The Bounces Road Surgery

Quality Report

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

Summary of findings

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Summary of findings

Overall summary

The Bounces Road Surgery is a small surgery consisting of two GP's, a trainee GP, practice nurse, practice manager and reception staff. The practice is located within the London Borough of Enfield and has a patient list size of 4800.

We carried out an announced inspection on 2 June 2013. As part of the inspection we spoke with patients awaiting their appointment and staff throughout the day. We also received feedback through Care Quality Commission (CQC) feedback cards which were available for patients to complete prior to the visit.

We inspected the following CQC regulated activities, diagnostic and screening procedures, family planning, surgical procedures and treatment of disease and disorder or injury.

We spoke with patients awaiting their appointments who told us that they were pleased with the service that they received from the practice and that staff were kind and considerate.

The practice was safe and had procedures in place to identify and learn from significant events. Medicines were managed in a safe way and arrangements were in place to respond to emergencies. Although we found that the practice needed to ensure that all equipment had been appropriately checked and all cleaning audits carried out

The practice had some systems in place to monitor the quality of care provided through the monmitoring of National Institute for Health and Care Excellence (NICE) guidelines and Quality and Outcome Framework (QOF) data. Staff told us they had received training and appraisals but they were unable to provide records of this.

A chaperone policy was in place but patients had not been made aware of it and some patients told us they had difficulty getting through on the phone to make an appointment.

The practice had a transparent culture which enabled good team working. Systems were in place to receive patient feedback to monitor performance. There was an active Patient Participation Group (PPG).

The practice was able to meet the needs of the different population groups who accessed the service.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice had systems in place to ensure patients received safe care. This included systems for reporting and learning from incidents and protecting patients from the risk of abuse. The practice had arrangements for the safe handling, storing and administration of medications. Equipment was available to deal with emergencies and staff had received training in basic life support.

The premises were clean and well maintained and procedures were in place to manage cross infection and prevention. Appropriate pre-employment checks had been carried out including disclosure and barring checks (DBS).

Are services effective?

The practice regularly reviewed published guidelines from the National Institute for Health and Care Excellence (NICE) and integrated these into practice. Quality and Outcomes Framework (QOF) data was used to monitor the performance of the practice. Clinical audits were carried out and changes made to patient's treatment and care.

Staff received a induction programme and had appraisals and on-going training through monthly staff meetings.

The practice worked closely with other health care professionals to discuss patient cases in multi-disciplinary meetings. Healthy living was promoted through literature provided by the surgery.

Are services caring?

Patients received services that were caring. Patients told us that Staff were empathetic and friendly and that their privacy was maintained.

Patients told us that they were supported by staff to make decisions regarding their treatment The national GP Patient Survey found that 66% of patients felt supported by staff to make decisions about their treatment and care, which was below the Clincial Comssioning Group (CCG) average. Policies were in place to obtain consent from patients under the age of eighteen where it was judged that the patient had capacity to consent and staff were aware of the Mental Capacity Act 2005.

Summary of findings

The practice operated a chaperone policy but this was not publicised and patients were unaware of the service.

Are services responsive to people's needs?

The premises had been adapted to accommodate wheelchair users and a . lift was available for patients to gain access to services located on the first floor of the health centre. A translation service was available for patients who did not have English as a first language and information leaflets were available in a range of languages on request.

Patients could book appointments for the same day and a telephone consultation service was offered. Emergency and evening appointments were available but patients told us they had difficult getting through on the telephone and said they were unhappy with the reception triage service.

The practice had a complaints policy which was advertised and used complaints and other feedback from patients to improve service.

Are services well-led?

The practice had an open and transparent culture and staff told us there was good team working. The practice had leads for clinical governance including safeguarding and prescriptions management.

Systems were in place to monitor performance which included a comparison of Clinical Commissioning Group (CCG) and Quality and Outcome Framework (QOF) data and carrying out clinical audit. However, there was no records of staff appraisals or training.

The practice had an active Patient Participation Group (PPG) that met regularly and took responsibility for the annual patient survey. Feedback from both patient and staff was assessed by the practice manager and reviewed in practice meetings.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

The practice provided an effective service to older people and had a GP that had undertaken further training in the care of older people. Each patient over 75 had their own named GP. Telephone consultations and home visits were available for those unable to attend the practice.

Full health checks were offered including blood pressure monitoring and seasonal flu jab.

People with long-term conditions

Patients received a service that was responsive to their needs. Routine health checks were carried out to avoid unnecessary hospital admissions. Care plans were developed to enable self-management of conditions. Periodic meetings were held between GP, patient and their carer to review the care plan.

The practice worked closely with other care providers within the health centre to provide clinics aimed at effectively managing long term conditions such as asthma and diabetes.

Mothers, babies, children and young people

Mothers, babies, children and young people received a service that was responsive and had arrangements in place to meet patient needs.

Immunisations were provided for children and sexual health advice for young people.

Families at risk and in need of further care were discussed in multi-disciplinary meetings between health visitors, social services and the practice.

The working-age population and those recently retired

Working age people (and those recently retired) received services that were responsive to their need. The practice provided a flexible appointments system which included telephone consultations and evening appointments.

A telephone system for requesting doctors notes was available and a choice of referral to other services was available.

Summary of findings

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

Patients in vulnerable circumstances received a service that was responsive and had arrangements in place to meet patient's needs. All people were able to register but for those who did not wish to, the practice provided advice which included how to access community health services and emergency treatment.

The practice worked with carers to discuss patient care and were involved in multi-disciplinary meetings to discuss complex cases.

The practice offered annual health checks to those with a learning disability and held registers for those with a learning disability, patients with a vulnerable disease and a high priority patient list.

People experiencing poor mental health

People experiencing a mental health problem received a service that was responsive and met patient need. The practice carried out a full health assessment prior to referring a patient to local mental health teams. The GP continued to be involved in the patient care through regular health checks and involvement in multi-disciplinary meetings.

Summary of findings

What people who use the service say

During our inspection, we spoke with patients eight patients and ten members of the Patient Participation Group (PPG) who told us they felt safe and confident in the GPs, nurses and staff at the practice. They spoke positively about the service; typically describing the service provided as excellent. Patients felt that their views were listened to and that they were provided with sufficient information to make informed decisions about their health. They also felt involved in decisions about their care and treatment and were treated with dignity and respect. They said the practice always looked clean and tidy when they attended their appointments.

We also reviewed 20 comments cards which had been completed by patients in the two week period before our inspection. The cards enabled patients to record their views on the service. All the comments were positive and emphasised the standard of quality and safe care that patents received.

We viewed the national GP Patient Survey 2013 which gave higher than average results for patient satisfaction, however the survey showed that a high proportion of those who completed the survey found it difficult to get through to the practice on the phone.

Areas for improvement

Action the service COULD take to improve

Need to ensure that all equipment has been checked.

Have a system in place to ensure that cleaning audits have been carried out.

Implement an online appointment system.

Ensure patients are aware they have a chaperone policy.

Fully document appraisals, including outcomes and record training for all staff

Improve the process for involving patients in decisions about their care.

Good practice

Our inspection team highlighted the following areas of good practice:

- One GP had a special interest in elderly care and had undertaken further training in the management of health in older people.

The Bounces Road Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector who was accompanied by a GP, Practice Manager and an Expert by Experience. The GP, Practice Manager and Expert-by-Experience were granted the same authority to enter the practice as the CQC inspector.

Background to The Bounces Road Surgery

The Bounces Road Surgery is a small practice situated within a larger health centre based on Hertford Road, Enfield. It is operated by two GP's, a trainee GP, practice nurses, Practice Manager and reception staff. The practice currently has a patient list of 4800. 33% of patients are aged 18-65 and only 18% are over 65 years of age. Patients come from a mix of ethnicity, white British and Afro-Carribean are the main ethnic groups but the practice also has a large proportion of Asian and Turkish patients.

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 including the Enfield Clinical Commissioning Group (CCG) and NHS England to share their information about the service. We carried out an announced visit on 2 June 2014.

During our visit we spoke with a range of staff, including both GP's, trainee GP, Practice Manager and reception staff. There was no practice nurses available on the day of inspection.

Detailed findings

We also spoke with patients who used the service. We observed how people were being cared for and reviewed practice policies and audits that the practice had in place.

Are services safe?

Summary of findings

The practice had systems in place to ensure patients received safe care. This included systems for reporting and learning from incidents and protecting patients from the risk of abuse. The practice had arrangements for the safe handling, storing and administration of medications. Equipment was available to deal with emergencies and staff had received training in basic life support.

The premises were clean and well maintained and procedures were in place to manage cross infection and prevention. Appropriate pre-employment checks had been carried out including disclosure and barring checks (DBS).

Our findings

Safe patient care

The Bounces Road Surgery had a system for reporting and learning from incidents. We saw a process for escalating incidents to the management team for investigation and resolution including referral to other agencies. Staff stated that they were aware of the process in place for the reporting of incidents and felt able to raise any concerns with the practice manager and GP's for the necessary follow up.

Learning from incidents

Significant events, including prescribing errors and health and safety incidents were recorded by the practice. Significant Events Analysis (SEA), took place. One SEA that had been carried out concerned a same day cancer referral that was not sent on the same day as the appointment by administration staff. This was noticed by the GP the following day and actioned. The practice responded by issuing further guidance to staff on the importance of ensuring referrals were sent promptly.

The practice also used a 'near misses' book to record minor incidents. We found that incidents and near misses were discussed in team meetings to promote learning.

Patient safety alerts were reviewed by the practice manager with the appropriate action recorded. Staff were then informed of the safety alert at the practice meeting.

Safeguarding

The practice had child protection and safeguarding vulnerable adults' policies in place. It also had practice had a named individual responsible for safeguarding and staff were aware to contact the named person if they suspected any abuse. GP's had received Level 3 child protection training and the practice nurse was trained to Level 2. All clinical staff had received safeguarding vulnerable adults training.

We were provided with minutes of staff meetings where training in child protection and safeguarding of vulnerable adults was given by the practice manager. No further training records for training in this area were available.

Are services safe?

Monitoring safety and responding to risk

The practice had a range of systems in place to monitor safety and respond to risk. This included health and safety risk assessments including environmental risk assessments , and a fire safety risk assessment.

The practice had a business continuity plan which included the moving of a limited number of services to a local hall until the practice was fully functioning.

The practice had a system of being able to alert all staff of emergencies through the telephone system. The system sends an alert to all the phones within the practice with the location of where the emergency was situated. Staff could not give an example of when the system had been used but had been trained and were confident that they could respond if the system was activated.

Medicines management

The practice had suitable arrangements in place for the safe handling, storing and administering of medication. Immunisations and vaccinations were stored appropriately and were in date. Accurate records of vaccines held by the practice were kept which included a record of the batch number. The cold chain was maintained and the temperature of the medicines fridge was checked and recorded daily. . Best practice guidelines state that medicine fridges should be plugged into switchless sockets so they can not be turned off. However we found that the fridge was manually plugged into the wall and a sign was present stating that the fridge was not to be unplugged

The practice did not hold any controlled drugs.

The practice's repeat prescription policy stated that patients were to submit prescription forms to the practice reception who would process these on the computer system. Prescriptions were then authorised by the GP and issued to the pharmacy attached to the health centre or placed in reception for patients to collect. If a patient required a change to their prescription, the GP would either telephone them to discuss the change or an appointment would be made at the surgery. The practice did not have an online service for repeat prescriptions.

Cleanliness and infection control

The practice had policies and procedures in place for infection prevention and control. Lead responsibility for this was shared between the practice manager and one of the GP's. Clinical staff received online infection control training however we were not provided with evidence to confirm this. Non-clinical staff received training from the practice manager through team meetings. Staff confirmed that they had received this training.

We viewed an annual infection control audit had been completed for 2013/14 which had not identified any areas of concern.

NHS Property Services Ltd took responsibility for the cleaning of the practice. The service had an appointed facilities manager who liaised with the practice manager regarding the maintenance of the practice. The practice was clean and we saw evidence of cleaning schedules. The practice did not carry out a formal cleaning audit but any issues were reported to the practice manager to raise with the facilities manager. The practice manager also carried out a daily check of the practice to ensure that it was appropriately clean.

The practice had facilities for hand washing and hand gel was available. Hand washing signs were present to instruct staff and patients in correct procedure.

Clinical waste and sharps were stored in a lockable bin at the rear of the premises and collected on a monthly basis by a contracted company.

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Staffing and recruitment

The practice had a recruitment policy and process which included the submission of application, pre-employment checks and interview process.

Pre-employment checks had been carried out for all members of staff. These included proof of identity through passport submission, employment reference checks, confirmation of immunisation and disclosure barring Service (DBS) checks.

Dealing with Emergencies

Emergency medicines were kept in a 'grab bag' within the practice clinical store which was accessible to staff at all times. A list of emergency medication was held within the bag and checklist for monitoring expiry was present and up to date.

A defibrillator and oxygen cylinder was located in the main reception area and provided by the buildings facilities

management team. The practice did not check this equipment and there was no evidence provided that the equipment had been audited and tested by the facilities management team.

Each member of staff at the practice was up to date with their Basic Life Support training. Clinical staff received annual refresher training which included the use of the defibrillator while administration staff received training every three years.

Equipment

Equipment had been checked regularly. All Portable Appliance Testing (PAT) was in date. We viewed up to date calibration records for thermometers and the medicines fridge which showed that they had been checked regularly.

Are services effective?

(for example, treatment is effective)

Summary of findings

The practice regularly reviewed published guidelines from the National Institute for Health and Care Excellence (NICE) and integrated these into practice. Quality and Outcomes Framework (QOF) data was used to monitor the performance of the practice. Clinical audits were carried out and changes made to patient's treatment and care.

Staff received a induction programme and had appraisals and ongoing training through monthly staff meetings.

The practice worked closely with other health care professionals to discuss patient cases in multi-disciplinary meetings. Healthy living was promoted through literature provided by the surgery.

Our findings

Promoting best practice

The practice used National Institute for Health and Care Excellence (NICE) guidelines to ensure safe and effective treatment was provided. We viewed NICE guideline maps for immunisation and care of childhood illness on display in the nurses consulting room. The guidelines were reviewed at weekly clinical meetings to ensure the most up to date procedure was available for patient care.

The practice also used clinical pathways provided by Enfield Clinical Commissioning Group (CCG). Access to these pathways was provided through the practice intranet. The GPs and practice manager met with a larger practice within the health centre on a regular basis to discuss best practice. Those meetings discussed the way forward in clinical cases for particular patients as well as on a case study basis, local CCG plans for services and NICE guidelines.

Staff meetings were held on a fortnightly basis. These meetings discussed best practice in relation to consent, patient confidentiality, Mental Capacity Act 2005 and health and safety. Staff were aware of their obligations under the Mental Capacity Act 2005.

Management, monitoring and improving outcomes for people

The practice submitted information to the Quality and Outcomes Framework (QOF) which compared data from the practice and the local Clinical Commissioning Group (CCG) as a whole against the national average for England. The practice was below both the CCG (85.2%) and the national average (85.5%) at 84.4% in 2013. This is a general figure which included all areas that QOF covers (clinical care, how well the practice is organised, patient views, amount of extra services offered by the practice).

The practice undertook annual clinical audits to improve the care of patients. Audits were discussed in clinical team meetings where action points or changes to practice policy were made.

An audit requested by the Clinical Commissioning Group (CCG) was carried out into the use of steroids in inhalers. The audit resulted in a change to a number of patients' medicines.. An audit into patients who used amlodipine and simvastatin over a long period of time found that

Are services effective?

(for example, treatment is effective)

some medicines were becoming less effective and left patients open to side effects. In both cases patients were written to and informed that their medicines may have to be changed.

Staffing

New staff were given an induction and a copy of the programme was kept in their staff personnel files. Staff described the learning outcomes they had to achieve, including reading policies and procedures within the first few weeks of employment.

All staff received an annual appraisal which included a personal development plan. We viewed appraisal records and found that staff were asked to prepare for their appraisal using a self-assessment tool to complete a personal development plan. Administrative staff were also provided with the self-assessment tool but were not asked to complete a personal development plan. This plan was identified during their appraisal . We were informed that no formal appraisal outcome documents, objectives or personal development plan were provided to staff members after the interview. Staff informed us that they had received guidance on the appraisal system during team meetings and that they kept their own record of their training objectives.

Arrangements were in place for the GP's revalidation. (the process where doctors are required to demonstrate that their skills and knowledge are up to date and they are fit to practice). Both GP's were scheduled to be revalidated by the end of 2014.

Staff told us that they had received the training which had been agreed during their appraisal. but we found no record of the training being delivered. A staff training log was available but this was found to be confusing and did not provide sufficient information to show that training had been delivered. If a member of staff wished to develop their skills and undertake a role that was not in their job description, for example repeat prescription administration, training was be arranged for them.

Working with other services

The practice had links with local community services which included local mental health teams, midwives and health visitors, screening services, learning disability services and counselling services. This involved multi-disciplinary team meetings to discuss the needs of individual patients.

We viewed minutes of meetings between all the care providers within the health centre which discussed how the centre can work together to provide a full service to patients. If a patient at the practice could benefit from treatment by another service in the building such as the screening or counselling service, the GP would discuss this with the patient and make the referral where appropriate.

The practice worked with the local mental health teams to provide referrals to the service following an early assessment either at the practice or in the patient's home. The GP's remained involved in the ongoing care through multi-disciplinary case meetings.

Health, promotion and prevention

The practice promoted good health for all patients within the practice. Health literature was available for patients including sexual health advice, advice for alcohol and drug related conditions, exercise and healthy eating advice and smoking cessation.

The practice promoted services that were provided within the health centre which included counselling provided by the Improving Access to Psychological Therapies service (IAPT), mammography services, leg ulcer clinic, learning disability services and dental services. Services are accessed through a referral by the GP.

There was a practice policy to promote vaccinations and general health screening, including annual health checks to help identify any potential long term concerns arising. Patients were invited to participate in an annual health check.

Are services caring?

Summary of findings

Patients received services that were caring. Patients told us that Staff were empathetic and friendly and that their privacy was maintained.

Patients told us that they were supported by staff to make decisions regarding their treatment The national GP Patient Survey found that 66% of patients felt supported by staff to make decisions about their treatment and care, which was below the Clincial Comssioning Group (CCG) average. Policies were in place to obtain consent from patients under the age of eighteen where it was judged that the patient had capacity to consent and staff were aware of the Mental Capacity Act 2005.

The practice operated a chaperone policy but this was not publicised and patients were unaware of the service.

Our findings

Respect, dignity, compassion and empathy

We found staff were friendly and responsive to the needs of patients. We observed staff at the reception desk who were empathetic and friendly. Staff ensured that patients who were waiting for their appointment were kept informed at all times including i how many people were due to see the GP before their appointment. Patients commented that they were well cared for, treated with respect and supported by staff to make decisions regarding their treatment with enough time to discuss concerns with their GP.

The practice had a chaperone policy where reception staff who had received training would act as a chaperone. We found that the service was not advertised and patients were unaware of the service.

The waiting room was open plan and was shared with two further surgeries but a side room was available for patients to talk to staff privately. The consulting rooms had curtains to give privacy during an examination.

We were informed that patients received support at the time of bereavement. The GP would call the family as soon as the practice was made aware and then send a letter of condolence with a bereavement pack to the family.

Involvement in decisions and consent

Patients told us that they were supported to make informed decisions about their treatment through discussion with the GPs. Patients we spoke with stated that they were involved in the planning of their treatment especially when a hospital referral was needed. The latest national GP patient survey found that 66% of the patients who completed the survey said they felt involved in their treatment planning. This was below the CCG average.

The practice had a policy for obtaining consent from patients under the age of eighteen which included the principles of Gillick Competency assessment (an assessment tool used to assess whether a person under the age of sixteen has the capacity to provide consent). Staff had received training in the use of this tool.

Staff had received training in the Mental Capacity Act 2005 and were able to demonstrate their responsibilities under the act.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The premises had been adapted to accommodate wheelchair users and a lift was available for patients to gain access to services located on the first floor of the health centre. A translation service was available for patients who did not have English as a first language and information leaflets were available in a range of languages on request.

Patients could book appointments for the same day and a telephone consultation service was offered. Emergency and evening appointments were available but patients told us they had difficult getting through on the telephone and said they were unhappy with the reception triage service.

The practice had a complaints policy which was advertised and used complaints and other feedback from patients to improve service.

Our findings

Responding to and meeting people's needs

The practice had a culturally diverse patient list and had taken steps to ensure that all cultures and languages were accommodated. This included a touch screen sign-in screen available in the main community languages of Turkish, Greek, Urdu and Somali. Patients had access to a translation service as translation by members of the patients family was discouraged due to possible mis-interpretation. Practice leaflets were available in the main languages and printed from the computer system when needed.

The practice responded to patients with varying needs. There was ease of access to the premises for wheelchair users or patients who had walking difficulties as the surgery was on one level with an open plan waiting area and wide corridors to treatment rooms. A lift was available for patients to access services on the first floor of the health centre.

The practice had access to translation services and encouraged this service to be used rather than family members to discourage mis-interpretation and breaches in patient confidentiality. Patient information was printed from the computer system in the patients first language.

For patients who required a referral to another health professional, the practice offered an urgent referral the same day. The practice had a policy in place to refer patients who had no fixed abode to community health services. However the GP's would provide advice and any emergency treatment needed.

Out of hours provision was advertised in the practice and directed patients to the 111 number. The information was also available on the practice answering machine system.

Access to the service

Appointments were made in person or on the telephone. The practice did not have an online booking facility. Patients who needed to see a GP that day called in the morning to request an appointment. Telephone consultations were also offered at the end of the surgery session. Evening appointments were available for patients unable to attend during the day due to work commitments and emergency appointments were available at the end of each session. Patients said that they found it difficult to

Are services responsive to people's needs?

(for example, to feedback?)

connect to the surgery on the telephone and some opted to make appointments in person to avoid a long wait on the telephone. The practice had not provided a response to this at the time of our visit.

The practice had a triage system where receptionists would ask patients for information to determine whether an appointment was needed with a GP or the practice nurse. Receptionists received a checklist and set of questions to ask in order to triage the patient to the correct type of appointment. Patients we spoke with said that they were unhappy with this system as they did not want to give information in this way. This information was fed back to the practice who responded that it was an important part of the triage system as it enabled patients to see the most appropriate person and do not have any plans in place to modify the triage process.

Written information was available for patients who presented to make an appointment and a hearing loop was available.

The practice operated a vulnerable patients register. Patients on this register were reviewed at regular intervals by the GP and multi-disciplinary meetings were held to discuss the patient's progress. Those patients that were viewed as high priority were placed on a list and given access to a health professional on the same day if this was required. The practice referred patients to clinics situated within the health centre building and included health visitors, screening services and community nursing teams.

Annual health checks were undertaken for patients who were on the learning disability register.

Concerns and complaints

The practice had a complaints policy which was advertised on the notice board in the reception area and also in the patient leaflet. Complaints and comments were handled by the practice manager and a response was provided within three working days. Patients asked on the day of inspection were aware of the complaints policy but had not made a complaint. Verbal complaints were recorded in the practice manager's diary and the patient contacted to discuss concerns.

We were informed that complaints were discussed in team meetings and used as a basis for staff training. However no evidence of this was available as no minutes of meetings are held.

The practice had an active Patient Participation Group (PPG) who met on a monthly basis to discuss concerns raised within the surgery. The PPG meet with the GP's to discuss concerns and had recently discussed patient concerns about the attitude of members of the nursing staff being rude to patients. This was reviewed by the GP's and the members of staff involved were spoken to and further training offered.

Are services well-led?

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

Summary of findings

The practice had an open and transparent culture and staff told us there was good team working. The practice had leads for clinical governance including safeguarding and prescriptions management.

Systems were in place to monitor performance which included a comparison of Clinical Commissioning Group (CCG) and Quality and Outcome Framework (QOF) data and carrying out clinical audit. However, there was no records of staff appraisals or training.

The practice had an active Patient Participation Group (PPG) that met regularly and took responsibility for the annual patient survey. Feedback from both patient and staff was assessed by the practice manager and reviewed in practice meetings.

Our findings

Leadership and culture

The practice had an open and transparent culture. Staff were aware a of issues being addressed by the practice. There was good team working and all staff were clear about their role and responsibilities and felt valued as employees. The GPs and practice manager met weekly to discuss practice issues and all of the staff met on a fortnightly basis.

Governance arrangements

The practice had assigned persons to take responsibility for different areas of clinical governance. There was a named lead for safeguarding, health and safety and prescriptions management. The practice held weekly clinical governance meetings, attended by the GPs and practice manager.

Systems to monitor and improve quality and improvement

The practice had a system for monitoring performance through comparisons with local Clinical Commissioning Group (CCG) data. The practice learned from complaints, significant events and Quality Outcome Framework (QOF) data to improve services for patients. The practice undertook a schedule of regular clinical audits and had recently completed an audit into the use of medicine over a long period of time. The audit showed that some patients had conditions where new medicine was available but the prescription had remained the same. These patients were contacted and the medication updated.

The weekly governance meetings reviewed data provided by the Clinical Commissioning Group (CCG) was used to benchmark their service. This included comparing the data of inappropriate accident and emergency admissions and how they could be prevented through patient education about the services available at the practice.

Patient experience and involvement

The practice had a patient feedback book in reception for feedback regarding the service. Any issues were followed up by the practice manager and an raised in team meetings. The book contained positive comments about the service.

Are services well-led?

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

The practice has an active Patient Participation Group (PPG) consisting of 22 members representative of all patients on the practice list. The PPG met monthly to discuss service and had developed the patient survey for the last three years.

Patients were invited to take part in the annual online survey produced by the PPG. Following the latest PPG survey in February 2014 of which 282 surveys were completed it was found that patients were positive about the practice but the issue of access through the telephone system was an issue. This led to the PPG being involved in an action plan which implemented more telephone consultations and extended opening hours. However the issue with the telephone system remained as more phone lines were needed which the practice still needed to address.

Staff engagement and involvement

Staff provided feedback directly to the practice manager through informal meetings and in structured team meetings. Staff were aware of the practice whistleblowing policy and how this could be used.

Learning and improvement

The practice had a culture of continued development for staff. Each member of staff received induction training, an annual appraisal and personal development plan (PDP) to identify training needs for the following year. Although staff told us they had received training the training records did not include sufficient information to confirm what training they had received.

All staff were up to date with mandatory training which included governance management and Basic Life Support.

Identification and management of risk

The practice had clear systems in place for identifying and managing risk to patients. This included the use of health and safety risk assessments and clinical audit.

The practice had a business continuity plan which included the moving of a limited number of services to a local hall until the practice was fully functioning.

Up to date health and safety risk assessments for both the internal building areas and equipment were in place to minimise the risk to the health of both staff and patients while in the practice.

Older people

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

Summary of findings

The practice provided an effective service to older people and had a GP that had undertaken further training in the care of older people. Each patient over 75 had their own named GP. Telephone consultations and home visits were available for those unable to attend the practice.

Full health checks were offered including blood pressure monitoring and seasonal flu jab.

Our findings

Each person over 75 was assigned their own named GP. If a patient was unable to attend the practice they were offered a telephone consultation or home visit.

Older people received a full annual health check which included monitoring of their blood pressure and any long term conditions. A seasonal flu jab was also offered.

One of the GP's had a special interest in elderly care and had undertaken further training in the management of health in older people such as the early diagnosis of dementia.

People with long term conditions

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

Summary of findings

Patients received a service that was responsive to their needs. Routine health checks were carried out to avoid unnecessary hospital admissions. Care plans were developed to enable self-management of conditions. Periodic meetings were held between GP, patient and their carer to review the care plan.

The practice worked closely with other care providers within the health centre to provide clinics aimed at effectively managing long term conditions such as asthma and diabetes.

Our findings

Support was given to patients with long term conditions and their carers by the practice. Routine health checks were carried out by the practice nurse. A consultation with the GP was made if there was a significant change in their condition.

The GP's worked closely with patients and their carers to develop a care plan to support patients and enable them to self-manage their conditions. Periodic meetings were held with the patient and carer to review the care plan to ensure appropriate support was given.

The practice worked closely with community nurses for those patients that were receiving long term palliative care. The practice also worked closely with service providers within the health centre to refer patients to clinics for Chronic Obstructive Pulmonary Disease (COPD), diabetes and asthma. Newly diagnosed diabetics were also referred to a local diabetes educational support group.

Mothers, babies, children and young people

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

Summary of findings

Mothers, babies, children and young people received a service that was responsive and had arrangements in place to meet patient needs.

Immunisations were provided for children and sexual health advice for young people. .

Families at risk and in need of further care were discussed in multi-disciplinary meetings between health visitors, social services and the practice.

Our findings

We found that the practice had access to health visitors and community midwives within the health centre where patients could be referred to by the GP. The practice also ran a full child immunisation programme and regular child development checks which included pre-school checks.

The practice were involved in multi-disciplinary meetings with health visitors and social services to discuss families that were judged to be at risk. The practice held a register to ensure that these families were monitored and the appropriate support given.

A sexual health clinic was operated by the practice. Patients were referred by the GP to this service. The clinic offered sexual health and advice and screening for sexually transmitted infections including chlamydia.

Working age people (and those recently retired)

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

Summary of findings

Working age people (and those recently retired) received services that were responsive to their need. The practice provided a flexible appointments system which included telephone consultations and evening appointments.

A telephone system for requesting doctors notes was available and a choice of referral to other services was available.

Our findings

The practice offered a flexible appointment system which included extended opening hours in the evening to allow those patients that work to attend the surgery. Same day telephone consultations were available and patients were able to book an appropriate time for a call back from the GP. Follow up consultations at the surgery were arranged at a mutually convenient time.

Patients were offered a flexible referral system which allowed referral appointments to be offered closer to where they worked if it was more convenient to do so.

For patients who were unable to work and were in need of a doctor's certificate, a telephone request service was offered. Patients could collect the certificate once authorised by the GP.

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

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

Summary of findings

Patients in vulnerable circumstances received a service that was responsive and had arrangements in place to meet patient's needs. All people were able to register but for those who did not wish to, the practice provided advice which included how to access community health services and emergency treatment.

The practice worked with carers to discuss patient care and were involved in multi-disciplinary meetings to discuss complex cases.

The practice offered annual health checks to those with a learning disability and held registers for those with a learning disability, patients with a vulnerable disease and a high priority patient list.

Our findings

The practice had a policy in place to refer patients who had no fixed abode to community health services. However the GP's would provide advice and any emergency treatment needed.

Patients with learning disabilities were offered double appointments in order for the patient and GP to discuss health concerns without being rushed. Carers were invited to meetings to discuss a patients care and treatment needs and the practice was involved in multi-disciplinary meetings to discuss complex cases. The practice had a learning disability register and annual health checks are provided to patients on the register.

The practice had a vulnerable disease register in place. Patients who were on this register were reviewed at regular intervals both through meetings with their carer and in multi-disciplinary meetings. The practice also had a high priority list which comprised of mainly cancer patients which enabled same day access to health professionals if required.

People experiencing poor mental health

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

Summary of findings

People experiencing a mental health problem received a service that was responsive and met patient need. The practice carried out a full health assessment prior to referring a patient to local mental health teams. The GP continued to be involved in the patient care through regular health checks and involvement in multi-disciplinary meetings.

Our findings

The practice had some procedures in place to meet the needs of people experiencing poor mental health including a named GP to allow consistency of care, patient confidentiality policy and referral policy.

The practice worked closely with local community mental health teams. GP's provided a full health assessment prior to patients being referred to the community mental health team. Once referred the GP continued to provide support and we were provided with minutes of a multi-disciplinary meeting where the GP provided regular health updates.

Staff at the practice showed good awareness of the Mental Capacity Act 2005 and their obligations under it.