Leybourne Surgery

Quality Report

1 Leybourne Avenue,
Ensbury Park,
Winton,
Bournemouth,
Dorset
BH10 6ES
Tel: 01202 527003
Website: www.leybournesurgery.co.uk

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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

Leybourne Surgery is a GP practice situated in the North of Bournemouth and has approximately 3,900 registered patients. The practice provides a range of services for patients.

We spoke with patients about their experiences of care at this practice and also received written feedback from patients about the quality of services. The majority of patients gave positive feedback about the practice and staff. We reviewed the results of the last patient survey undertaken in 2014. This showed patients were consistently pleased with the service they received.

Leybourne surgery was patient-focused in its approach to care and treatment. It provided information and support to help patients understand their care and treatment and help them make informed choices. The practice ran a number of specialist clinics to help patients manage their long term conditions. Patients were treated kindly and with dignity and respect. There was clear leadership within the practice, with a focus on learning from incidents and events and continuous professional development. The practice actively sought comments and feedback from patients and acted on these to improve 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 was safe. The practice had effective infection control and medicines management procedures in place. There was an embedded culture of learning from incidents and accidents to improve patient care and the practice had robust internal safeguarding procedures to protect patients at risk of abuse. The practice proactively identified and monitored clinical risks to patients. However, the practice did not regularly identify and review environmental risks and business risks.

Are services effective?

The practice was effective. The practice delivered care and treatment in line with recognised best practice and worked with other support services to provide a holistic service to patients. Staff received the necessary training and development for their role. There was a proactive approach to using data to analyse and improve outcomes for patients. There had been a range of clinical audits which had resulted in improvements to patient care and treatment. There were robust recruitment procedures in place.

Are services caring?

The practice was caring towards patients. Staff put patients at the heart of their work. We saw that staff provided compassionate care and treated patients with dignity and respect, and patients confirmed this. The practice encouraged patients to be informed by providing explanations when required and through written information. Patients were involved in making decisions about their care and treatment. The GPs were aware of how to support patients who lacked capacity to provide consent. The practice did not always make use of local services to support patients with specific communication needs.

Are services responsive to people's needs?

The practice was responsive to patients needs. There was an open culture within the organisation, and the practice actively asked patients and staff for suggestions to improve the practice and implemented changes. The practice understood the different needs of the population it served and acted on these to ensure the service supported patients appropriately.

Are services well-led?

The practice was well led. Staff were clear about what decisions they were required to make within their areas of responsibility. The lead GP was a strong and visible leader and empowered staff to take on

Summary of findings

responsibility. The practice encouraged ongoing development for clinicians and administrative staff. There were effective communication channels in place for staff. The practice encouraged feedback from patients and learned from feedback when it was given. Governance structures for clinical areas were robust. However, systems for managing environmental and business risks needed to be reviewed and updated.

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 operated a system where patients who were 74 years old and above were allocated a named GP. The GP had specialist end of life care training and remained involved in palliative care for patients. The practice worked closely with the community nursing team and palliative care team to ensure good provision of end of life care. The GPs conducted home visits and visited patients at a local nursing home.

People with long-term conditions
The practice offered a range of clinics run by specially trained nurses for patients with long term health conditions. Patients were provided with information and support to manage their conditions. The practice had a proactive approach to identifying patients with long term conditions and ensuring they received necessary care and treatment. The practice offered a range of clinics run by specially trained nurses for patients with long term health conditions. Patients were provided with information and support to manage their conditions. The practice had a proactive approach to identifying patients with long term conditions and ensuring they received necessary care and treatment.

Mothers, babies, children and young people
The practice offered clinics for pregnant women and mothers and babies. Staff worked closely with the local health visitors to identify children who were at risk and ensure they received appropriate care and treatment. Staff demonstrated a caring and respectful attitude to this population group.

The working-age population and those recently retired
The practice offered late appointments on a Monday and telephone appointments to ensure patients who worked were able to access advice, care and treatment. Staff had educated themselves about obesity and the care and treatment options available for obese patients.

People in vulnerable circumstances who may have poor access to primary care
Staff described how they offered care and support to patients who had no fixed address. The practice had a system to ensure patients with a learning disability were identified and received an annual health check. Staff showed a caring, respectful approach to patients in vulnerable circumstances.

Summary of findings

People experiencing poor mental health

The practice worked with local mental health services to ensure patients were well supported. Staff were educated and informed about local support services and provided information to patients. The appointment system enabled patients with poor mental health to be seen quickly. If patients took medications that were prescribed for mental health and presented a risk to the heart, they were supported to maintain good health through appropriate health checks.

Summary of findings

What people who use the service say

We spoke with 15 patients on the day of our inspection and received online feedback from five patients in the two weeks leading up to our inspection. We also received three comments cards from patients who had visited the practice in the previous two weeks. Generally, patients were complimentary of the staff and the care and treatment they received. In particular, feedback from patients about the reception staff was very positive, including that they were friendly, helpful and supportive. The majority of patients told us they had enough time to discuss their concerns and were given information and support to understand their condition and the treatment options.

There was mixed feedback from patients about getting appointments. Some patients told us they appreciated always being able to get an appointment on the day they called. Other patients told us it was frustrating that they were often not able to book appointments in advance. In particular, patients found it difficult to get through on the telephone in the morning to book an appointment.

The practice results for the national GP patient survey were higher than average for the local Clinical Commissioning Group (CCG) and higher than the national average. Overall 91% of patients said they would recommend their GP practice and 91% rated their experience of making an appointment as good or very good.

Areas for improvement

Action the service MUST take to improve

- Risk assessments must be undertaken to identify whether staff require a criminal records check via the Disclosure and Barring Service to ensure that patients are not at risk from staff who are not suitable to work with vulnerable patients.

Action the service COULD take to improve

- The practice could improve the availability of information for patients about how to complain.
- The practice could improve access by telephone in the morning for patients who wish to book an appointment for that day.

Good practice

Our inspection team highlighted the following areas of good practice:

- There was an extensive history of significant event analysis and learning from incidents to improve the practice.

Leybourne Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP. The team included a practice manager and another CQC inspector.

Background to Leybourne Surgery

Leybourne Surgery is located in the north of Bournemouth. The practice occupies a converted house. A local pharmacy is situated opposite the building.

The practice provides a range of primary medical services to approximately 3,900 patients. Patients are supported by two GPs, three nurses, a phlebotomist (someone who is trained to take blood samples) and administration staff. The practice is a member of the Dorset Clinical Commissioning Group (CCG).

Why we carried out this inspection

We inspected this GP practice as part of our new inspection programme to test our approach going forward. This practice 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 GP practice and asked other organisations to share their information about the service.

We carried out an announced visit on 3 June 2014 between 9am and 5pm.

As part of the inspection we looked at management records as well as policies and procedures. We observed how staff cared for and interacted with patients and spoke with patients about their experiences of care at the practice. We also spoke with a range of staff, including GPs, nurses, a phlebotomist and administrative staff.

Are services safe?

Summary of findings

The practice was safe. The practice had effective infection control and medicines management procedures in place. There was an embedded culture of learning from incidents and accidents to improve patient care and the practice had robust internal safeguarding procedures to protect patients at risk of abuse. The practice proactively identified and monitored clinical risks to patients. However, the practice did not regularly identify and review environmental risks and business risks.

Our findings

Safe patient care

The practice had an incident reporting process which was included in the staff handbook. Staff we spoke with described how they would respond to and report safety-related incidents and told us they felt able to do so.

The GP told us that when they received MHRA alerts (medical alerts about drug safety) they searched their patient records to check whether any patients would be affected, to ensure they took appropriate actions to protect patients. The lead GP also shared medical alert information with other clinical staff in the practice.

Learning from incidents

The practice had a robust procedure to review significant events. We saw records of significant events that had been analysed. It is important that services analyse significant events so that they can prevent similar incidents from occurring in the future. The significant event analysis records had been fully completed with clear action plans and staff leads who were accountable for ensuring actions were implemented. The practice held regular significant event analysis meetings to ensure that learning was shared and records of these meetings were kept. During the meetings the actions from previous events were reviewed and new significant event records were analysed. We saw several examples where patients had been contacted and given an apology as a result of the event and an explanation of what would be done to resolve it and prevent similar incidents in the future. We did not find any concerning patterns of significant events. Learning from significant event reviews was discussed and recorded at practice meetings.

Safeguarding

Children and adults were protected from the risk of abuse because the practice took reasonable steps to identify and prevent abuse from happening. There were systems in place to identify patients who may be at risk of abuse. For example, the practice maintained a list of 'looked after children' ('looked after children and young people' is generally used to mean those looked after by the state).

All staff had received an appropriate level of training for protecting vulnerable children and adults. The practice safeguarding policies and flow charts displayed in the office and surgeries provided guidance to staff on how to

Are services safe?

raise safeguarding concerns. We spoke with staff about identifying and preventing abuse. They had a good understanding of the different types of abuse and were able to describe the procedure to be followed if they suspected or witnessed any concerns. All staff said they would raise their concerns with the GP safeguarding lead. The practice provided safeguarding information for patients in the waiting room about how to respond to concerns involving abuse.

Monitoring safety and responding to risk

The practice did not always have a robust approach to identifying and responding to risks. There was a business continuity plan, but this was not regularly reviewed and updated. Senior staff told us what the plans were if the practice premises became unavailable, but these were not documented. There was a risk that if senior staff suddenly became unavailable the practice would not be able to offer a service to patients. The practice had a corporate risk register within its business continuity plan. However, this was not completed or regularly reviewed.

The practice had undertaken fire drills, completed a fire risk assessment and there was a maintenance contract in place for fire extinguishing equipment. Staff we spoke with were aware of how to respond in the event of a fire.

We spoke with staff about maintenance of the premises. There were contracts in place to maintain heating, electrical and water systems. Any safety concerns or maintenance requirements were logged in a book, which was reviewed by the lead GP.

Medicines management

Safe management of medicines was mostly in place. Two senior nurses were responsible for the management of medicines within the practice and there were up-to-date medicines management policies. Staff we spoke with were able to show us where medicines were stored and explain their responsibilities. However, medicines were not always kept securely. Emergency medicines were kept in a clinical treatment room in a cupboard that was not locked. The nurse told us the cupboard was unlocked when the room was unattended. Expiry date checks were undertaken regularly and recorded. Fridge temperatures were also checked daily to ensure medications were stored at the correct temperatures. The practice did not hold any controlled drugs on the premises.

The practice intranet contained up-to-date information on prescribing advice. We spoke with administrative staff and the GPs about repeat prescribing. All staff consistently described the correct repeat prescribing system. We were told the practice IT system blocked repeat prescription requests if there was over-ordering of medication by patients. The GP told us 'strong medication' such as morphine was not routinely available on repeat prescription, unless there was a detailed management plan in place and the GP had reviewed this with the patient.

Cleanliness and infection control

Effective systems were in place to reduce the risk and spread of infection. The practice had an infection control lead and appropriate infection control policies and procedures. An infection control audit had been completed. Most of the actions from the action plan were completed, but we noted that an action for an additional task to be added to the cleaning schedule was not completed.

The senior nurse, who was the infection control lead, undertook specialist training and attended external infection control meetings. Staff told us and records confirmed that the infection control lead updated other staff at regular practice meetings. All clinical staff had recently taken part in an infection control knowledge and skills quiz. The infection control lead had completed a hand washing audit for all staff within the last 12 months and found good infection control techniques were used.

Three practice nurses had recently completed an aseptic (under sterile conditions) techniques competency document and we saw records of these. The practice had ensured that it met the requirements outlined in Department of Health's publication, The Code of Practice for health and adult social care on the prevention and control of infections and related guidance (2009). Hand washing guidance was available above most sinks in the treatment rooms and toilets. There were wall mounted soap dispensers and hand towels at every sink throughout the practice. Staff had a good supply of gloves and other personal protective equipment and knew when they should be used.

Patients were cared for in clean and hygienic environment. We noted all areas of the practice were visibly clean and tidy and the treatment and consulting rooms had clutter free work surfaces, which were easy to clean. We looked at the practice cleaning schedule and the treatment room

Are services safe?

cleaning schedules and found them to be in line with the code of practice. Seats in the waiting room had surfaces which were easy to wipe clean. Cleaning records were completed on a daily and fortnightly basis.

We spoke with patients about the cleanliness of the practice. All of them told us they were happy with the environment and cleanliness.

Staffing and recruitment

Clinical staff had undergone criminal record bureau (CRB) or disclosure and barring (DBS) checks before they started work. The practice had not assured themselves that staff undertaking chaperone duties were suitable to work with vulnerable adults and children. Some non-clinical staff who acted as chaperones had not undergone a CRB/DBS check, nor had the practice carried out a risk assessment in relation to the role. Not all staff who were chaperones had received training for the role. The chaperone procedure that staff described to us was not consistent with the practice's chaperone policy.

The practice had a checklist for pre-employment checks for locum GPs. Most of the required information was held on file for locum GPs who the practice had employed in the past. Missing information included some references and regular checks of GP registration with the General Medical Council. The practice told us these records would be revisited to ensure that all aspects of the checklist had been completed and documents were held on file.

Dealing with emergencies

Appropriate equipment and drugs were available for use in a medical emergency. The practice had identified a need to purchase oxygen for use in an emergency and an order had been placed for delivery after our inspection. The emergency drugs and automated external defibrillator (AED) were checked regularly to ensure they were in date and in working condition. We saw evidence of these checks. Staff had received recent basic life support training.

Equipment

We saw records to demonstrate that practice equipment was regularly checked and maintained.

Are services effective?

(for example, treatment is effective)

Summary of findings

The practice was effective. The practice delivered care and treatment in line with recognised best practice and worked with other support services to provide a holistic service to patients. Staff received the necessary training and development for their role. There was a proactive approach to using data to analyse and improve outcomes for patients. There had been a range of clinical audits which had resulted in improvements to patient care and treatment. There were robust recruitment procedures in place.

Our findings

Promoting best practice

Care and treatment was delivered in line with recognised best practice standards and guidelines. The practice ensured staff kept up to date with new guidance, legislation and regulations. The lead GP explained how they kept abreast of updated guidelines and standards and disseminated this information to staff within the practice. Clinicians followed the relevant National Institute for Health and Care Excellence (NICE) guidelines for long term condition management.

The practice had a Mental Capacity Act 2005 (MCA) policy to provide guidance for staff supporting patients with diminished mental capacity. The GPs had undertaken training in relation to the MCA and were consulted by other clinical staff about patients capacity to consent. We found the nursing staff we spoke with did not have a clear understanding of the MCA and how this impacted on their role. However, they told us they would seek advice and support from the GP if they had any concerns over a patients capacity to consent. The meant that patients who were unable to make decisions about their care and treatment would be protected.

Management, monitoring and improving outcomes for people

The practice achieved high results in all domains of the Quality and Outcomes Framework (QOF) in 2012/13. The QOF was introduced in 2004 as part of the General Medical Services Contract. It is a voluntary incentive scheme for GP practices in the UK, rewarding them for how well they care for patients. The lead GP at Leybourne Surgery described how they used data from the QOF and local enhanced services to ensure appropriate health checks were offered to patients.

We looked at a comprehensive range of clinical audits, which were held centrally on the practice intranet. Follow-ups of audits demonstrated that the practice took effective action to improve patient care and treatment. For example, a full audit cycle in relation to antibiotic prescribing had been conducted in 2013/2014. Audit results found that actions the practice had taken led to improvements in the management of antibiotic prescribing..

Are services effective?

(for example, treatment is effective)

Staffing

The practice had a range of comprehensive recruitment and selection policies and effective processes were in place to ensure patients were supported by suitably skilled, qualified and experienced staff. We looked at staff files, which mostly contained information on pre-employment checks and mostly met recruitment guidelines. Some information was missing, for example none of the staff files contained a signed confidentiality agreement, which was a practice policy. We were told the selection and interview process followed policies for equal opportunities and diversity.

We found there was effective induction training in place for recently recruited staff and records of induction were held on file. Staff we spoke with told us about the induction process they had completed at the start of their employment with the practice. This was in line with the practice induction procedure. A nurse told us their clinical competence had been assessed when they first joined the practice and before they provided care and treatment to patients.

Staff told us they had undertaken essential training including basic life support, safeguarding of vulnerable adults and children, and infection control. We saw a selection of training records which showed evidence that mandatory training was provided.

Continuing professional development and training was available for clinical staff. Training was identified from staff appraisals and linked to personal development plans. Staff we spoke with told us about the training they had undertaken. One nurse told us they had completed a Diploma in COPD (chronic obstructive pulmonary disease – lung disease), which had enabled them to run the specialist clinic at the practice.

Working with other services

The practice proactively engaged with other health and social care providers to coordinate care and meet patients needs. The lead GP regularly invited external speakers from other health and social care providers to present at practice meetings and to ensure staff were aware of services to which they could refer patients.

The GPs and nurses were involved in monthly multi-agency 'admission avoidance meetings'. At these meetings clinicians discussed patients who were at risk of being admitted to hospital. The aim of these meetings was to identify how health and social care services could work together to support patients who were at risk to remain safe and in good health.

The GP explained how they maintained responsibility for end of life care for patients. When providing end of life care they sought specialist palliative advice and support from the local Macmillan service and community nurses. Patients we spoke with whose relative had received end of life support from the practice were complimentary about the service they received.

The practice ensured correspondence from other health services was promptly reviewed and attached to electronic patient records. We saw records to confirm that GPs read correspondence when it first arrived at the practice. We were told the information was usually attached to the electronic patient records within 48 hours of being received. This enabled clinical staff to remain up to date with patients care.

Health, promotion and prevention

The practice had developed a number of patient letter templates containing self-help advice in relation to a number of medical conditions. These included links to relevant websites and support groups along with information about the condition.

Health promotion information was presented on a television screen in the waiting area and included information about salt in the diet, smoking, obesity and dental health. There were also some health promotion leaflets within the reception area, although these were not well organised or clearly displayed. Suggestions from the recent patient survey action plan included tidying and organising the patient information leaflets. The completion date for the action had been reached at the time of our inspection. There was information available to patients to direct them to local support groups.

Are services caring?

Summary of findings

The practice was caring towards patients. Staff put patients at the heart of their work. We saw that staff provided compassionate care and treated patients with dignity and respect, and patients confirmed this. The practice encouraged patients to be informed by providing explanations when required and through written information. Patients were involved in making decisions about their care and treatment. The GPs were aware of how to support patients who lacked capacity to provide consent. The practice did not always make use of local services to support patients with specific communication needs.

Our findings

Respect, dignity, compassion and empathy

The practice had a clearly embedded culture of providing a caring, friendly and helpful service. All staff we spoke with told us patients were their priority and providing a caring and supportive service was their aim. Patients were complimentary about the way staff treated them with dignity and respect. They also told us their privacy was respected during consultations. We observed staff treating patients with dignity and respect during our inspection and making sure patients were assisted as a priority before other business related tasks. Staff told us they prided themselves on working for a small practice where they were able to get to know the patients individually and develop supportive relationships with them.

The practice had developed a detailed end of life supportive care template for planning end of life care. This included a variety of information including a section about patients spiritual needs. This document supported staff from a variety of services to provide end of life care and treatment in the way that patients wanted.

Involvement in decisions and consent

Patients we spoke with told us they were involved in making decisions about their care and treatment. We spoke with the GPs about how they involved patients. We were told patients were given all the information they needed to enable them to make informed decisions about treatment. This included information about the implications of not having treatment. We were told patients were able to choose between treatments or refuse treatment. However, if patients refused treatment the lead GP told us they would try and empathise with the patient and understand the reasons why they did not want to take up treatment. The practice operated a 'choose and book' system, which meant patients were able to choose where they wanted to be referred to for specialist care and treatment.

We spoke with staff about the communication needs of their patients and whether any communication aids were ever used. Staff told us the patients they saw who had a learning disability were able to communicate verbally with ease. We were told a patient who was deaf usually

Are services caring?

communicated in writing. Staff were unaware of local support services which could provide translation or signing services for patients and, therefore, did not offer these services to patients.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The practice was responsive to patients needs. There was an open culture within the organisation, and the practice actively asked patients and staff for suggestions to improve the practice and implemented changes. The practice understood the different needs of the population it served and acted on these to ensure the service supported patients appropriately.

Our findings

Responding to and meeting people's needs

The practice understood its patient population group and was responsive to their needs. New patients registering at the practice completed a registration form that gathered comprehensive details of their health and lifestyle choices. All new patients were offered an appointment either in person or over the phone. The lead GP told us they used the registration form and initial appointment to identify patients who were at risk or required specific support with a long term condition. Staff demonstrated an understanding of their patient population group and knew they had a larger than average number of elderly patients. They had undertaken work to identify patients who were carers, so they were able to offer support to these people. Two members of staff, one clinical and one administrative, had taken lead roles for patients who were carers and were proactively engaged with identifying and supporting this patient group. For example, the practice was using a prescription pad to collect information and contact details for carers. These details were passed from the GP to the administration lead for carers so they could make contact with carers and offer support.

The practice environment had been adapted to accommodate a variety of patient needs. There was wheelchair access and toilet facilities and the waiting room offered seating that was accessible to patients with restricted mobility. However, there were no arrangements to support patients with particular communication needs, for example, translation or signing services. There was a risk that patients who did not speak English as their first language or patients who were deaf may not receive appropriate support to enable them to communicate with staff and understand their care and treatment.

There was a range of health-related information for patients available in both the waiting room and on the practice website. For example, we found information explaining how patients could access out-of-hours care. Patients we spoke with understood where they could access advice and support when the practice was not open.

The practice was aware of and had links with a variety of other healthcare services to support its patients. Staff had

Are services responsive to people's needs?

(for example, to feedback?)

links with specialist nurses in learning disabilities, mental health and long term conditions. They were also able to refer patients to the local drug and alcohol support service and mental health service.

Access to the service

The practice operated an appointment system where the majority of appointments were booked on the day. There was an hour at the start of each day when GP appointments as well as Monday evening. There were three GP appointments on a Tuesday afternoon which patients could book online. The rest of the available GP appointments were reserved for patients calling on the day. Nurse appointments could be booked in advance for any day or time. The practice offered late appointments on a Monday and telephone appointments to ensure patients who worked were able to access advice, care and treatment. Patients gave us mixed feedback about the appointment system. Some felt it was positive that they were always able to book an appointment on the day, whilst others felt it would be better to have more appointments that could be booked in advance. The majority of patients we spoke with did not know that appointments could be booked in advance. Some patients expressed frustration that they were unable to get through on the phone during the morning to book an appointment for that day. The GPs acknowledged that the appointment system was one of their biggest problems and they were conscious that they needed to review it. The most recent patient survey had focused on the appointment system and access to the GPs and nurses. The results of the survey had identified largely positive feedback from patients about the appointment system.

Patients who phoned to request an appointment were able to speak with a GP that day if they did not receive an appointment. The lead GP felt it was important to identify why patients were phoning for appointments and look at ways of reducing the need for patients to attend the practice if it was not necessary. Patients expressed satisfaction with their telephone access to GP advice and support.

They told us it was often difficult to book an appointment with the nurse. On the day of our inspection the nurse's clinic was running late and we were told nurse clinics were generally fully booked. We asked how the practice how it identified what patients needs were in respect of nurse appointments. We were told it had not specifically looked at the nursing appointment times and skill mix to ensure available appointments met the needs of patients.

Patients who found it difficult to access the practice premises were provided with access to care and treatment. The practice told us it often conducted home visits for patients who required them and also visited patients in a local nursing home.

Concerns and complaints

The practice had a proactive approach to seeking feedback from its patients. Patients were able to leave comments and suggestions on the practice website. The practice also undertook an annual patient satisfaction survey and reviewed comments left on the NHS choices website. There was a practice complaints procedure and the practice maintained a 'grumbles book' to log informal complaints.

The practice had only received one formal complaint. This had been addressed in line with the practice's complaints procedures. The patient had received a written apology and the practice staff had discussed the complaint in order to learn from it. We reviewed the 'grumbles book' and saw informal complaints were logged along with details of what action was taken. Each entry was always reviewed by a GP.

We spoke with patients about making a complaint. Patients told us they did not have a need to make a complaint, but also said they did not know how to make a complaint. We could not find any information for patients relating to the practice complaints procedure in the waiting room.

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 was well led. Staff were clear about what decisions they were required to make within their areas of responsibility. The lead GP was a strong and visible leader and empowered staff to take on responsibility. The practice encouraged ongoing development for clinicians and administrative staff. There were effective communication channels in place for staff. The practice encouraged feedback from patients and learned from feedback when it was given. Governance structures for clinical areas were robust. However, systems for managing environmental and business risks needed to be reviewed and updated.

Our findings

Leadership and culture

We spoke with staff about the ethos of the organisation. They consistently told us their focus was to provide a caring, friendly and supportive service with patients at the heart of their work. The lead GP provided clear leadership within the practice and empowered staff to undertake additional activities. For example, the lead GP held regular staff meetings for the whole practice and for different staff groups. Minutes of these meetings demonstrated clear actions were agreed and named staff were accountable for actioning them. Staff we spoke with told us the practice worked well as a team.

We spoke with the lead GP about their long term strategy for the practice. They told us they attended the locality group meetings within the local clinical commissioning group (CCG) and met with a group of local practices to discuss the long term vision and future of primary care in the area. Staff we spoke with were unsure of the long term strategy for the practice. The practice had a plan in place for developing the administration and reception team. This plan identified tasks which needed to be completed by different members of staff. It was linked to staff training needs in order to improve the reception function.

Governance arrangements

The practice was small but had leaders in nursing and reception. The senior nurse and senior receptionist had designated responsibilities. For example, the nurse was responsible for infection control and determining which vaccines were required. The practice had also appointed other leads such as safeguarding. All staff we spoke with knew how and who to approach for advice if a concern arose. Most of the policies and procedures we reviewed were in date and had been regularly reviewed.

Systems to monitor and improve quality and improvement

The practice used available data, for example from QOF (Quality Outcomes framework), to identify areas for improvement. For example, staff found the practice had a higher than average A&E attendance rate for its patient group. Staff investigated the reasons for this and contacted patients to enquire whether any support from the practice was required.

Are services well-led?

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

The practice operated an effective staff performance management system. Staff received an annual appraisal which was linked to their performance development plan. Where poor performance had been identified, it was addressed with the member of staff concerned. Staff were able to give an example of a member of staff who had been dismissed recently due to performance issues.

Patient experience and involvement

The practice had a patient participation group (PPG). A PPG is a group of patients registered with the practice who have an interest in the services provided. The aim of the PPG is to represent patient views, to work in partnership with the practice, and to improve the services patients receive. We spoke with the coordinator of the PPG. The group was involved in agreeing the questions for the annual patient survey and reviewing the resulting action plans. The practice website encouraged patients to join the PPG. At the time of our inspection the PPG was not used for collating and providing feedback outside of the annual patient survey.

The practice encouraged patients to provide comments or suggestions through its website and maintained a 'grumble' book in the reception area to record informal complaints. Each entry was clearly documented, addressed and reviewed by a GP. Where a formal complaint was made it was resolved in line with the practice procedure. The practice responded to comments left on the NHS choices website and reflected on these to improve patient care and treatment. Patient comments and complaints, along with actions from the patient survey, were discussed and reviewed at staff meetings.

Staff engagement and involvement

Staff we spoke with told us the practice had an open and transparent culture. Staff felt listened to and confirmed that their views were acted upon. The lead GP held regular practice, reception team, and clinical team meetings. These meetings had clear agendas which staff told us they could add to. We looked at minutes of these meetings and found they included a comprehensive range of clinical and non-clinical topics and a variety of learning and development opportunities.

Learning and improvement

All staff had regular training and development opportunities. Staff had annual appraisals to discuss areas in which they needed support in order to develop their knowledge and skills. These were linked to personal development plans. Staff we spoke with told us the practice encouraged staff to seek further training and made good use of protected learning time for staff. Training was also included as part of the regular staff meetings. Staff had access to new legislation and changes through team meetings and updates were cascaded electronically.

Identification and management of risk

The practice had a proactive approach to the identification and management of patient risks. For example, through attending regular admission avoidance meetings. However, the practice had not regularly reviewed and updated business risk assessments. For example, the business continuity plan and risk register.

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 operated a system where patients who were 74 years old and above were allocated a named GP. The GP had specialist end of life care training and remained involved in palliative care for patients. The practice worked closely with the community nursing team and palliative care team to ensure good provision of end of life care. The GPs conducted home visits and visited patients at a local nursing home.

Our findings

Safe

All staff had received safeguarding of vulnerable adults training and were able to describe how they would identify suspected signs of neglect in elderly patients and report this appropriately.

Caring

The practice had a system to ensure every patient aged 74 and above had a named GP within the practice. Patients we spoke with who had a named GP told us this was beneficial for their health and wellbeing. The practice had undertaken recent work to identify patients who had caring responsibilities. Staff told us they did this to ensure carers were offered support and signposted to external support services.

Effective

The practice had close working relationships with the community nursing team. Staff told us they received regular updates from the community nurses regarding care of elderly patients in their own homes.

Responsive

Practice staff were aware they had a higher proportion of elderly patients than average for their clinical commissioning group area. Staff told us when elderly patients needed somebody to help them visit the practice they would ensure an appointment could be booked in advance, at any time of the day. This was to ensure the patient was able to make advance arrangements. The GPs undertook home visits and visited the local nursing home.

Well-led

The practice held proactive 'admission avoidance' meetings to ensure patients remained well and safe. The meetings identified elderly patients who were at risk of being admitted to hospital and ensured they were appropriately supported by a range of health and social care services.

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

The practice offered a range of clinics run by specially trained nurses for patients with long term health conditions. Patients were provided with information and support to manage their conditions. The practice had a proactive approach to identifying patients with long term conditions and ensuring they received necessary care and treatment.

Our findings

Safe

Nurses attended regular training in relation to the specialist long term condition clinics they offered. This enabled them to provide patients with up-to-date information about their condition and their medications. For example, one nurse told us they were educating patients with COPD (lung disease) about keeping their 'rescue medication' at home to keep them safe.

Caring

Staff put patients at the heart of their work. We saw that staff provided compassionate care and treated patients with dignity and respect, and patients confirmed this. The practice had undertaken recent work to identify patients who had caring responsibilities. Staff told us they did this to ensure carers were offered support and directed to external support services. The practice helped patients to manage their conditions by providing written leaflets and information.

Effective

The practice ran clinics for patients with diabetes, COPD and asthma. These clinics were delivered by the practice nurses who had undertaken specialist training. The diabetes clinic often involved a specialist external diabetes nurse. The nurse told us they talked with patients about managing their long term health condition and developed management plans with patients. The GP told us they did not run clinics for other conditions because they did not have a high enough number of patients. The GPs managed other long term conditions with the individual patient.

Responsive

The lead GP explained how they used QOF data and medication review appointments to identify patients who required additional support with long term conditions.

People with long term conditions

Well-led

The practice had identified nurse leads for some long term conditions. For example, diabetes and COPD (lung disease). The nurses who held these lead roles were well supported with training and development and knew what their responsibilities were for relevant patient groups.

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

The practice offered clinics for pregnant women and mothers and babies. Staff worked closely with the local health visitors to identify children who were at risk and ensure they received appropriate care and treatment. Staff demonstrated a caring and respectful attitude to this population group.

Our findings

Safe

Staff had training in relation to safeguarding of children and knew how to identify and report suspected abuse. The practice had good working relationships with local health visitors and held meetings to discuss children who were at risk. A member of reception staff took a lead role for child immunisations and highlighted any concerns to the health visitor if there was non-attendance for immunisations. The practice record system highlighted children who were on a child protection plan.

Caring

Patients we spoke with told us the staff were good at communicating with young patients and explaining care and treatment options to them.

Effective

The practice had good working relationships with local health visitors and the community midwives. Patients were provided with appropriate support and joined up care as services worked together to provide them with consistent care and treatment that met their needs.

Responsive

The practice hosted a midwife clinic on a Tuesday morning for pregnant women and mothers and babies. Appointments for this service were bookable in advance.

Well-led

Safeguarding of vulnerable children was discussed at regular staff meetings. We saw records of these meetings. This ensured staff would be alerted to concerns and were aware of how to report them.

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

The practice offered late appointments on a Monday and telephone appointments to ensure patients who worked were able to access advice, care and treatment. Staff had educated themselves about obesity and the care and treatment options available for obese patients.

Our findings

Safe
The practice had robust infection control and medicines management procedures to protect patients. There were effective systems in place to ensure that vulnerable adults were protected from abuse.

Caring
Staff put patients at the heart of their work. We saw that staff provided compassionate care and treated patients with dignity and respect, and patients confirmed this.

Effective
The lead GP had recently invited a gastric surgeon to speak at a practice meeting to educate clinical staff about obesity and the care and treatment options available for patients.

Responsive
The practice offered appointments until 7.30pm every Monday evening. Some of these were bookable in advance. This ensured patients could access the GP and nurse outside of normal working hours. The practice also offered a number of bookable telephone appointments and responded to requests for a telephone call on the day. This ensured patients who were working were still able to access advice and support.

Well-led
The lead GP was a strong and visible leader and staff had clear responsibilities. The practice encouraged continual learning and improvement through patient feedback, significant event analysis and training and development opportunities.

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

Staff described how they offered care and support to patients who had no fixed address. The practice had a system to ensure patients with a learning disability were identified and received an annual health check. Staff showed a caring, respectful approach to patients in vulnerable circumstances.

Our findings

Safe

All staff had training in safeguarding vulnerable adults. Staff we spoke with knew how to identify suspected abuse and where to report it to. The practice had a safeguarding lead.

Caring

We spoke with staff about how they would treat patients with a learning disability. Staff told us they would treat them with the same respect they would show all other patients. They said they would give patients with learning disabilities additional time when speaking with them and, if necessary, involve their carer to support with communication.

Effective

The practice had a system in place to identify patients with a learning disability and to ensure GPs arranged annual health checks for these patients. The GPs used a nationally recognised template to ensure comprehensive health checks were undertaken.

Responsive

We spoke with reception staff about patients who did not have a fixed address within the practice local area. Reception staff told us about some patients who did not have a fixed address but who attended the practice when they required medical care and treatment. Staff told us they never turned patients away who required urgent treatment. They also tried to keep in touch with patients so they could offer regular health checks.

Well-led

Safeguarding of vulnerable adults was discussed at regular staff meetings. We saw records of these meetings. This ensured staff would be alerted to concerns and were aware of how to report them.

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

The practice worked with local mental health services to ensure patients were well supported. Staff were educated and informed about local support services and provided information to patients. The appointment system enabled patients with poor mental health to be seen quickly. If patients took medications that were prescribed for mental health and presented a risk to the heart, they were supported to maintain good health through appropriate health checks.

Our findings

Safe

Nurses explained how they undertook regular ECG (electrocardiography) tests (to examine the electrical activity of the heart) for patients within this population group who were on certain medication. This ensured that the risks associated with specific medications were appropriately monitored.

Caring

Staff we spoke with displayed a non-judgemental attitude towards their patients. We were told that all patients were treated with the same dignity and respect whatever their health needs were.

Effective

The lead GP had invited external mental health support services to speak at practice meetings. They told us this was to ensure staff were aware of the services to which they could refer patients. Patients we spoke with, who had experienced care and treatment in relation to mental health told us their condition was dealt with thoroughly, they were provided with information about support, and were encouraged to pursue self-help treatments.

Responsive

The practice appointment system offered an accessible service for patients experiencing varying mental health problems and for those who required flexibility.

Well-led

The lead GP was a strong and visible leader and staff had clear responsibilities. The practice encouraged continual learning and improvement through patient feedback, significant event analysis and training and development opportunities. The lead GP had invited a psychiatrist to speak at a practice meeting to ensure clinicians were aware of the support offered by the local mental health service. Staff we spoke with told us the session was interesting and informative.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 requirements relating to workers. People who use services and others were not protected against the risks associated with employing staff who had not been checked or had a risk assessment to ensure they were safe to work with vulnerable people. Regulation 21 (a) (i).