Norwood Medical Centre

Quality Report

99 Abbey Road
Barrow in Furness
Tel: 01229 402525
Website: www.norwoodmedicalcentre.co.uk

Date of inspection visit: 7 May 2014
Date of publication: 30/07/2014

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

Contents

Summary of this inspection

Page

Overall summary 3

The five questions we ask and what we found 4

What people who use the service say 6

Areas for improvement 6

Good practice 6

Detailed findings from this inspection

Our inspection team 7

Background to Norwood Medical Centre 7

Why we carried out this inspection 7

How we carried out this inspection 7

Findings by main service 9

Summary of findings

Overall summary

Norwood Medical Centre provides primary medical care services for patients living in Barrow in Furness, Cumbria. There are 11,200 patients registered at the practice. The practice is open Monday to Friday 8am until 6pm. Provision for early appointments before 8am and after 6pm for patients who work, are available on request.

The practice provides care and treatments in an environment which is clean and well organised. The building is well maintained and fit for purpose.

All patients we spoke with were very satisfied with the standard of care and treatment provided. Patients spoke positively about the attitude of staff; however we received consistent feedback about the difficulty in booking same day appointments. We were told appointments were always available in urgent and emergency cases on the same day.

Patients said staff were caring and always maintained privacy and dignity. Doctors and nurses explained treatments and choices available. Patients told us they would recommend the practice to family and friends and people new to the area.

Robust monitoring arrangements are in place for the management of medicines. Drug safety alerts are managed appropriately. There is a nominated GP who monitored prescribing, along with the nurse practitioner. There is also an administration lead for prescribing monitoring.

The practice is registered with the Care Quality Commission to deliver the the following regulated activities: Treatment of disease, disorder and injury, surgical procedures, family planning, diagnostic and screening procedures and maternity and midwifery services.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

We found the service was safe. The practice had clear systems in place to support staff to recognise, report and mange any safeguarding issue. There were robust arrangements to report any incident or concern. We found staff were safely and effectively recruited and employed. Comprehensive plans to deal with any emergencies that may occur, which could disrupt the safe running of the practice, were in place.

Are services effective?

We found the service was effective. Care and treatment was provided in line with evidence based practice and national agreed guidelines. Patient's needs were consistently met. Referrals to secondary care were timely. The practice signposted patients to additional support groups. These included help with chronic disease management, domestic violence and anger management. The performance of staff was appropriately assessed via appraisal and the practice undertook regular monitoring by clinical audits

Are services caring?

We found the service was caring. All patients we spoke with during the inspection were very complimentary about the practice.We observed patients were spoken to in a professional but friendly manner. Staff showed patience when dealing with patients on the telephone, booking in or attending the reception desk. Patients told us how they felt the GP's discussed issues with them in a manner which ensured they fully understood what was happening. Patients felt their privacy and confidentiality was maintained.

Are services responsive to people's needs?

We found the service was responsive to patient's needs. The practice had created a post of Patient Liaison Advisor (PLA). The advisor was seen to work as an independent advocate for patients and championed patient's and carer's needs. Patients were given the opportunity to give feedback about the service they received. The practice had appropriate systems in place to acknowledge, investigate, report and respond to any concern or complaint.

Are services well-led?

We found the service was well led. The practice had an established management structure, with clear lines of responsibility and accountability. The practice functioned well as a team. Leadership and management styles promoted openness and transparency.

Summary of findings

There was an established structure for effectively managing the risks and governance of the practice. Staff were well engaged with the quality improvement strategy and with the practice ethos of improving outcomes for patients.	

Summary of findings

What people who use the service say

We spoke with a total of eight patients who were visiting the practice during the inspection. Overall comments made about the care and treatment patients received were very positive.

Patients said at consultations, treatment options were explained and choices made clear. They felt consultations were never rushed and that they were given time to ask questions.

Patients said reception staff were helpful and always tried to do as much as possible.

Patients commented that recalls for health checks were good and that they felt their medical conditions were being managed well.

The only negative comments were in relation to the availability of appointments. Comment was also made about the long wait on the telephone when ringing the practice to try to access a same day appointment.

This reflected the overall comments made by patients who participated in the 2013 GP National Patient Survey.

Areas for improvement

Action the service COULD take to improve

The practice had no written documentation to demonstrate when Gillick competency, for consent, had been assessed.

Staff files were not maintained in a chronological order to ensure that personal information was more effectively managed

Good practice

Our inspection team highlighted the following areas of good practice:

The practice was committed to working with external agencies to help improve outcomes. For example when patients were diagnosed with depression, other options were considered before automatically prescribing anti-depressant medication.

The practice had recently achieved the Royal College of GP's (RCGP) practice accreditation. This was awarded in recognition of the range and quality of operational systems, processes, procedures the practice had in place

Norwood Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Inspector. The team included a GP, a Specialist Advisor and an Expert by Experience.

Experts by Experience are part of the inspection team. They are granted the same authority to enter registered persons' premises as the CQC inspectors.

Background to Norwood Medical Centre

Norwood Medical Centre provides primary medical care and treatment for 11,200 patients who live in Barrow in Furness. The practice is based close to the town centre, with easy access by public transport and main roads. There are two treatment rooms and eleven consultation rooms.

The practice serves a population which has 21.29% of patients who were over 65 years of age.

Out of hours services are provided by Cumbria Health on Call (CHOC

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?

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

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

Before visiting, we reviewed a range of information we had received from the out-of-hours service and asked other organisations to share their information about the service.

We carried out an announced visit on 7th May 2014 from 9am until 6pm

During our visit we spoke with a range of staff, including GP's, Nurse Practitioner, Practice Nurses, Health Care Assistants, Reception and Administration staff.

We spoke with 12 patients who were using the service on the day of the visit and we contacted two members of the Patient Participation Group by telephone.

Detailed findings

Comment cards were available for patients on the day, however none were completed.

Are services safe?

Summary of findings

We found the service was safe. The practice had clear systems in place to support staff to recognise, report and mange any safeguarding issue. There were robust arrangements to report any incident or concern. We found staff were safely and effectively recruited and employed. Comprehensive plans to deal with any emergencies that may occur, which could disrupt the safe running of the practice, were in place.

Our findings

Safe patient care

We found effective arrangements were in place to report any incident or concern. There were clear lines of accountability and staff were familiar with and confident in, ensuring that policies and procedures were followed effectively.

It was clear the practice used various methods to ensure continual review of safe patient care. These included acting on complaints, undertaking effective monitoring of operational systems and outcomes and ensuring action on any feedback from patients, carers and staff.

Robust systems were in place for the protection of adults and children and vulnerable patient groups. Dedicated clinical leads and administration staff support had been identified to ensure the practice was aware of vulnerable patient groups and that available resources were utilised effectively. These included patients across the population groups with mental health issues, dementia, learning difficulties, eating disorders and drug and alcohol misuse.

The practice had an effective system in place to follow up any patient who had attended the accident and emergency department or out of hour's medical centres. Electronic notifications of patients' attendance were received from other providers in a timely manner. The patient was then contacted to establish if a further appointment or advice was needed. This ensured the practice was aware of the current status of the patient. Patient records were then updated.

Care and treatment was provided in an environment which was well maintained. We saw appropriate contracts in place for the maintenance of the building. Fire exits were well sign posted and were free from any hazards to prevent escape in any emergency. Fire alarms and fire extinguishers were placed throughout the building checks were in date.

Learning from incidents

The practice had a comprehensive significant/critical event policy. There was clear guidance for all grades of staff on the definition of such events, the objective and purpose of investigating and recording events and the importance of actions taken and learning achieved.

We found a "blame free culture" policy was in place. Staff confirmed they would report and have felt supported,

Are services safe?

when escalating any incidents. Staff unanimously stated there was a "real effort" across the practice to learn from any incident in order to improve care and treatment for patients. This meant the practice was proactive in using learning from incidents to minimise future risks.

Regular monitoring of risks and analysis of incidents took place and any specific issues were able to be raised with individuals. Feedback and learning was disseminated at weekly practice meetings and monthly clinical staff meetings. Quality improvement meetings were held every three months which all grades of staff attended. Incidents were discussed, along with the action and outcomes to date. We noted action taken following a recent incident. This resulted in a review of internal processes, with a new process flowchart implemented and additional staff training

Safeguarding

The practice had clear systems in place to support staff to recognise, report and mange any safeguarding concerns. There were robust policies and procedures in place to protect both adult and children. Staff we spoke with were able to confidently demonstrate both their understanding of safeguarding and describe the procedure they would follow when escalating any concerns. Lead staff had been identified. These were a lead GP, a practice nurse and administration staff. This meant staff had clear lines of support and management to follow. All staff had received training in vulnerable adult and child safeguarding, with leads having undertaken training to level 3, as recommended by the professional intercollegiate safeguarding guidance.

We noted the lead GP attended regular multi-disciplinary safeguarding meetings with health visitors, midwives, and other health and social care professionals. We were told that reports were submitted to serious case reviews when requested. We saw regular liaison and effective links with appropriate external professionals and organisations. Systems were in place to readily identify children on child protection plans. The practice had a contact protocol with a local children's home, were children who were in local authority care were placed. Regular liaison meetings were undertaken to ensure children had immediate access to the practice. Also we saw when these children reached 18 years of age; they were automatically identified as a vulnerable adult to ensure a supported transition into adult services.

Regular self-assessment of safeguarding processes had taken place. The local clinical commissioning group (CCG) GP safeguarding audit tool was completed in December 2013. The practice had achieved the required criteria, with just one area to be completely actioned. This was in relation to more regular liaison with health visitors, which was being addressed. Safeguarding was a standard agenda item on weekly and monthly meetings held within the practice by GP's, managers and nurses and at the quality improvement group

Monitoring safety and responding to risk

We saw the practice had systems in place to identify, analyse and review risks. Environment checks and risk assessments were in place and were up to date. Staff had access to comprehensive health and safety information, policies and procedures. There was an effective system in place to report, investigate, record and respond to any significant or adverse event. We noted event reports were concise, with clear investigation and documentation of outcomes. We were able to check when actions had been taken to reduce or prevent the risk of reoccurrence.

Incidents were discussed at clinical and practice meetings and we saw that actions and outcomes were clearly disseminated to all staff. This ensured key learning was shared and understood. When required external agencies had also been included. The practice had "Whistle blowing" and "Performance concern" guidance for staff and again when we spoke with staff, we were told they would feel confident that any concerns raised would be dealt with in a sensitive and supportive manner.

Systems were in place and demonstrated the practice responded effectively to external safety alerts. These included alerts from the Medicines and Healthcare products Regulatory Agency (MHRA).

The practice had arrangements in place to carry out regular checks to monitor fire and other health and safety requirements to ensure the practice was safe and fit for purpose.

Medicines management

GP's and other clinical staff had up to date policy and procedure guidance for medicines management, with an additional policy for the handling, storage and destruction of controlled drugs. Controlled drugs are medicines that require extra checks and specific storage arrangements. We found appropriate processes in place to safely manage

Are services safe?

controlled drugs within the practice. British National Formularies were available and were current. This is a joint publication by the British Medical Association and the Royal Pharmaceutical Society, which provides prescribing information about medicines, their use and contra-indications. It is updated twice a year.

There was a nominated GP who monitored prescribing, along with the nurse practitioner. There was also an administration lead for prescribing monitoring. The nurse practitioner also was responsible for the management of controlled drugs. Monthly management review meetings were held and each week, or as required, the lead GP and the administration lead met to discuss any prescribing issues or changes required. Drug safety alerts were managed appropriately. Staff reported "an ethos of open discussion and support" in relation to medicines management.

The nurse practitioner had undertaken nurse prescribers training and was able to independently prescribe. The other practice nurses worked from agreed patient group directives. These are specific written instructions for the supply and administration of a range of licensed named medicine. We were able to verify the training the nurses had received. Regular monitoring of the prescribing practice had been undertaken.

There was a list of emergency drugs and their location throughout the practice. These were checked and expiry dates documented. Equipment bags and drugs for home visits were checked and drugs replaced as required. Oxygen cylinders were full and checked weekly. Appropriate safety signage to alert staff to the storage of the cylinders was noted.

The prescribing process was being reviewed, with all GP's and clinical staff involved. Work was in progress to ensure medication reviews were up to date and that medications recorded correlated with current clinical diagnosis. Month of birth had recently been agreed for routine reviews of medicines for patients. Other monitoring reviews of medications determined by chronic disease management or by routine presentation of patients were on going. Plans were in place, following work as part of the prescribing process review, to create alert messages for patients on prescriptions, when medication reviews were due or overdue.

Cleanliness and infection control

We observed all areas and found the practice was clean, tidy and organised. Staff had access to comprehensive infection control procedures, which supported appropriate infection prevention and control practice. The minor procedure room was clean but had some clutter on work tops when first visited in the morning. We were aware this was cleared and organised prior to use for minor procedures in the afternoon. Curtains in treatment rooms were not disposable; however there was a cleaning procedure and these were cleaned and replaced on a monthly basis or as required.

Staff had received infection prevention and control training. Risk assessments had been reviewed on a regular basis. An infection control audit had been undertaken by an external medical education service in November 2013, with no major concerns highlighted. Minor recommendations had been actioned. A repeat audit was planned annually. We observed staff had access to stocks of gloves, aprons and masks. Hand wash sinks, throughout staff and patient areas, had good supplies of soap and paper towels. Hand washing guidance was displayed.

Clinical and domestic waste was well segregated, with robust systems in place for disposal and collection. Specimens were handled in a safe manner. When brought into the practice by patients, specimens were placed onto a collection box and then transferred to a specimen fridge in reception. We observed reception staff using antibacterial hand gel once specimens had been handled. These practices helped to protect patients and staff from the risks of cross infection.

Staffing and recruitment

The practice had a comprehensive and current recruitment policy in place. Formal processes were followed when staff were recruited and employed. We looked at sample of ten personnel files across all grades of staff. This included GP's, nurses, health care assistants and administration staff. We noted appropriate recruitment and employment checks had been undertaken which included; a check of personal skills and experience via individual curriculum vitae (CV), references and criminal records checks. All files contained individual identity checks, contracts and job descriptions.

We found before employment checks were made on registration with professional bodies. Appropriate

membership with professional medical insurers was checked. The practice had effective systems in place to continually monitor professional registration and indemnity insurance membership.

The practice had robust disciplinary procedures in place. We were able to establish policy and procedure had been followed and robust records made, when disciplinary procedures had to be implemented.

Dealing with Emergencies

We found comprehensive plans to deal with any emergencies that may occur, which could disrupt the safe and smooth running of the practice. A detailed business continuity plan was in place, which was reviewed on an annual basis or as required. This had been agreed by the local CCG and other relevant organisations. The plan covered personnel, records/electronic systems, clinical events, environmental events and premises. It included identification of other suitable premises in the event of the practice being unavailable for any reason.

All staff had received basic life support training and had guidance on dealing with medical emergencies such as any collapse of a patient or anaphylaxis (a severe reaction or sensitivity). Reception and clinical staff were also able to describe the actions they would take in clinical emergencies, such as a patient presenting or on the telephone with chest pain or symptoms of a stroke.

We noted when an unexpected patient death had occurred during a routine visit, this had been investigated as a serious event and appropriate action taken. This resulted in additional equipment being placed in the GP's emergency bag.

Equipment

Emergency equipment was readily available. This included emergency drugs, oxygen and a defibrillator. Emergency bags were available in reception and contained fluids for intravenous use, cannulas, airways, infant and child breathing bags. These were checked on a daily basis.

We asked about equipment for GP's or other clinical staff to carry out examinations or checks and no issues were raised about the availability, reliability or condition of equipment. We saw that all electrical equipment was portable appliance tested and that equipment within the practice was maintained in good working order

Are services effective?

(for example, treatment is effective)

Summary of findings

We found the service was effective. Care and treatment was provided in line with evidence based practice and national agreed guidelines. Patient's needs were consistently met. Referrals to secondary care were timely. The practice signposted patients to additional support groups. These included help with chronic disease management, domestic violence and anger management. The performance of staff was appropriately assessed via appraisal and the practice undertook regular monitoring by clinical audits.

Our findings

Promoting best practice

We found care and treatment was provided in line with evidence based practice and national agreed guidelines. The practice had a well-established clinical and managerial lead structure and this was the mechanism by which new guidance and best practice was accessed, implemented and reviewed.

Each GP lead was responsible for ensuring reviews of National Clinical Institute for Health and Clinical Excellence (NICE) guidance on clinical treatments, were up to date for their specific lead area. They were also responsible to ensure information was disseminated to GP partners and clinical staff. As a failsafe one GP was nominated to summarise all NICE guidelines and this was reviewed at quarterly quality improvement meetings.

The practice subscribed to a number of current medical journals and the library had a good range of medical text books. There was evidence of on-going training and tutorials undertaken within the practice during protected learning times.

The practice had links with or were members of external agencies and organisations and these were utilised to gain information on best practice or bench marking. These included the CCG, the local NHS hospital, the Local Medical Committee, Out of Hours Service and the End of Life/ Palliative care team.

Management, monitoring and improving outcomes for people

Each GP along with a nurse lead, was responsible for the management and monitoring of specific conditions and illness. This included diabetes, cardio vascular disease, mental health, sexual health, chronic obstructive pulmonary disease (COPD), cancer and treating patients with learning difficulties. This meant the practice had a system in place which GP's and other clinical staff had a focus to improve clinical outcomes for patients.

Nursing staff explained during consultations information could be printed from patient information web sources and the practice's own electronic management system EMIS Web. These supplemented any verbal advice and gave patient the optimal expectations to keep healthy and help improve long term conditions.

Are services effective?

(for example, treatment is effective)

The practice was committed to working with external agencies to help improve outcomes. For example when patients were diagnosed with depression, other options were considered before automatically prescribing anti-depressant medication. Local counselling services were contacted either by self or GP referral. Options were available to access the NHS Programme; Improving Access to Psychological Therapies (IAPT) This enables early intervention using alternative techniques and resources to assist patients.

The practice signposted patients to additional support groups. These included help with chronic disease management and domestic violence and anger management.

The practice had a buddy system were GP's were allocated a colleague as a buddy. This ensured that each GP could action any outstanding results, requests or tasks. This means there were no delays that may have resulted in a poor experience for a patient.

Regular monitoring and peer review was undertaken. The practice had an audit programme which included clinical as well as administration staff. This had included a medicines management audit which had seen the reduction in use of NSAID's, a heart failure audit, to measure increase in prevalence rates and an end of life audit to demonstrate patient choices were agreed and completed.

Risk profiling of patients was on going. A protocol to identify risk factors for all patients and in particular, vulnerable patients had been implemented. Patients with complex medical and social factors, and therefore at greater risk of hospital admission, had been identified.

The practice had held meetings with representatives of vulnerable patients groups. These were the Blind Society, a local hearing impairment group 'Caritas' and the learning difficulties team. It was reported that key information and insight was gained from discussions with these groups as to how the practice could improve communication with these patients.

The practice participated in significant event audits (SEA). The SEA is a quality improvement tool that is in routine use within general practice. The aim was to ensure learning from any significant event in which there had been a significant occurrence (not necessarily involving an undesirable outcome for the patient) to determine what can be learnt about the overall quality of care and to indicate changes that lead to future improved outcomes for patients.

Work was on going to identify elderly patients who had suffered falls, either at home or whilst in hospital. Health checks and medications reviews were brought forward to help reduce any reoccurrence.

Staffing

When we sampled ten personnel files we were able to verify staff had undertaken a comprehensive induction when first joining the practice. Mentors had been identified for each role in the practice. We saw training for relevant to roles and responsibilities had been undertaken, along with annual mandatory training which included; basic life support, infection control and safeguarding. Staff confirmed that during induction competency assessments were completed. Staff reported that throughout the induction they had felt supported and not rushed into undertaking health assessments or other duties expected of them.

Training needs and attendance at training was monitored by the lead clinical and administration managers and was overseen the practice manager. We were told the practice had participated in a training needs analysis undertaken by the local CCG last year as part of the Cumbria Learning and Improvement Collaborative. The aim of this was to provide a baseline educational needs assessment to help develop CCG wide education and training plans.

We found some of the personnel files were disorganised and had various pieces of paper and review documents which were not in chronological order so this made it more difficult to determine if regular appraisals had been undertaken. Staff did confirm they had annual appraisals and said they were well supported when any training needs or development, personal or professional had been requested. Another staff member told us they had undertaken a range of training since joining the practice and they felt that educational needs and development was taken seriously.

Group supervision was undertaken during monthly clinical staff meetings and we were told that individual clinical supervision was also available. During discussions with

Are services effective?

(for example, treatment is effective)

nurses and healthcare assistants it was verified the staff felt they received professional support and leadership. One staff member told us this had become much more structured since the nurse practitioner had been in post.

Working with other services

We saw evidence of proactive engagement with other health professionals. When patients from the practice had attended the accident and emergency department at hospital or out of hours services there was notifications sent within 24 hours. The out of hours service was provided by Cumbria Health On Call (CHOC). The practice liaised with these services to ensure the attendance was appropriate. Patients were then contacted to ensure if a further appointment was required or if a health review was due or needed to be brought forward.

Appropriate referrals were made to mental health teams and other specialised services when required. These included drug and alcohol services and counselling services.

Information sharing protocols were in place. Liaison with midwives and health visitors was undertaken. The practice reported that as both midwives and health visitors worked in clusters rather than assigned to specific practices, contacting them was not always easy. We were told in the past both health visitors and midwives would visit the practice on a regular basis, however now they would only come when requested for meetings about specific patients.

The practice liaised with the local hospital bereavement team to ensure appropriate support for patients and other family members in the event of a death.

One GP was a member of the out of hour's service (CHOC) board and was able to escalate any concerns and facilitate shared learning.

Health, promotion and prevention

For all new patients to the practice the healthcare assistants carried out new patient checks. During these checks patients were able to be signposted to other services, to improve health and wellbeing. These included smoking cessation, mental health support and general healthy living.

The practice had a wide range of health promotion leaflets that were readily available for all patients. These were found in the main reception, each smaller waiting area and in each treatment and consultation room.

Patients had access to health promotion support and advice programmes in respect of weight management, diet and exercise. Patients were regularly monitored, led by the health care assistants and overseen by the nurses and GP's.

Individual lead GP's and clinical staff for chronic conditions ensured that health promotion and wellbeing was always discussed at any consultations, but especially at chronic diseases management reviews

Are services caring?

Summary of findings

We found the service was caring. All patients we spoke with during the inspection were very complimentary about the practice. We observed patients were spoken to in a professional but friendly manner. Staff showed patience when dealing with patients on the telephone, booking in or attending the reception desk.

Patients told us how they felt the GP's discussed issues with them in a manner which ensured they fully understood what was happening. Patients felt their privacy and confidentiality was maintained.

Our findings

Respect, dignity, compassion and empathy

We found patients were treated with dignity and respect by all grades of staff. We observed, at times unseen by staff, that patients were spoken to in a professional but friendly manner. Staff showed patience when dealing with patients on the telephone, booking in or attending the reception desk. We saw reception staff assisting less able, elderly patients when moving around the practice. We saw GP's coming out of each of the consultation rooms for their next patient and greeting each in a polite manner and by name.

In addition to the main waiting area in reception the practice had multiple smaller waiting areas across all floors, which were near to each consulting room. These areas provided a calmer atmosphere than the main reception area.

A total of eight patients, who were visiting the practice during our inspection, were happy to speak with us. We were told unanimously staff treated patients with respect. Patients said they felt they were treated as individuals. One patient said when arrangements were made for a GP to telephone or respond to a request to ring a patient, that this always happened as agreed. We were told "staff here are excellent", "they (reception staff) are very helpful and go the extra mile" and "the Doctors listen, you never feel rushed".

Another patient described how staff ensured that they fully understood what had been discussed; whilst another commented that it didn't matter which GP they saw as they felt records were updated and so the Doctor had all the information needed.

One patient expressed how the GP had showed compassion and support when there was a family bereavement. Bereavement or "In your Loss" packs gave practical information and support for patients and family members in a sensitive manner.

Patients commented that their privacy and confidentiality was maintained.

Involvement in decisions and consent

The practice had a strong ethos of encouraging feedback from patients. Annual patient surveys and GP questionnaires had been completed for some time. We saw evidence when suggestions to improve patient experience

Are services caring?

were made, that every effort was made to implement these when practical. The next patient survey was planned for summer 2014. A patient suggestion box was situated in the main reception. We were told there was not a huge response via the suggestion box, however a recent suggestion to move the repeat prescriptions desk and provide a calendar, was quickly implemented.

Patients said they were satisfied with how they were involved in their care. One patient told us: “The Doctor always gives clear explanations; the choices available to me are always talked through”. Another said a lot of verbal information was given during consultations but not much written information about the actual diagnosis We were told signposting, or advice to contact other agencies, for advice and support was common when appropriate.

Clinical staff explained how patients were supported in making decisions and always given the choices available. We were told this was part of the documented consultation. Leaflets and other written information were available within the practice on various conditions.

We saw consent policies, procedures and forms were in place for a range of treatments and procedures. This meant care and treatment was delivered after explanations were given and patient understanding was confirmed.

For patients under sixteen years of age, staff had guidance for Gillick Competency. This is guidance used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions. The practice guidelines did not make reference to Fraser Guidelines. These are additional guidelines to assist clinical staff in ensuring the understanding and competency to consent to care and treatment. We were told by staff they documented when Gillick Competency had been assessed on patient electronic records, however staff acknowledged that there was nothing to demonstrate how that was achieved.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

We found the service was responsive to patient's needs. The practice had created a post of Patient Liaison Advisor (PLA). The advisor was seen to work as an independent advocate for patients and championed patient's and carer's needs. Patients were given the opportunity to give feedback about the service they received. The practice had appropriate systems in place to acknowledge, investigate, report and respond to any concern or complaint.

Our findings

Responding to and meeting people's needs

Following meetings with vulnerable patients groups to help the practice improve how their met individual needs, a range of actions were taken. To assist patients with visual impairments all notices throughout the practice had been reproduced on yellow paper, with large black type. This is recognised to help visual impairment. The practice was praised for communications with patients with learning difficulties. This was due to information provided in pictorial format. A hearing loop system was utilised in reception and a member of staff was fluent in sign language. Whenever possible they assisted when required during consultations and for any queries at reception.

The practice had created a post of Patient Liaison Advisor (PLA) around six years ago. There were posters throughout the practice advertising the role and how patients were supported by the advisor. Business cards were in reception and waiting areas, treatments rooms and all consultation rooms. The PLA had a direct telephone line for easy access by patients. Reception staff were briefed in situations when any patient arrived in any state of anxiety or upset, that they were to contact the PLA. Although employed by the practice it was clear the PLA was seen to work as an independent advocate for patients and championed patient's needs. The PLA attended the patient participation group (PPG) and worked closely to promote and action any suggestions made to improve patient experience.

Staff explained how patients would be contacted by either telephone or letter if a medical review was due or overdue, particularly for chronic conditions. Patients confirmed this was undertaken.

Patients commented they felt the practice was forward thinking and responsive, and each said they would recommend to friends and family and anyone new to the area.

During last year's survey patients were asked if they felt the premises met the needs of patients or would they prefer moving into new building. There was an overwhelming response that they thought the current premises were fit for purpose and one patient commented "don't fix what's not broken! "

Are services responsive to people's needs?

(for example, to feedback?)

We were told patients thought telephone consultations were an excellent idea. One patient confirmed the GP always responded at the time when informed a call would be made. Another patient said the GP spent time to discuss problems thoroughly.

There was a chaperone policy and procedure in place. Notices around the practice were displayed to inform patients of this service. One patient we spoke with explained how a chaperone was offered on occasions, without requesting or prompting. Staff confirmed they have received training on how to chaperone effectively.

Access to the service

A great deal of work had been undertaken by the practice to improve access to appointments. An external review had been sourced in relation to appointment demand and capacity. Following this various ways to improve access to appointments had been implemented; Mixed pre booking, same day and next day slots were allocated. There was a staggered release of appointment slots and on line bookings. GP's and nurses had worked to review capacity and more efficient use of time. This had resulted in improved triage by the emergency care practitioner, practice nurses and GP's.

Getting an appointment, at a time convenient for the patient, was the main issue, both from patient surveys and when we spoke with patients. The practice had endeavoured to improve access to appointments for patients. Early and late appointment times had been introduced, with extended practice opening times. These provided more flexibility for those patients who worked.

Telephone consultations were also available. Home visits had been changed from after surgery times only to the allocation of one GP responsible for all home visits from 8.30 am each day. This meant more urgent calls were able to be assessed and undertaken earlier.

Access to nurses and health care assistant's appointments had been improved by the increase of nursing hours. This meant an increase in capacity to carry out routine health reviews and reduce pressure on GP surgeries.

One patient commented that continuity of access to the same GP was important but said that may take a numbers of days to see specified GP. It was verified that patients were always able to see on same day if required in an emergency.

Patients were given a wide range of information on how to access the service. The practice information booklet was comprehensive with information about opening times, staff employed within the practice, accessing appointments, the services available and self-treatment options. There was a list of useful local contact numbers for health and social care groups. The practice web site was easy to navigate and very informative. Information was also available in a range other languages if required, although the vast majority of patients were white British and English speaking. Translation services were available via Language Line.

Notice boards were prominent throughout the practice and were maintained in a neat and ordered manner. We noted all information was current, with staff allocated to ensure information was in date. Information was available about: complaints, appointments, medical records, prescriptions, consent, confidentiality, chaperones, bereavement and the patient liaison advisor. New patient packs were given to each new patient. These contained registration forms, health questionnaire, information on how to arrange a new patient health check, the practice information booklet, records and data protection information, a guide to out of hour's services and carer information and support guide.

Concerns and complaints

We found the practice had appropriate systems in place to acknowledge, investigate, report and respond to any concern or complaint. The patient liaison advisor was involved in managing and investigating all complaints. They were able to explain in detail the complaints process. The advisor acted as an advocate for patients, ensuring patients were supported effectively when any complaint was raised. There was a commitment within the practice to act upon any issue raised as quickly as possible and preferably face to face. This meant that some situations could be easily resolved to avoid escalation to formal complaint stage.

There was information for patients on how to raise a concern or make a complaint on line, within the practice information booklet and a complaints information leaflet. Complaint information was also displayed on notice boards. Information included how to contact external agencies, such as NHS England and the Health Ombudsman.

Staff had access to a current complaints management policy and procedure. This reflected current guidance on how to handle complaints, within appropriate time frames.

Are services responsive to people's needs?

(for example, to feedback?)

We were able to review the practice complaints log. We saw complaints were acknowledged and investigated within the required time frames. We saw responses to complaints were made in an appropriate manner; either in writing or face to face meetings with either the practice liaison advisor, the practice manger or relevant GP or senior GP. We saw the majority of complaints were not about care or treatment but access to appointments

Are services well-led?

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

Summary of findings

We found the service was well led. The practice had an established management structure, with clear lines of responsibility and accountability. The practice functioned well as a team. Leadership and management styles promoted openness and transparency. There was an established structure for effectively managing the risks and governance of the practice. Staff were well engaged with the quality improvement strategy and with the practice ethos of improving outcomes for patients

Our findings

Leadership and culture

Both clinical and administration staff spoke of a culture within the practice of support, openness and approachability. We saw evidence in minutes from various meetings, that all grades of staff were able to give opinions and suggestions during discussions.

It was clear the practice functioned well as a team. Leadership and management styles promoted openness and transparency. Colleagues clearly valued and had respect for each other. Buddy systems were utilised and provided effective peer support.

The practice had a well-established management structure, with lines of responsibility and accountability. Individual tasks for each team member were clearly defined. When we spoke with GP's, nurses and administration leads, they each were able to demonstrate clear understanding of their areas of responsibility. This was reflected in the practice's quality improvement strategy.

Staff told us they felt the practice was "forward thinking" and "inclusive" with all staff, when discussing any developments. They said they felt their opinions mattered and were taken seriously. Staff were able to clearly explain the practice's values and quality improvement strategy to achieve good outcomes for patients.

Governance arrangements

There was an established structure for effectively managing the governance of the practice. Key leads from clinical and administration staff had been identified for each area of governance and risk. These included: safeguarding, medicines management, complaints, significant events and patient risk profiling. Staff had undertaken appropriate training to support them undertake the lead roles effectively. Weekly practice meetings were held, along with monthly nursing staff meetings and quarterly improvement meetings. At these meetings review of incidents, risks and other quality issues were discussed and actioned.

The practice submitted governance and performance data to the local commissioning group. We were aware there were no areas of concern.

Are services well-led?

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

Systems to monitor and improve quality and improvement

The quality improvement strategy was the main mechanism by which the practice monitored, reviewed and improved the quality of care and patient outcomes. It encompassed all areas of clinical practice, risk management, significant events and staff training. Quality improvement meetings were held every three months and all staff were invited to attend and encouraged to participate. We reviewed minutes from the last two meetings. Standard agenda items included; safeguarding, clinical reviews and updates, risk management, complaints, significant events, vulnerable patients and referral management. We noted attendance at these meetings was good.

The practice had a comprehensive audit programme in place to monitor various areas of clinical practice, with GP's and nurses taking the lead for specified areas. These included minor surgery, cancer, diabetes, stroke care and eating disorders. Alongside the audits the practice was participating in various projects which included networking with voluntary sectors to improve mental health of patients, particularly young people, the development of rescue packs for patients with asthma and chronic obstructive pulmonary disease and improving health reviews for patients with learning difficulties. Audits also were undertaken on patient attendances at accident and emergency, referral management and emergency admissions.

Our intelligence data in relation to GP High Level Indicators, a national tool developed by the Department of Health, highlighted the practice as a low prescriber of non-steroidal anti-inflammatory drugs (NSAIDs). This was 36.89% compared with the national average of 56.98%. These are drugs used to reduce pain, fever and for anti-inflammatory treatments. We established the practice had undertaken a lot of work based on recent Medicine and Healthcare Agency (MHRA) alerts, as some of these medicines can have a range of side effects. The practice had undertaken detailed audits and reviews to ensure NSAID's were used for the shortest time and at the lowest dose necessary to control symptoms. Also alternative medications were being prescribed were ever possible

The practice had recently achieved the Royal College of GP's (RCGP) practice accreditation. This was awarded in recognition of the range and quality of operational systems, processes, procedures the practice had in place. This demonstrated the practice had effective systems in place by which to deliver safe patient-centred care and services.

Patient experience and involvement

There was a well-established patient participation group (PPG). We were able to speak with two members. Although it was reported the group was "lacking in numbers" both members felt the contribution of the PPG was welcomed and taken seriously. The membership was confirmed at 26 patients. We noted there were no members under 25 years of age. The practice manager explained a variety of ways had been tried to encourage more young people to join the PPG. This had included holdings meetings in hotels.

We saw notices advertising the group and promoting additional membership. We noted the group did however cover other population groups; this included mothers, adults who worked and adults who had retired. We were informed patients with specific additional needs had recently agreed to join. Efforts were continuing to improve overall representation of the patients registered with the practice. An annual report was produced by the group. It was available within the practice and also on the web site.

Patient surveys were undertaken annually. The last patient survey had revealed some concerns with staff attitude. It was our experience on the inspection that we received no negative feedback about the attitude or behaviour of any grade of staff.

During the inspection all patients we spoke with expressed satisfaction with their care and treatment

Staff engagement and involvement

We found all staff we spoke with to be well engaged with the quality improvement strategy and with the practice ethos of improving outcomes for patients. We noted when new staff were employed, at whatever grade; they were supported by a mentor. Staff spoke enthusiastically about the support they had received when joining and how this had made them feel like "part of a team" very quickly.

Each grade of staff could explain their own values and professional accountability, whilst promoting the positive involvement each individual had towards the day to day and the future developments of the practice. Staff spoke about being valued by GP's and their own expertise recognised and utilised effectively.

Are services well-led?

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

Monthly nursing meetings were held for nurses and the health care assistants. Minute's demonstrated staff were able to discuss practice issues and these were appropriately escalated, either for immediate action or via the quality improvement meetings.

Staff had access to whistle blowing guidance. When we spoke with staff they were confident that they would be able to raise any concerns and these would be dealt with in a confidential and professional manner. One staff member explained the process they had followed when raising some concerns about a colleague and was assured in the way this had been dealt with.

Learning and improvement

We found all practice staff had annual appraisals. We sampled a number of appraisal documents and found these contained self-assessment, performance reviews, training requirements and personal development requests. All staff we spoke with on the day of the inspection were very positive about the amount and availability of training, both for mandatory topics and personal developments. We were aware the practice had recently supported a healthcare assistant through nurse training and was soon to return as a practice nurse. GP appraisals were up to date and revalidation was on going. Revalidation is the process by which all registered doctors have to demonstrate to the General Medical Council (GMC) that they are up to date and fit to practise and complying with the relevant professional standards.

GP's reported good communication between partners. Benchmarking and use of each individual's expertise was also expressed as assisting learning. We found the GP's were actively involved in training and delivering tutorials to students and doctors in training.

Identification and management of risk

Risks were identified appropriately through effective governance systems within the practice. Risk assessments were in place and were reviewed as required in order to reduce the risk of harm to both patients and staff. . The practice had a current risk register and any risk identified was discussed and actioned at the quality improvement meetings.

We discussed management of risk with GP's and the practice manager. One example discussed was the introduction of a new administrative system to improve the management of documentation coming into the practice. Processes for the flow of documentation were streamlined. Coding was reviewed and his significantly reduced the time taken to scan important patient information and facilitated a safer mechanism to ensure that the GP had read the information. Any urgent information was automatically highlighted and the GP could not move through the system until they had confirmed this had been read.

A robust system was in place to respond to safety alerts from external sources which may have implications or risk for the practice. These included NHS England, Medicines and Healthcare Products Regulatory Agency (MHRA) and National Patient Safety Agency (NPSA).