicines that require extra checks were followed. All drugs we checked were in date, and staff ensured stock was used in a systematic order. Any changes in guidance about medicines were communicated to clinical staff in person and electronically via the webform for prescriptions. This ensured staff were aware of any changes and patients received the best treatment for their condition.

The medicine management 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 the latest prescribing guidance was being used. The medicine management staff were becoming familiar with a new IT system so were in the process of learning the skills needed to analyse GP prescribing patterns. The IT system flagged up relevant medicines alerts when the GP went to prescribe medicines. We found that following the receipt of an alert the GPs had not always stopped using this particular medicine but could clearly outline why they continued to prescribe them. We found that the medicine management team were not checking whether the advice from alerts was followed or collating information about GPs rationale to continue its use.

There were standard operating procedures (SOP) in place for using certain drugs and equipment. The nurse prescribers used patient group directives (PGD) when deciding what medicines to prescribe. These documents ensured all clinical staff followed the same procedures and nurses who prescribed medicines did so safely. The SOPs and PGDs were reviewed, were in date and clearly marked, which ensured staff knew it was the current version. This meant patients could be confident that they received the most appropriate treatment for their condition.

Are services safe?

Cleanliness & Infection Control

We spoke with the nurse who had the lead role for infection control and found her to be extremely knowledgeable. We also spoke with the domestic staff and found they had a very comprehensive system in place and could clearly outline how to reduce and control the potential for infection. We found all of the most recent COSHH guidance was available and the domestic cupboard was spotless as was the rest of the building. This guaranteed the practice was cleaned in line with infection control guidelines.

We also inspected all the treatment and clinical rooms. The provider was replacing fabric curtains with disposable ones, as this provided more effective infection control measures. All areas were exceptionally clean and a system was in place for ensuring all parts of the practice were thoroughly cleaned on a regular basis. We saw that a recent local Trust audit found they met 98% of their infection control requirements.

There was an up-to-date Infection Control Policy in place, and a routine audit had been undertaken within the last few months. A needlestick policy was in place, which outlined what to do and who to contact. Spillage kits were available in the locked sluice room. Infection control training was part of induction for all staff (including hand washing). Clinical staff completed this training at induction and then refresher training on an annual basis. Non-clinical staff completed the training during their induction and had access to the information produced by the infection control lead.

Staffing & Recruitment

The provider recruitment policy was in place and up-to-date. Appropriate pre-employment checks were completed for a successful applicant before they could start work in the service. We looked at a sample of recruitment files for doctors, administrative staff and nurses. They showed that the recruitment procedure had been followed. We made the practice manager aware of the need to obtain more information about the locum staff as well as health statements for all employees so they knew the person was physically and mentally able to perform their role.

We noted that the practice did not take their own steps to check suitability of locum doctors other than reviewing the NHS performers lists. We also highlighted that as a routine part of the quality assurance and clinical governance the provider needed to check the General Medical Council (GMC) and Nursing Midwifery Council (NMC) registration lists each year to make sure the doctors and nurses were still deemed fit to practice.

Dealing with Emergencies

There were robust business continuity plans in place to deal with emergencies that might interrupt the smooth running of the service such as power cuts and adverse weather conditions. The paper records of these plans were kept in service operation procedures folder which were held by the practice manager and copies were also stored on the computer, which meant all staff had access but if the power failed the plans could still be accessed.

Equipment

Emergency drugs were stored in a separate locked cabinet and vaccines were stored in a vaccine fridge. Temperature logs for the vaccine fridge were accurate and complete. Defibrillator and oxygen was available for use in a medical emergency and checked each day to ensure it was in working condition. A log of maintenance of clinical/ emergency equipment was in place and noted when any items identified as faulty were repaired or replaced. We saw that all of the equipment had been tested and the provider had contracts in place for personal appliance tests (PAT) to be completed on an annual basis and for the routine servicing and calibration, where needed, of equipment.

Are services effective?

(for example, treatment is effective)

Summary of findings

The service was effective. Care and treatment was being delivered in line with current published best practice. Patients' needs were consistently met and referrals to secondary care were made in a timely manner. Healthcare professionals ensured that patient's consent to treatment was obtained appropriately at all times. The team used clinical audit tools, clinical supervision and staff meetings to assess the performance of the staff and how well they delivered the service.

Our findings

Promoting Best Practice

The staff we spoke with all knew how to work in a patient centred manner and wanted to ensure the wellbeing of the patient was always at the forefront of their work. The clinicians were familiar with and using current best practice guidance. The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches and we found that this was aimed at ensuring the best outcome for each patient. We found that staff completed thorough assessments of patients needs and these were reviewed when appropriate.

The practice provided a service for all age groups and GP's apart from having the overall competence to assess each patient had particular interest areas. For example one of the GP's had developed additional competencies around working with people with respiratory diseases. We found that patients, when appropriate, saw the clinicians with particular specialities.

We found that the staff providing gynaecology and family planning services received regular updates. They, in line with the expectations of the Royal College of General Practitioners guidelines, were assessed in their delivery of these services as well as other general practice expectations. Health care assistants had completed accredited training around checking patient's physical health such as blood pressure and to take blood samples. We found that the nurses and GPs ensured they continually updated their skills and competencies. This meant clinical staff were up to date and competent to treat patients.

Management, monitoring and improving outcomes for people

The team was making use of clinical audits tools, clinical supervision and staff meetings to assess the performance of clinical staff. We found that the practice manager and providers had a variety of mechanisms in place to monitor the performance of the practice. The staff we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved. We found that records showing how they had evaluated the service and success of any changes were not routinely compiled.

The GPs received both internal appraisal and an external professional appraisal. They, as well as the nursing staff

Are services effective?

(for example, treatment is effective)

also routinely accessed clinical supervision. The appraisals involved a 360 degree process, which asks staff to complete a personal reflection on their skills and behaviour. Internal colleagues were also asked to provide open and honest feedback about the appraisee's interpersonal skills and clinical competence.

Staffing

From our review of information about staff training, the induction programme covered a wide range of topics such as dignity and privacy, equality and diversity as well as mandatory training. The practice provided training opportunities for medical students and trainee GPs. At the time of our visit a medical student had just commenced their placement and we saw that staff spent the day making sure the person was fully familiar with the expectations of the practice including how to use the computer resources.

The provider had clear expectations around refresher training and this was completed in line with national expectations as well as those of the local CCG. The provider ensured that the clinicians had access to a variety of training resources. The practice manager had recently arranged for the practice to purchase an e-learning training resource, which meant all staff could readily update both mandatory and non-mandatory training. We saw that the mandatory training for all staff included fire awareness, information governance, emergency trolley, sharps boxes, handling samples, and equality and diversity. Staff also had access to additional training related to their role. For example reception staff told us they had received conflict resolution and customer care training.

The staff files we reviewed showed that staff of all disciplines received annual appraisal and the clinicians had access to regular clinical supervision sessions. The administrative staff told us they were well-supported and regularly had conversations about their performance with their line manager. However, we found these sessions were not formally recorded.

Working with other services

We found that the practice staff also worked closely with the local community nursing team and provided facilities for those staff. We heard that good links had also been established with local hospital consultants and this aided the flow of information to them in respect of assisting patients to come to terms with their diagnosis and treatment. They also worked with the CHOC to make sure doctors working the out of hours service had full information about patients needs including care plans for people receiving palliative care.

Health Promotion & Prevention

We found that the staff proactively gathered information on the types of needs patient and understood the number and prevalence of different health conditions being managed by the practice. The practice manager and medicines management staff could clearly outline the numbers of people with long-term conditions; what these were; and how the clinicians took action to regularly review their needs. We saw that this knowledge of patients' needs led to targeted services being in place such as immunisation schedules being followed and the running of diabetic and respiratory clinics.

We heard and found that the staff at the practice were currently completing work to identify people on their patient list who also provided a carer's role. We saw that health promotion information was on display in the areas patients used and leaflets explaining different conditions were also freely available.This meant that preventative work could be completed with all these groups to assist them to assist tem to improve their health and wellbeing.

Are services caring?

Summary of findings

The service was caring. All the patients who responded to our comment cards and those we spoke with during our inspection were extremely complimentary about the service. They all found the staff to be kind and compassionate and felt they were treated with respect. The provider had a well-established patient participation group. A member of the group told us that they had an active voice in shaping the service felt the provider was actively patient centred approaches to care were always at the forefront for the practice.

Our findings

Respect, Dignity, Compassion & Empathy

The service had a patient dignity policy in place. Staff were familiar with the steps they needed to take to protect people's dignity. Consultations took place in purposely designed rooms with an appropriate couch for examinations and screens to maintain privacy and dignity. We noted that the screens were moveable and not every room had them in place. Also the consultation room doors did not have internal locks albeit a light on the outside wall came on when a patient was being seen. We raised this with the practice manager and registered manager who told us that they would ensure all consultation rooms had appropriate screens. They stated that the doors throughout the building were in the process of being changed and they would ensure these new doors were lockable.

There were signs explaining that patients could ask for a chaperone during examinations if they wanted one. Patients we spoke with told us about the process for using chaperones and felt confident that this was effective as it was always used with them when needed. Patients also told us that they felt the staff and doctors effectively maintained their privacy and dignity.

We observed that the reception staff treated people with respect and ensured conversations were conducted in a confidential manner. The provider had designated room for staff taking calls for appointments, however at times these were taken at the front desk. We observed that when phoning in patients would be asked for brief reasons as to why they needed an appointment. This was to allow staff to complete a checklist triage, which gave them sufficient information to be able to determine if the person may be able to see a nurse practitioner but also allowed confidentiality to be maintained. However this only occurred if the call was picked up by staff in the room but when staff at the front desk took the call. This meant that patient confidentiality could be maintained.

All the patients we spoke with told us they were satisfied with the approaches adopted by staff and felt clinicians were extremely empathetic and compassionate. They said "The staff are very helpful and friendly", "The GPs really take the time to look after you and know what is what" and "I

Are services caring?

always feel they are taking the time to listen to me". We heard how the clinicians were attentative to patients needs and referred people to counselling and bereavement counselling services when this was appropriate.

Involvement in decisions and consent

Staff said they had access to interpreter or translation services for patients who needed it, and there was guidance about using interpreter services and the contact details. The reception staff told us that they were familiar with which patients needed this type of support and when these patients booked an appointment they made sure an interpreter was available.

We saw that healthcare professionals adhered to the requirements of the Mental Capacity Act 2005 and the Children Act 1989 and 2004. Capacity assessments and Gillick competency of children and young people, which check whether children and young people have the maturity to make decisions about their treatment, were an integral part of clinical staff practices. We found that clinical staff understood how to make 'best interest' decisions for people who lacked capacity and sought approval for treatments such as vaccinations from children's legal guardian.

The patients we spoke with confirmed that their consent was always sought and obtained before any examinations were conducted. We found that where patients had capacity to make their own decisions, appropriate consent was obtained for example for the minor surgery completed in the practice.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The service was accessible and responsive to patients' needs. The provider had a clear complaints policy and responded appropriately to complaints about the service. Regular patient surveys were conducted, which covered their satisfaction with the service and the provider took action to make suggested improvements.

Our findings

Responding to and meeting people's needs

We found that the practice was accessible to patients with mobility difficulties. The consulting rooms were large and accessible for patients with mobility difficulties. There were also toilets for disabled patients. Hearing loops were installed at the reception desk and patients could identify they were being called for the appointment because there was an audible bell and the electronic display boards flashed up their name. People could alert staff to their arrival for an appointment via an IPad or by notifying the staff at the desk. The clinical staff also had access to telephonic interpreting services, which meant a patient who needed this support could still be seen by the practice.

We saw that the medicine management staff carried out a comprehensive analysis of its activity data across all the practice. We found that these staff had all of this information to hand so for example they could quickly tell us how many patients had a respiratory condition or a learning disability and needed support to make treatment decisions. The practice manager used this information to ensure that the correct number of staff with the most appropriate skill mix were deployed in the most effective way to meet patient demand. The activity analysis was shared with the local CCG on a monthly basis and formed a part of the quality framework. It also assisted the clinicians to check that all relevant people had been called in for a review of their health conditions and for completion of medication reviews.

We found that well-women and well-men services were provided to patients when required and this was individually tailored to the needs of the patient. The practice held regular clinics for a variety of complex and long-term conditions such as respiratory disease and diabetes. This meant that the patients could be confident that, if they had a long-term health condition the GPs and clinicians would make sure any adverse effects of the condition were reduced.

Access to the service

We saw in the 2013 practice patient survey and comments on the NHS choices website that patients were extremely complimentary. Patients could book appointments either

Are services responsive to people's needs?

(for example, to feedback?)

face-to-face; over the telephone or online. Also one of the GPs provided a pre-book email service for their patients so that they could readily discuss any of their current health concerns.

Two of the senior administrative staff worked with patients to ensure appointments secondary care services were obtained on the day the GP identified the need for them to see consultants and hospital teams. Patients discussed this practice with us and told us they found it an exemplary piece of work, which really reduced their anxiety about accessing secondary care in a timely manner.

The provider operated a patient participation group (PPG) and we saw that members of the group regularly attended meetings. We met one of the members of this group and they discussed how the provider valued their contribution to the operation of the service and listened to their insights into patient experience. The providers work with the PPG had led to the development of a newsletter. We found that the PPG members suggested items to go into this document. The practice manager discussed with us the work the practice is currently doing to widen the age group. The practice provides a service to the local University students. To increase participation from younger patients the practice manager had worked with the University student union to identify a couple of people who would be interested in being involved in the PPG.

Concerns & Complaints

We saw that there was a robust complaints procedure in place and on display throughout the practice. The people we spoke with were all aware of the process to follow should they wish to make a complaint. During the visit one of the patients contacted the practice manager to share their experience of CQC staff speaking with them. We were party to this discussion and found the practice manager was very adept at putting the person at ease and listening to their view.

From a review of the complaints records we saw that the practice manager had investigated all of the complaints. We saw that these investigations were extremely thorough and impartial. This meant patients could expect a full investigation of their complaint. We found that process was not in place to analyse each complaint to see if themes were emerging or to look at trends in complaint rates or topics. We saw that the majority of complaints had related to issues outside of the practice's remit and the lack of analysis meant the practice had missed the opportunity to discuss, for instance, in the newsletter how to make complaints about hospitals and the role of the GP.

Are services well-led?

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

Summary of findings

The service was well led but some improvements were needed. Governance and risk management structures were in place but needed strengthening. The leadership team had a clear vision and purpose.

Our findings

Leadership & Culture

We found that the management team had a clear vision and purpose. The GPs we spoke with demonstrated a deep understanding of their area of responsibility and each one clearly took an active role in ensuring that a high level of service was provided on a daily basis. All the staff we spoke with told us they felt the provider valued them and their views about how to develop the service. We heard that clinicians were allowed to be autonomous and could trial new ways of working. For example one GP had set up an email consultation service and was looking at how they could provide more flexibility around availability of GPs at different times during the day.

We saw that induction and initial training programmes for clinical staff covered listening effectively, communicating effectively, and shared decision making. This helped to ensure a consistent approach to patient care across the service. However we found that there was not a process in place to monitor whether staff had received refresher training and the ongoing fitness of clinicians to practice. Thus routine checks that clinicians registrations remained current were not in place. The provider had not put in a process to monitor whetherr scheduled supervision and appraisal had occurred. This meant the provider could not be assured that the staff were meeting their expectations and ensuring they remained fit to practice and competent to work at the practice.

Governance Arrangements

There was a well-established management structure in place and there had been a clear allocation of responsibilities. The practice manager, GPs and staff we spoke with were very clear on their roles and responsibilities. We found that the nursing team had allocated lead roles such as for infection control but the GPs did not follow this practice. This meant that each GP had to ensure that they personally made sure their practice was up to date rather than one GP, for instance, collating and sharing information on recent NICE or patient safety updates across the team. The registered manager told us they had recognised this could lead to inconsistent implementation of guidance and in response the GPs had recently started to hold monthly clinical meetings and were they discussed recent clinical updates.

Are services well-led?

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

Governance structures were in place for managing risks. However, none of the GP partners took a leadership role for overseeing that the systems in place were consistently being used, were effective, or that they captured information about incidents and the lessons learnt. For example there was no process in place for the medicine manager to determine when medicine alerts were received they were seen by all GPs and that appropriate action was taken. There was no evidence of forward planning within the practice around the need to review and update policies and check the accuracy of current risk management tools.

The practice manager anticipated that the use of the Productive General Practice programme would ensure the provider established stronger governance arrangements. The registered manager and practice manager agreed that the current arrangements did not help them demonstrate that they benchmarked current performance and determine if any changes they made to the design of the service improved patient experience and access to appropriate treatments.

Systems to monitor and improve quality & improvement

We saw evidence that showed the provider regularly engaged with the local CCG on a regular basis to discuss current performance issues and how to adapt the service to meet the demands of local people. For instance, the provider was working with the CCG to ensure information about the work they completed with patients who had long-term conditions was captured and the action they took to support these people have the best quality of life.

The practice was involved in the 'Productive General Practice' programme, which encouraged both staff and the patient participation group members to openly review the service and determine where they could improve. All the staff we spoke with discussed how this programme was assisting them to constantly review and improve their practices and the overall service being provided.

Patient Experience & Involvement

The providers actively encouraged patients to be involved in shaping the service and we found that the senior management team, and staff constantly used the information from patients to look at how to improve the service being delivered.

We received four completed patient comment cards and spoke with 19 people on the day of our visit. We spoke with people from different age groups, including parents and children, patients with different physical health care needs and with various levels of contact with the practice. All these patients were very complimentary about the clinical staff and the overall friendliness and behaviour of all staff. They all felt the doctors and nurses were extremely competent and knowledgeable about their treatment needs. They felt that the service was exceptionally good and that their views were valued by the staff.

The practice had a well-established patient participation group and from a review of the minutes of their meetings we found this group were very effective and engaged. Their views were listened to and used to improve the service being offered at the practice.

Staff engagement & Involvement

Staff we spoke with and the documents reviewed showed that they regularly attended staff meetings and these provided them with the opportunity to discuss the service being delivered. We saw that the provider used the meetings to share information about any changes or action they were taking to improve the service and actively encouraged staff to discus these points.

Learning & Improvement

We saw that the doctors and clinical staff held regular clinical meetings, which discussed changes to practice. The provider also scheduled meetings for the whole staff team, clinical, non-clinical and operations management. Staff were encouraged to attend staff meetings and we saw from the minutes from these meetings that they discussed improvements that could be made to the service.

However the lack of consistent and effective governance arrangements meant no processes were in place to determine if suggestions were acted upon and how effective they were. For instance one GP had introduced an on-line consultation service which allowed patients to email him directly about their concerns. This practice was innovative but no action had been taken to determine if this system worked; where it could be made more effective; to evaluate up take; or to share it across the practice. Thus it was a piece of practice that could not be said made improvements to the service.

Are services well-led?

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

Identification & Management of Risk

We heard how the provider looked at future needs of the practice and planned for events such as GPs leaving or retiring by ensuring they had access to GPs and started recruitment processes early.

Staff told us they felt confident about raising any issues and felt that if incidents did occur these would be investigated and dealt with in a proportionate manner. Clinicians had systems for monitoring their areas, such as whether they were using the latest guidance and protocols. However these actions were not effectively monitored by the practice manager and senior staff.