Elgar House

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.

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We inspected this service on 4 November 2014 as part of our new comprehensive inspection programme.

The overall rating for this service is good. We found the practice to be good in the safe, effective, caring, responsive and well-led domains. We found the practice provided good care to older people, people with long term conditions, families, children and young people, the working age population and those recently retired, people in vulnerable circumstances and people experiencing poor mental health.

Our key findings were as follows:

- Patients were kept safe because there were arrangements in place for staff to report and learn from key safety risks. The practice had a system in place for reporting, recording and monitoring significant events over time.
- There were systems in place to keep patients safe from the risk and spread of infection.
- Evidence we reviewed demonstrated that patients were satisfied with how they were treated and that this was with compassion, dignity and respect. It also demonstrated that the GPs were good at listening to patients and gave them enough time.
- The practice had an open culture that was effective and encouraged staff to share their views through staff meetings and significant event meetings.

We saw an area of outstanding practice including:

- The practice provided an Xpert Diabetes Programme (XDP). The aim of this programme was to provide patients with the knowledge, skills and confidence necessary to self-manage their diabetes. This programme was supported by the GP partners as they placed a high value on patient education and self-management of long term conditions. The national database figures for 2014 showed improved outcomes for patients such as weight loss, reduction

Summary of findings

in HbA1c (blood sugar levels) and reduced cholesterol. We saw that very positive comments had been received from patients who had attended one of these courses.

However, there were also areas of practice where the provider needs to make improvements.

In addition the provider should:

- Carry out a Legionella risk assessment in line with guidance from Health and Safety Executive to assess any potential risk at the practice.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and planned. The practice had undertaken appraisals including personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others nationally for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS Local Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.

Summary of findings

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. There was evidence of learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) had had their first meeting. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who failed to attend appointments or clinics. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered

Summary of findings

to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. They had carried out annual health checks for people with a learning disability. They had offered longer appointments for people with a learning disability. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had advised vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice offered structured reviews to all patients with severe and enduring mental health conditions with at least annual reviews of their physical and mental health, medicines and revision of their agreed care plan. In-house counselling was also available at the practice.

For patients with suspected dementia, where the practice had concerns about diagnosis they referred patients to the memory clinic and worked in partnership with the Old Age Psychiatry service to ensure patients received the best care and treatment. The Admiral Nurse (specialist dementia nurse) service was available to support families in caring for relatives affected by dementia. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We reviewed eight comment cards from our Care Quality Commission (CQC) comments box that we had asked to be placed in the practice prior to our inspection. They were all very positive about the care they received from the GPs and nurses at the practice. Patients told us the staff were always friendly and helpful. One comment said that it could take one or two weeks for an appointment.

The practice published information on their website before the inspection to inform patients they were being inspected. This information invited patients to contact CQC with their comments. Contact details for CQC were provided for patients. At the time of writing the report we had not received any comments from patients.

We did not speak with any members of the patient participation group (PPG) as they had only had their first meeting on 27 October 2014 and were not fully operational. A PPG is made up of practice staff and patients that are representative of the practice population. The main aim of the PPG is to ensure that patients are involved in decisions about the range and quality of services provided by the practice.

We looked at the national GP patient survey dated July 2014 which found that 80% of patients described the overall experience of Elgar House as fairly good or very good. The satisfaction scores on consultations with GPs was high with 93% of practice respondents saying the GP was good at listening to them, 89% saying the GP gave them enough time and 95% had confidence and trust in the last GP they saw or spoke to. 76% of practice respondents said the GP was good at involving them in care decisions and 85% felt the GP was good at explaining treatment and results. These results were all above the national average.

Written comments received at an event held at the practice in July 2014 were all very positive.

Areas for improvement

Action the service SHOULD take to improve

The practice should carry out a Legionella risk assessment in line with guidance from Health and Safety Executive to assess any potential risk at the practice.

Outstanding practice

There was an example of outstanding practice at Elgar House as follows:

The practice provided an Xpert Diabetes Programme (XDP). The aim of this programme was to provide patients with the knowledge, skills and confidence necessary to self-manage their diabetes. This programme was supported by the GP partners as they placed a high value on patient education and self-management of long term conditions. The national database figures for 2014 showed improved outcomes for patients such as weight loss, reduction in HbA1c (blood sugar levels) and reduced cholesterol. We saw that very positive comments had been received from patients who had attended one of these courses.

Elgar House

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The lead inspector was accompanied by a GP specialist advisor, a second CQC inspector, and a practice nurse specialist advisor.

Background to Elgar House

Elgar House is located in Redditch and provides primary medical services to patients. The practice is located in the centre of the area that it covers which includes Alvechurch, Studley, Astwood Bank and Upper Bentley.

The practice has five GP Partners (three male and two female) and four salaried GPs (one male and three female). There is a practice manager, a deputy practice manager, one specialist nurse practitioner, one nurse manager, two practice nurses, two healthcare assistants, a reception manager and reception and administrative staff. There are 14324 patients registered with the practice. The practice is open from 8am to 6.30pm Monday to Friday. Patients can access the service for appointments from 8am and on line booking of appointments is also available. The practice offers extended hours Monday to Thursday evenings until 8pm and alternate Saturdays 8.30am to 11.30am. The practice treats patients of all ages and provides a range of medical services. Elgar House has a higher percentage of its practice population in the 25 to 34 and 60 to 69 and over age group than the England average.

Elgar House has a General Medical Services contract. The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities.

The practice was inspected by CQC in October 2013 as part of a routine inspection programme and they were compliant with all of the areas inspected. This inspection report is available on our website www.cqc.org.uk.

The practice is an approved GP training practice. This means that fully qualified doctors who want to enter into general practice spend 12 months working at the practice to gain the experience they need to become a GP.

The practice provides services for patients with respiratory problems, diabetes and heart disease. It offers child immunisations, influenza and travel vaccinations and maternity and family planning services. The practice also provides a minor surgery and phlebotomy (taking blood) service.

Elgar House does not provide an out-of-hours service to its own patients but has alternative arrangements for patients to be seen when the practice is closed.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Please note that references to the Quality and Outcomes Framework data in this report relate to the most recent information available to CQC at the time of the inspection.

Detailed findings

How we carried out this inspection

Before the inspection we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We received information from the Clinical Commissioning Group (CCG) and the NHS England Local Area Team (LAT).

We carried out an announced inspection on 4 November 2014. During our inspection we spoke with four GPs, one specialist nurse, one nurse manager, one health care assistant, the practice manager, the reception manager and one receptionist. We reviewed eight patient comment cards from patients sharing their views and experiences of the practice. We also spoke with two care home managers who receive a service from the practice. We also looked at procedures and systems used by the practice.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Good

Are services safe?

Our findings

Safe Track Record

We saw that the practice had robust systems in place to assess and monitor the consistency of their performance over time. We saw records which showed that multiple sources of information were used by the practice to check the safety of the service and action was taken to address any areas in need of improvement. These included significant events and complaints. We found clear procedures were in place for reporting safety incidents, complaints or safeguarding concerns. Staff we spoke with knew it was important to report incidents and significant events to keep patients safe from harm. Staff told us they were actively encouraged and supported to raise any concerns that they may have and were able to explain and demonstrate the process in place.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred since the mid 1990s. Records were made available to us. Staff told us they were responsible for completing significant event forms, and significant event audits or analysis were carried out each time there was a patient safety incident. Staff told us they were informed of the outcome from these and debriefed. An action plan was put in place to ensure improvements were made so that the incident did not happen again.

We saw that incident forms and templates were available on the practice intranet and staff had access to them. The practice manager and GPs told us incidents were discussed at the weekly partners' meetings. The senior partner told us dedicated significant event meetings were held three to four times a year and the minutes were shared with all relevant staff. We attended a significant event meeting held on the day of the inspection and observed the information that was discussed at this meeting. This meeting was attended by GPs, the practice manager, nurses and the reception manager. We found that a variety of significant events were appropriately discussed at this meeting. We tracked seven incidents and saw they were comprehensively completed with regard to content, subject matter and procedures followed. For example, we saw that a patient had been misidentified at a clinic through being asked to confirm their date of birth rather than state their date of birth. An action plan was put into place to ensure the practice team were made aware of the potential pitfalls when confirming patient identities. We saw that the practice procedures had been followed, with action taken accordingly.

National patient safety alerts, medical devices alerts and other patient safety alerts were disseminated by email to practice staff. Staff told us an action plan would be attached to this email which they had to respond to. The senior partner told us that the GP partners received copies of all alerts received by the practice and other staff received these alerts in line with their individual roles and responsibilities. The GP told us what action they would take if they received an alert about equipment for the management of diabetes. They told us the process would be that the lead nurse would contact the relevant patients by telephone to discuss and take appropriate action to recall any potentially faulty equipment.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible.

The practice had a dedicated GP appointed as the lead for safeguarding vulnerable adults and children. The GP had been trained to level three, and demonstrated they had gained the necessary knowledge from this training to enable them to fulfil this role. Staff confirmed they knew who the safeguarding lead was and that they were able to access policies and procedures through the practice's intranet site. Staff explained to us the processes they would follow in the event they became concerned that a patient may be at risk of harm. For example, a clinician told us about the procedure they had followed recently when they had concerns about children who had attended their clinic.

Good

Are services safe?

Patient's individual records were written and managed in a way that helped to ensure their safety. Records were kept on an electronic system called EMIS, which collated all communications about the patient including scanned copies of communications from hospitals. Staff told us that the system was used to highlight vulnerable patients which ensured staff were alerted to any relevant issues when patients attended appointments. We found that GPs used the required codes on this electronic case management system to ensure risks were clearly flagged and reviewed.

In 2014 the practice had prioritised the review of their system for working in partnership with health visitors (HV) about child safeguarding. The safeguarding lead told us they had done this as they wanted to be as effective as possible in identifying and acting on safeguarding concerns. A new safeguarding template had been produced. This ensured that the practice and HVs held the same list of children with safeguarding concerns. Childrens' records had appropriate alert codes and were kept up to date. There was improved communication with the HV team, who now worked geographically rather than attached to the practice. Some of the outcomes found were that this had generated more detailed discussions with HVs and included the mothers of children with safeguarding concerns. The practice had ensured that those mothers with mental health concerns were reviewed by a GP.

A chaperone policy was in place and information about the service was visible on the waiting room noticeboard and in consulting rooms. Staff told us that they always asked patients whether they required a chaperone when they received any intimate treatment. Staff told us that chaperone duties were only carried out by clinical staff.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring refrigerated medicines were kept at the required temperatures. This was being followed by the practice staff, and the action to take in the event of a potential failure was described. However, there were no procedures in place to ensure that medicines stored in the treatment rooms were kept within the temperature guidelines recommended by the manufacturer. The practice manager sent us a copy of the revised policy for the storage, distribution and disposal of vaccines and medication. This had been reviewed to include the procedures for monitoring the storage temperature of non-refrigerated medicines.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Medicines were administered safely. We saw there were signed Patient Group Directions (PGD) in place to support the nursing staff in the administration of vaccines. A PGD is a written instruction from a qualified and registered prescriber, such as a doctor, enabling a nurse to administer a medicine to groups of patients without individual prescriptions.

Two members of the nursing staff were qualified as independent prescribers. One nurse prescriber we spoke with told us they received regular supervision and support in their role from a named GP.

The practice had a protocol for repeat prescribing which was in line with General Medical Council (GMC) guidance. This protocol was last reviewed in October 2014. This covered how staff that generated prescriptions were trained, how changes to patients' repeat medicines were managed and the system for reviewing patients' repeat medicines. We saw minutes from a meeting in July 2014 with the Clinical Commissioning Group (CCG). CCGs are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England. This stated that the practice had an excellent record in appropriate prescribing.

We saw that there was a pharmacy run by another company within the building. Minutes of the meeting in July 2014 with the CCG showed that the practice valued the support from the 'In House' pharmacist. The pharmacist gave medicine advice to GPs when requested and was able to assist in searching and locating patient contact details when the practice received specific medicine safety alerts. This ensured that all patients that might be affected were contacted.

All prescriptions were reviewed and signed by a GP before they were given to the patient. We saw that blank prescription forms and prescription pads were tracked through the practice and kept securely at all times.

Good

Are services safe?

Cleanliness and infection control

There were systems in place to keep patients safe from the risk and spread of infection. There was an appropriate infection control policy dated January 2013 available for staff to refer to. We saw that the infection control lead had received appropriate infection control training. An infection control audit had been carried out in October 2014. An issue had been identified and this had been raised with and addressed by the cleaning contractor. Minor surgery was carried out at the practice. We saw that single use instruments were used and they were in date. There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We saw evidence that their disposal was arranged through a suitable company.

On the day of our inspection all areas seen at the practice was clean and tidy. Information on the patient comment cards received confirmed this. Staff confirmed personal protective equipment and hand sanitising gel was readily available and we saw that it was.

The practice had taken reasonable steps to protect staff and patients from the risks of health care associated infections. We saw that staff had received the relevant immunisations and support to manage the risks of health care associated infections. The senior partner told us that a legionella risk assessment had not been completed at the practice as there was a domestic water supply at the practice and no shower facilities were provided for staff. This was discussed with the provider during feedback and they agreed to undertake a written assessment for legionella to assess any risk at this practice.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance records and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the next test was due to be done in May 2015. We saw evidence of calibration of relevant equipment, for example weighing scales.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications and registration with the appropriate professional body. We saw that Disclosure and Barring Service (DBS) checks had been completed for all staff who worked at the practice. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable adults and children.

The practice had a recruitment policy that set out the standards it followed when recruiting staff. However, we saw that the policy did not cover clinical staff and did not make reference to all of the information required to be obtained prior to employment in accordance with the regulation. The practice manager reviewed their recruitment policy and procedures in line with this regulation and submitted this to us three days after the inspection.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure there were enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave. Newly appointed staff had this expectation written in their contracts. We saw the staffing policy dated January 2013 which provided clear information for the procedures in place for the maintenance of staffing levels for unplanned and planned absences.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. For example we saw that internal fire system checks had last been completed on 03 November 2014. The fire system had been inspected by an external contractor on 30 October 2014 and no issues were recorded.

Good

Are services safe?

The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

The GPs and practice manager informed us there were sufficient appointments available for high risk patients, such as patients with long term conditions, older patients, and babies and young children. Patients were offered appointments that suited them, for example same day, next day or pre-bookable appointments with their choice of GP. There was a system in place that ensured patients with long term conditions were invited for regular health and medicine reviews, and followed up if they did not attend.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a patient's heart in an emergency). All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest (heart stopping), anaphylactic shock (allergic reaction) and hypoglycaemia (low blood sugar). Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity and recovery plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risk areas covered the computer systems, personnel, clinical and the premises. For example, risks identified included power failure, adverse weather, loss of key staff, access to the building and clinical risks such as infection, epidemic and pandemic. The document also contained relevant contact details for staff to refer to. For example, contact details of the electric and gas service suppliers to contact in the event of failure of these services. Copies of this plan were held off site by the partners and management team at the practice.

A fire risk assessment had been undertaken in February 2013 that included actions required to maintain fire safety. For example, the electrical installation certificate had been overdue. We saw this had been completed on 01 June 2013. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients' needs were assessed and care and treatment was delivered in line with current legislation and recognised best practice. The GPs confirmed they received information regarding the National Institute for Health and Care Excellence (NICE) guidelines via email and these were used as a point of reference. For example, NICE guidelines for asthma were referred to almost daily. They told us that any new information was discussed at the informal morning coffee meetings, at the monthly clinical meetings and at the quarterly long term condition meetings. This was supported by the minutes of the clinical meetings and staff meetings.

Patients with long term conditions received an annual review assessment. We saw management plans for patients with diabetes and respiratory problems. Staff told us patients were encouraged to be involved with these.

Every patient over 75 years had a named GP, this included patients who lived in three of the care homes the practice provided support to. We spoke with representatives from two of these three care homes. They confirmed that needs assessments were completed when required. They told us weekly visits were made by one of the GPs. They felt it was a good practice and that the GPs worked with the staff at the homes to ensure people got the best care possible.

Management, monitoring and improving outcomes for people

The practice partly participated in the Quality and Outcomes Framework (QOF). The QOF rewards practices for providing quality care and helps to fund further improvements. We saw that there was a robust system in place to frequently review QOF data for asthma, chronic obstructive pulmonary disease (COPD) and diabetes and recall patients when needed. The senior partner was aware that the practice was an outlier in QOF. (An outlier is where the value for the practice lies outside nationally set values). They told us the practice did not fully support this performance monitoring process. We saw that the practice's QOF performance had been discussed with the CCG at a meeting in July 2014. These minutes also stated that the life expectancy for patients at the practice was good taking into consideration the practice's demographics. The practice participated in a benchmarking process through meetings with the Redditch and Bromsgrove CCG and the NHS Local Area Team.

The practice had a system in place for completing clinical audit cycles. Examples of completed clinical audits included an audit of ophthalmology referrals in Feb 2014 and a repeat audit of monitoring for patients prescribed Methotrexate under a shared care arrangement dated May 2014. (Methotrexate is a medicine used for rheumatoid arthritis). These both showed good and improved outcomes for patients. For example, blood tests for liver function monitoring had increased from 89% to 97% for 2014. When bloods had not been done, clinicians had identified this and requested tests for those identified patients.

An Xpert Diabetes Programme (XDP) was run by the advanced nurse practitioner at the practice. This was a six week structured group based education programme for patients with diabetes. At the time of the inspection this was the only practice in Redditch and Bromsgrove that offered this in-house programme. The aim of this programme was to provide patients with the knowledge, skills and confidence necessary to self-manage their diabetes. This programme was supported by the GP partners as they placed a high value on patient education and self-management of long term conditions. 10-18 patients attended each week for two and a half hours. The national database figures for 2014 showed improved outcomes for patients such as weight loss, reduction in HbA1c (blood sugar levels) and reduced cholesterol. We saw that very positive comments had been received from patients who had attended one of these courses.

The team made use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how as a group they had reflected upon the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake regular audits.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest

Good

Are services effective?

(for example, treatment is effective)

prescribing guidance was being used. The computer system flagged up relevant medicines alerts when the GP went to prescribe medicines. We were shown evidence to confirm that following the receipt of an alert the GPs had reviewed the use of the medicine in question and where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

GPs at the practice undertook minor surgical procedures in line with their registration and NICE guidance. The staff were appropriately trained and kept up to date. They also carried out annual clinical audits on their results and used that in their learning. The senior partner told us that the current audit was in progress.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending courses that the practice saw as essential such as annual basic life support. A good skill mix was noted amongst the GPs with six having additional diplomas in sexual and reproductive medicine including family planning, and one with a diploma in child health. All GPs were up to date with their yearly continuing professional development requirements and all had either been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

The GPs attended educational meetings facilitated by the Clinical Commissioning Group (CCG), and engaged in annual appraisal and other educational support. The annual appraisal process requires GPs to demonstrate that they have kept up to date with current practice, evaluated the quality of their work and gained feedback from their peers. Clinical staff told us they ensured best practice was implemented through regular training, networking with other clinical staff and regular discussions with the clinical staff team at the practice. We were told that GPs were very approachable and that clinical staff would have no hesitation in asking for support or advice if they felt they needed it.

The GPs told us they were flexible with their hours, and would increase the number of hours they worked to accommodate the needs of the service. The practice nurses told us they were able to cover annual leave when colleagues were away. Other staff who worked in the practice were organised into teams, for example reception staff and administration staff. This enabled flexible staffing levels, whereby staff would cover any shortfalls. Staff told us that the practice manager would provide cover as and when required.

All staff undertook annual appraisals which identified learning needs from which action plans were documented. We saw that the most recent of these were done in February 2014. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses, for example the Xpert diabetes programme update course. The practice manager told us the GP partners had never refused any training for staff. As the practice was a training practice, doctors who were in training to be qualified as GPs were offered adequate appointment times and had access to a senior GP throughout the day for support. Feedback from the trainee we spoke with was positive.

Practice nurses and nurse practitioners had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, for the administration of vaccines, cervical cytology and nurse prescribing. (Cytology is the examination of tissue cells from the body). Those with extended roles such as the nurse practitioners cared for and reviewed patients with long-term conditions such as asthma, chronic kidney disease (CKD), diabetes and coronary heart disease (CHD). They were also able to demonstrate they had appropriate training to fulfil these roles. They were supported by designated clinical lead GPs for each long term condition. We saw that group clinical supervision meetings were held monthly and the last one was held on 10 October 2014.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, x-ray results, letters from the local hospital including discharge summaries and out of hours providers were received both electronically and by post. The practice had a system that identified the responsibilities of all relevant staff in passing on, reading and taking action on any issues arising from communications with other care providers on the day they were received. The GP who saw the

Good

Are services effective?

(for example, treatment is effective)

documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system worked well. We were told there were no instances within the last year of any results or discharge summaries which were not followed up appropriately.

The practice held multidisciplinary team meetings regularly to discuss the needs of complex patients, such as those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers and palliative care nurses. Decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

Training records showed all members of staff had completed training about information governance. This helped to ensure that information at the practice was dealt with safely with regard to patients' rights as to how their information was gathered, used and shared.

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the local out-of-hours provider to enable patient data to be shared in a secure and timely manner. The practice made referrals following discussion with the patient about their preferred choice of hospital.

The practice had signed up to the electronic Summary Care Record and this was fully operational for all patients, except those that had chosen to opt out. (Summary Care Records provide healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information). Information for patients was available on the practice website with an opt out form should patients choose to do so.

The practice had systems in place to provide staff with the information they needed. An electronic patient record known as EMIS was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system. There was a system in place to scan paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We saw that the practice had policies on consent and assessment of Gillick competency of children and young adults. (These help clinicians to identify children under 16 years of age who have the legal capacity to consent to medical examination and treatment). All clinical staff demonstrated a clear understanding of Gillick competencies.

We saw a policy about the Mental Capacity Act 2005 (MCA). (Health and care providers must work within the Code of Practice for the Mental Capacity Act 2005 to ensure that, in circumstances where people lack capacity to make some decisions through illness or disability, decisions about care and treatment are made in their best interest). We saw examples of where the guidance had been put into practice and had been signed off by the GPs. Staff we spoke with gave examples of how patients' best interests were taken into account if patients did not have capacity. Clinical staff told us that patients had a choice about whether they wished for a procedure to be carried out or not. For example, a practice nurse told us how they talked through the procedure when they took blood samples from a patient if they were anxious or uncertain. They told us they would discuss any concerns or anxieties they had. We were told that if the patient was unsure and needed more time to consider the procedure this was agreed with them. An appointment was made for them to return to the practice to allow them more time to make their decision.

Staff told us they completed Mental Capacity Act training through an on-line course. Clinical staff we spoke with understood the key parts of the legislation and were able to describe to us how they implemented it in their practice.

We saw examples of consent forms that had been completed. GPs told us that consent forms were always completed and checked before they carried out procedures that involved cutting patients' skin, such as removal of cysts or skin lesions.

Staff told us the patient always came first and they were encouraged to be involved in the decision making process. They described that even if a patient attended with a carer or relative, they would always speak with the patient and obtain their agreement for any treatment or intervention. The nurses told us that if they thought a patient lacked capacity, they would ask their GP to review them.

Patients with learning disabilities and patients with dementia were supported to make decisions through care plans which they were encouraged to be involved in. These care plans were reviewed annually (or more frequently if

Good

Are services effective?

(for example, treatment is effective)

changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. We saw examples of records that showed care plans were in place and that reviews had been carried out.

Health promotion and prevention

It was practice policy to offer all new patients registering with the practice a health check with the GP. Nursing staff told us they offered opportunistic health reviews for patients whilst they attended appointments for other reasons. We noted a culture amongst the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by carrying out opportunistic medicine reviews or to review the patient's long term condition.

The practice provided a range of support to enable patients to live healthier lives. Examples of this included an Xpert diabetes programme, travel advice and vaccinations and weight management. We saw patient self-care was promoted by the practice. For example, there was a blood pressure monitoring machine in place that patients could use to monitor their own blood pressure. We saw there were clear instructions to guide patients on how to operate the equipment.

The practice offered a full range of immunisations for children. The percentage of children receiving the vaccines was in line with the average for the local CCG area.

The practice offered a travel vaccination service, although this did not include yellow fever. This was being done once a week by a locum nurse. The practice was aware that the current uptake figures for cervical smears were lower than the national average. This was due to the recent changes in the nursing staff team. Cervical smears were being done by a locum nurse who was at the practice once a week, until the practice's own nursing staff were fully trained to carry out this role.

Flu vaccination was offered to all over the age of 65, those in at risk groups and pregnant women. The percentage of eligible patients receiving the flu vaccination was in line with the national average.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities and patients were offered an annual physical health check. Similar mechanisms of identifying at risk groups were used for patients who were receiving end of life care. These groups were offered further support in line with their needs.

Patients with a learning disability received an annual health assessment. We saw these were done by one GP using a nationally recognised template.

The practice offered structured reviews to all patients with severe and enduring mental health conditions with at least annual reviews of their physical and mental health, medicines and revision of their agreed care plan. Discussion with a GP confirmed this. In-house counselling was also available at the practice.

For patients with suspected dementia, where the practice had concerns about diagnosis they referred patients to the memory clinic. The Old Age Psychiatry service initiated medication as needed once the patient's diagnosis was established. This was then continued by the GPs under their guidance. The Admiral Nurse (specialist dementia nurse) service was available to support families in caring for relatives affected by dementia.

Clinical staff told us they no longer held clinics for mothers and babies at the practice, but operated a more flexible approach of open appointments instead. This was because they had found that not all mothers could attend the clinic appointment times if, for example they also worked. Attendance at appointments had improved by offering routine appointments with the nurse where the baby monitoring could be done at times to suit the mother.

GPs told us they offered a family friendly service. For example, they took an integrated approach to the eight week check where they saw the mother for their postnatal check, baby for their eight week development assessment and then immediately offered the first immunisation, all in the same appointment. GPs told us they often saw children when they accompanied their parent to an appointment despite them not having made an appointment for the child. Although this approach was not encouraged, the GPs would not risk not seeing the child if they were suspected to be unwell.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This was the information from the national GP patient survey published July 2014 and comments received by the practice when they held an event in July 2014 to celebrate 66 years of the NHS. The evidence from these sources showed patients had differing views about how they were treated. For example, data from the national GP patient survey showed the practice was rated 'among the worst' for patients rating the practice as good or very good. However, the practice was well above average for its satisfaction scores on consultations with GPs. 93% of practice respondents confirmed that the GP was good at listening to them, 89% responded that the GP gave them enough time and 95% had confidence and trust in the last GP they saw or spoke to. Written comments received at the NHS66 tea party held by the practice in July 2014 were all very positive.

Patients completed CQC comment cards to provide us with feedback on the practice. We received eight completed cards and they were all positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect.

We saw that consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Staff told us they worked to ensure patients' privacy and dignity was respected. We saw that patients were encouraged to stand back from the reception desk and wait their turn to speak with the receptionist. This made sure that each patient was given the respect and privacy they needed.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. Staff told us they ensured patients' dignity was maintained by making sure the door was locked and that screens were used to enable patients to undress in private.

We spoke with managers from two care homes that were supported by the practice. They described to us the caring, professional and supportive attitude of the GPs. They told us staff at the practice listened to them and worked well with them to make sure the people they cared for received the best care.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 76% of practice respondents said the GP was good at involving them in care decisions and 85% felt the GP was good at explaining treatment and results. These results were both above the average. Patient feedback on the comment cards we received was also positive and aligned with these views.

The practice placed high values on communication with their patients on the basis that better help in understanding their present problems would allow for better outcomes in their long term health. For example, the provision of the structured education programme for diabetes and clinics for long term conditions had been provided at the practice for around 20 years. Staff told us patients could access patient information leaflets from any member of staff from GPs to reception staff. Information was also available on their website.

Staff told us that translation services were available for patients who did not have English as a first language. The check-in facilities at the practice were automated and multilingual. A telephone translation service was available and information leaflets were also available in other languages. Two of the GPs spoke Polish which reflected the make up of the community.

Mental Capacity Act training was completed by management staff, nurses and healthcare assistants annually through online training. (Health and care providers must work within the Code of Practice for the Mental Capacity Act 2005 to ensure that, in circumstances

Good

Are services caring?

where people lack capacity to make some decisions through illness or disability, decisions about care and treatment are made in their best interest). Staff were provided with protected time to undertake all training. Staff demonstrated knowledge regarding best interest decisions for patients who lacked capacity. Staff told us the patient always came first and was involved in decision making. They described that even if a patient attended with a carer or relative, they would always speak with the patient and obtain their agreement for any treatment or intervention. The nurses told us that if they thought a patient lacked capacity, they would ask their GP to review them.

The practice was able to evidence joint working arrangements with other appropriate agencies and professionals. For example, palliative care was carried out in an integrated way. This was done using a Multi-Disciplinary Team (MDT) approach with district nurses, palliative care nurse and hospitals. We saw that the Gold Standard Framework (GSF) palliative care meetings were held monthly and recorded. The GSF is a practice based system to improve the quality of palliative care in the community so that patients received supportive and dignified end of life care, where they chose.

Patient/carer support to cope emotionally with care and treatment

Staff told us families who had suffered bereavement were called by their usual GP. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and, or signposting to a support service.

Notices in the patient waiting room and patient website also signposted people to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Managers from two of the care homes the practice supported told us the GPs were very good at supporting bereaved relatives and would always make themselves available if the family required support.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs. For example the practice had a system in place that ensured patients with long term conditions such as asthma and diabetes received regular health reviews. The lead nurse for diabetes showed us the structured education programme for diabetes.

The NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. GPs told us they attended these quarterly meetings and shared information with practice staff. The practice manager told us they and one of the GPs attended monthly CCG Advisory Forum meetings. A suggestions box was available at the practice for patients to put suggestions forward to the CCG. The practice manager told us this was taken to the meetings they attended.

The practice had their first meeting on 27 October 2014 with their patient participation group (PPG). A PPG is made up of practice staff and patients that are representative of the practice population. The main aim of the PPG is to ensure that patients are involved in decisions about the range and quality of services provided by the practice. The meeting minutes stated their aim of this group was that it would become a strong voice for patients and for the practice with the patients. The practice wanted the PPG to help them to develop and improve their services, and to communicate these developments and improvements with their patients.

Longer appointments were available for people who needed them. Appointments for patients with long term conditions were always 20 minutes; 30 minute appointments could be made available for people with a learning disability and dementia. Appointments could be made with a named GP or nurse. Weekly home visits were made to three local care homes on a specific day each week. This was carried out by a number of GPs to those patients who needed a consultation.

We spoke with managers from three care homes the practice supported. They told us a GP visited the home on a set day each week. If patients had an acute problem, care home staff told us the GP would visit the same day.

Tackling inequity and promoting equality

The practice proactively removed any barriers that some people faced in accessing or using the service. Staff we spoke with told us there was a small minority of patients who accessed the service where English was their second language. They told us that usually the patient was accompanied by a family member or friend who would translate for them. Staff told us they would arrange for access to a telephone interpreter if required and that information could also be translated via the website. We were told that a number of Eastern European patients were registered with the practice, which was supported by two GPs at the practice who were able to speak Polish.

The practice accepted any patient who lived within their practice boundary irrespective of ethnicity, culture, religion or sexual preference. They told us all patients received the same quality of service from all staff to ensure their needs were met. Staff told us that no homeless patients were currently registered with the practice. Staff told us however that should a homeless person need to register as a patient at the practice, this would be done so they could receive treatment. Staff told us that no one would be turned away from the practice.

Female GPs worked at the practice and were able to support patients who preferred to see a female GP. This also reduced any barriers to care and supported the equality and diversity needs of the patients.

There were arrangements to ensure that care and treatment was provided to patients with regard to their disability. For example, there was a hearing loop system available for patients with a hearing impairment and clear signage informing patients where to go within the practice. There were disabled toilets and wheelchair access to the practice for patients with mobility difficulties. A stair lift was provided for people to enable them to access consulting rooms on the second floor. However, there was also the flexibility to see patients on the ground floor as required. We saw there was a door bell at the front door at a suitable height to enable patients in a wheelchair to request assistance from staff as needed.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice had recognised the needs of different groups in the planning of its services such as carers and vulnerable people who were at risk of harm. The computer system used by the practice alerted GPs if patients were at risk of harm, or if a patient was also a carer. For example, where patients were also identified as carers we saw that information was provided to ensure they understood the various avenues of support available to them should they need it.

The practice had a system in place to alert staff to any patients who might be vulnerable or who had special needs, such as patients with poor mental health or patients with a learning disability. Some patients had been identified as always needing longer appointments and the system in place ensured that staff were alerted to this need as necessary.

The practice provided equality and diversity training via e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training.

The practice's building was fully accessible to patients with mobility aids. The practice had its own wheelchair which was used to transport patients from a nearby car park if required.

Access to the service

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients on leaflets, through information displayed in the waiting room and on the practice website.

The practice opened from Monday to Friday from 8am to 6.30pm each week. All clinics were available by appointment and patients could book these by telephone, online or at the reception desk at the practice. A nurse was available at all times Monday to Friday between 8.30am till 1pm and 2pm to 6pm. The practice offered extended hours with late appointments Monday to Thursday, and alternate Saturday morning appointments for those patients who were unable to attend appointments during the normal working day. Longer appointment times were made available to patients as needed, such as patients with poor mental health and long term conditions.

Clinical staff told us that appointment times used to be a problem in that the timeslots were too short for them to meet each patient's needs. For example, when they undertook childhood immunisations the appointment time was 10 minutes. After discussions with the practice manager these timeslots were changed so that each patient had 20 minute timeslots.

The practice was able to monitor the appointment system to make sure the needs of patients were being met. Data from the national GP patient survey dated July 2014 showed that the proportion of respondents to the patient survey who stated that the last time they wanted to see or speak to a GP or nurse from their GP surgery they were able to get an appointment was better than national average. The practice scored 0.087 and the national average was 0.037. Extra surgeries were made available if there was an increase in demand. This included two duty GPs, who would be made available if necessary.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We looked at the complaints log for the last 12 months and found that these were handled in line with the practice policy on complaints and dealt with in a timely way.

The practice reviewed complaints on an annual basis to detect themes or trends. We looked at the report for the last review and no themes had been identified, however lessons learnt from individual complaints had been acted upon.

The GPs and the practice manager told us that complaints were discussed at the weekly management meetings. We saw that the outcome and learning from complaints was then shared with the staff team at team meetings. Staff told

Good

Are services responsive to people's needs?

(for example, to feedback?)

us they were aware of what action they should take if a patient complained. Staff confirmed that complaints were discussed at practice meetings and they were made aware of any outcomes and action plans.

We saw that information was available to help patients understand the complaints system. The process was described in patient leaflets and on the practice website.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and values were set out in a practice document. Their aim was to assist their patients to achieve a state of well-being, using the best primary and secondary health care available to the practice. This mission statement was published on their website.

The practice placed high values on communication with their patients as they felt this would help patients to understand their present needs and improve their outcomes for long term health. We spoke with five members of staff and they were all familiar with the values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at nine of these policies and procedures. All nine policies and procedures we looked at had been reviewed annually and were up to date.

The practice partly participated in the Quality and Outcomes Framework (QOF). The QOF rewards practices for providing quality care and helps to fund further improvements. The senior partner was aware that the practice was an outlier in QOF. (An outlier is where the value for the practice lies outside nationally set values). They told us the practice did not fully support this performance monitoring process. We saw that the practice's QOF performance had been discussed with the CCG at a meeting in July 2014. These minutes also stated that the life expectancy for patients at the practice was good taking into consideration the practice's demographics. The practice participated in a benchmarking process through meetings with the Redditch and Bromsgrove CCG (CCG) and the NHS Local Area Team.

The practice had a system in place for completing clinical audit cycles. Examples of completed clinical audits included an audit of ophthalmology referrals in Feb 2014 and a repeat audit of monitoring for patients prescribed Methotrexate under a shared care arrangement dated May 2014. (Methotrexate is a medicine used for rheumatoid arthritis). These both showed good and improved outcomes for patients. For example, blood tests for liver function monitoring had increased from 89% to 97% for 2014. When bloods had not been done, clinicians had identified this and requested tests for those identified patients.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us their risk log which addressed a wide range of potential issues, such as spillages. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. Staff showed us risk assessments that had been completed for risks identified such as needle stick injuries.

Leadership, openness and transparency

There was a clear and visible leadership and management structure in place. For example one of the GP partners was the lead for safeguarding, and another the training lead. We spoke with staff from different teams and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

Staff told us that the practice was well led. We saw that there was strong leadership within the practice and the senior management team were visible and accessible. There was evidence of strong team working. Records showed that regular meetings took place for all staff groups. The practice manager told us that they met with the GPs each week and information from these meetings was shared with staff. Staff told us that the GPs, practice manager and team leaders were very supportive.

Staff told us that there was a positive culture and focus on quality at the practice. We saw examples where staff had been supported and encouraged to develop their skills through discussions at team meetings and through individual appraisals. We spoke with a GP who confirmed that there was an open and transparent culture of leadership, encouragement of team working and concern for staff well-being.

We saw from minutes that a range of meetings were held weekly, monthly, quarterly and twice a year. Staff told us there was an open culture within the practice and they had the opportunity and were happy to raise issues at the meetings.

Are services well-led?

Good

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

The senior partner told us they had an experienced team of staff. There had been recent changes within the nursing team, however they felt this team was now stabilising. They told us the partners valued their team at the practice.

The practice manager had lead responsibility for human resources policies and procedures supported by the GP partners. We reviewed a number of policies, for example the recruitment and induction policies which were in place to support staff. Staff we spoke with knew where to find the policies if required.

We found the practice to be open and transparent, and prepared to learn from incidents and near misses. Quarterly significant events meetings were held where these were discussed. Lessons learned from these discussions were shared with the team. We saw the system in place for the dissemination of safety alerts and National Institute for Health and Care Excellence (NICE) guidance. Clinical staff told us they acted on alerts and kept a record of the action they had taken.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had their first meeting on 27 October 2014 with their patient participation group (PPG). A PPG is made up of practice staff and patients that are representative of the practice population. The main aim of the PPG is to ensure that patients are involved in decisions about the range and quality of services provided by the practice. Minutes of the meeting showed that the aim of this group was that it would become a strong voice for patients and for the practice to communicate with their patients. The practice wanted the PPG to help them to develop and improve their services, and to communicate these developments and improvements with their patients.

Staff told us they felt able to raise any concerns and would feel comfortable approaching any staff at the practice. The practice had a whistle blowing policy and procedure in place. Staff confirmed knowledge of this and confirmed they would use if all other attempts to resolve concerns had failed or they felt unable to raise concerns.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. Staff told us everyone got on at the practice as they were like minded professionals. They said they had one goal in mind and that was patients were at the centre of the service.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at three staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they were given protected time to undertake training.

The practice was a well-established GP training practice. Only approved training practices can employ GP Registrars and the practice must have at least one approved GP trainer. Elgar House had two approved GP trainers. A GP Registrar is a qualified doctor who is training to become a GP through a period of working and training in a practice. We spoke with one of the practice's current GP Registrars. They confirmed that they had a named GP trainer at the practice and felt well supported by the whole team.

The practice was committed to becoming a progressive learning environment, willing to embrace change but at the same time critically questioning and evaluating it. Teaching and training was a core part of their work. The practice had been training GP registrars since 1995. Also the senior partner was the lead GP for undergraduate teaching, taking final year medical students for their GP attachments since 1998.

The practice had completed reviews of significant events and other incidents and they had shared these with staff via meetings to ensure the practice improved outcomes for patients and shared good practice. For example, we were told about a recent incident involving a patient with mental health needs. We saw how the practice had recorded the incident as a significant event and had reviewed the way it had been handled. We saw that the consultant psychiatrist had been very complimentary about the practice's handling of this incident ensuring the safety of the patient until their arrival at the practice.