ISSA Medical Centre - Dr Z H Patel

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.

Contents

Summary of findings

Overall summary

Issa Medical Centre operates from purpose built premises opened in 2009. It has grown rapidly since then adding approximately 1000 patients each year since opening. The practice currently serves over 12,600 patients and continues to grow.

Issa Medical centre is registered with the Care Quality Commission (CQC), as responsible for providing primary care, which includes: access to GPs, family planning, maternity and midwifery services, treatment for disease, surgical procedures, disorder and injury and diagnostic and screening services.

The medical centre offers NHS care and is a teaching practice for GPs. Issa Medical Centre has two GP trainees.

Patients told us that they were very satisfied with the services they received and they told us that the clinical staff working at the medical centre were all held in high regard by the wider community.

The practice works collaboratively with other health and social care providers locally in order to offer a 'joined up' service to patients.

The practice evidenced its efforts to be responsive to a broad community by the way in which it gave support to the patients participation group (PPG).

The patients speak a number of languages and clinical healthcare professional staff in addition to speaking English, were fluent in, Bengali, Hindi, Punjabi, Urdu and Gujarati. There were systems in place to access translation services for other languages as necessary.

The values and visions of the practice were clearly demonstrated and the patients said that they enjoyed a respectful and compassionate service delivered by caring staff who were mindful of a wide range of cultural needs of patients.

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. Emergency equipment and medicines were available and generally correctly maintained.

Staff had received regular updated training in how to respond to medical emergencies. Staff took action to safeguard patients and when appropriate made safeguarding referrals. Infection control; measures were in place and effective. Clinicians were trained, up to date and seen to meet best practice guidelines in their practice.

Are services effective?

The practice was effective. Clinicians were trained and opportunities had been made available for staff to have update training as necessary and records of this were kept including certificated updates for clinician's skills. The GPs used structured audits and evaluations to help them to maintain and improve clinical outcomes for patients using a cycle of continuous improvement. As a teaching practice trainee doctors were supported and evaluated regularly.

All staff had regular supervision and an annual assessment of their performance was recorded in order to identify strengths and where any developmental or training needs were highlighted for the upcoming year.

Are services caring?

The practice was caring. We spoke with 16 patients during the inspection and received 29 completed Care Quality Commission (CQC) comment cards. Comments were very positive about the kindness shown by all staff and that they were treated with dignity and respect. All patients said they had confidence that their personal information was kept private at all times.

Are services responsive to people's needs?

The practice was responsive. Patients spoke very positively about the practice. Parents and grandparents were very positive about the support they received in relation to the care of their children / grandchildren.

The practice had set up a patient participation group (PPG). This group was active and felt supported by the practice. Members of the PPG said that they were able to have a voice and that the practice listened to them as they contributed to the on-going development of the practice.

The practice had a complaints policy and complaints were responded to in a timely manner.

Summary of findings

Are services well-led?

The practice was well led and effectively responded to changes. The lead GP had provided strong and clear leadership and had implemented a clear and concise strategy for the practice. ISSA Medical Centre was a relatively new practice which had demonstrated a strategy of a growing medical centre as many patients had joined within the last 12 months.

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 served a complex and broad community of different ages and cultural backgrounds. The practice was very clear about its ability to meet the health and social needs of older people in Preston. With reference to patient's culture and identity they had systems in place to deliver quality health care in conjunction with other health and social care services. Care Quality Commission (CQC) comment cards from older people were positive stating that the service provider and its staff were kind and helpful.

The practice had been working closely with Age UK. Age UK supplied four volunteers and the service had recruited them as employees at the practice.

People with long-term conditions

Doctors and nurses were informed and up to date with current clinical guidelines and treatments in relation to supporting people with long term conditions.

Patients described to us their very positive experience of support.

A register was maintained for those who had a long term condition led by a nurse. Nurses monitored and recalled patients for check-ups.

Mothers, babies, children and young people

There were lots of children and young mothers being supported by the practice. There were few young people (teenage and early adult age group) attending the practice and this group may present its own challenges to accessing services.

The practice was working hard to encourage women to attend for regular cervical smears tests and to reduce the use of prescribed antibiotics in this age group.

The working-age population and those recently retired

The practice is situated in an inner city community. Some patients told us they had occupations which they felt limited their opportunities to attend for a medical appointment at a time suitable to them and their working pattern. Some patients found it difficult to get an appointment at a time or on a day when the medical centre was open. Therefore some patients used local accident and emergency services to access medical advice.

No extended practice hours were offered and the practice had received few direct requests for the practice to provide it.

Summary of findings

Patients were able to have access to telephone appointments as necessary.

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

Staff were aware of the needs of vulnerable people including those who may have difficulty in accessing general medical services. Staff we spoke with knew which practice specialised in helping homeless people and how to refer patients to that practice.

Patients with learning difficulties said they were listened to with respect and the doctors and nurses were patient and explained things clearly in terms that they could easily understand.

The practice had good working relationships with the local drug and alcohol teams in order to provide appropriate targeted support.

People experiencing poor mental health

The practice was able to identify people who had mental health problems and they kept an up to date register. Patients in this population group were offered more same day appointments than those in other population groups.

The practice used a wide range of assessment and screening processes to asses those with depression. The practice used other services such as Crisis Resolution and Home Treatment Teams (CRHTT) and the psychological wellbeing practitioner to support those with mental health problems.

Summary of findings

What people who use the service say

We received 29 completed Care Quality Commission (CQC) comment cards and spoke with 16 patients on the day of our inspection. We spoke with a selection of patients who had been registered with the practice for differing lengths of time. Some had been with the practice for years.

The patients we spoke with were generally very positive about the practice stating that the staff were friendly and kind but many said that they did not know how to complain about aspects of the practice.

The feedback from the comment cards echoed this. One said that there were not enough words to express the gratitude they have towards the staff and many commented on the kindness of staff and the cleanliness of the building.

Patients reported that staff treated them with dignity and respect and that the practice was efficient and caring

Areas for improvement

Action the service SHOULD take to improve

There were few retained reviews of the analyses of trends of significant events audits (SEA).

Palliative care meetings had not been minuted.

The practice did not keep a log of issuing prescription pads and monitoring the loss or the prevention of the loss of prescription pads.

Fire alarm procedure checks were not always followed.

Some patients told us that they did not understand the process for making a complaint.

ISSA Medical Centre - Dr Z H Patel

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP , a Practice Manager and an Expert by Experience.

Background to ISSA Medical Centre - Dr Z H Patel

Issa Medical Centre operates form a large purpose built facility and serving a large inner city community.

The practice has grown from 2,500 patients in 2009 to 12, 662. This is in part due to the recent merger between two practices. The practice continues to grow.

The team at Issa Medical Centre is made up of four GPs, including two male and two female GPs, two practice nurses, one healthcare assistant, five administrative staff, nine reception staff and one practice manager.

The practice is open from 8:30am to 6:00pm Monday to Friday. The practice treats patients of all ages and serves wide ranging communities from the city of Preston.

The practice is a training practice for doctors who wish to become GPs. The trainee doctors have access to training and are given the supervised responsibility for patient care.

Surgery opening times are between 8:30am and 6pm Monday to Friday and 12:30pm on Thursdays. There are limited out of hour's services available and therefore patients are advised to contact NHS direct, attend the accident and emergency department or to call for an emergency appointment the following day. There are two telephone lines in operation until 10:30am. At 1pm one of the telephone lines becomes a dedicated repeat prescription line. Out of hour's services are provided by Preston Primary Care based at The Royal Preston Hospital.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people

Detailed findings

- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health.

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

We carried out an announced visit on 18 July 2014.

During our visit we spoke with a range of staff including the doctors and receptionists on duty, two part time practice nurses, a healthcare assistant, a cleaner, administrative manager, three administrative staff, the reception manager and the practice manager. We spoke with representatives of the Patient Participation Group (PPG) and with patients who used the service. We observed how people were being spoken to and supported and we talked with carers and/or family members. We did not review any personal care or treatment records of patients. We spoke with 16 patients during the inspection and received 29 completed Care Quality Commission (CQC) comment cards.

Are services safe?

Our findings

The practice was safe. Emergency equipment and medicines were available and generally correctly maintained.

Staff had received regular updated training in how to respond to medical emergencies. Staff took action to safeguard patients and when appropriate made safeguarding referrals. Infection control; measures were in place and effective. Clinicians were trained, up to date and seen to meet best practice guidelines in their practice.

Safe Patient Care

We reviewed information held by the Care Quality Commission, NHS England and the local Clinical Commissioning Group and we saw that the information indicated the practice had a track record for clinical safety.

The practice regularly monitored patient safety in the practice. Information from the Quality and Outcomes Framework (QOF), which is a national performance management tool, was being used in the practice to ensure that identification and reporting of incidents was appropriately actioned and to demonstrate a track record of safety.

Informal and formal discussions took place with the Clinical Commissioning Group (CCG) and this provided the practice with outcomes and targets to work towards to ensure safe patient care.

Learning from Incidents

Incidents that occurred and significant events audits or analysis (SEA) were verbally reported to staff and later discussed at clinical meetings. The meetings were held every three months to discuss the issues and to ensure a resolution was made. These events were recorded for the meeting.

Shared learning records from these events were not formally recorded in a log.

Policies and procedures were in place and available to all staff to assist them to carry out their roles in a safe manner.

Safeguarding

We spoke with staff who were able to demonstrate an understanding of safeguarding procedures to protect vulnerable patients. All staff had safeguarding training, completed within the last 12 months. Staff knew the procedure in relation to reporting safeguarding incidents with use of minuted meetings and contact with the local authority. One of the GPs took responsibility for leading on safeguarding in the practice, but time pressure meant that external meetings could not always be routinely attended in person.

Monitoring Safety & Responding to Risk

The practice had developed clear lines of accountability for the care and treatment of patients. There were systems in place to monitor safety and report risk. This was monitored by the practice manager and senior staff.

Staff felt supported by the GP and practice manager in that training was provided to ensure that staff could respond to risks accordingly. We were informed that the practice held a morning briefing each day in order to highlight any safety or risk issues and to secure the vision for the practice.

Some members of staff clearly knew who was the leader of certain clinical roles such as safeguarding and infection control whilst others did not know who was the lead for each role.

The practice had grown rapidly in size and many staff in the team were relatively new to Issa Medical Centre having joined from other practices. The team provided their own cover for holidays and sickness absence and addressed busy periods in the practice. The team knew what action to take in responding to urgent or emergency situations. Staff joining the team from other practices were subject to ongoing checks in keeping with the practice policies.

Medicines Management

ISSA medical centre had a process in place for prescribing and reviewing prescription medicines. There was a dedicated prescription telephone line for repeat prescriptions that was open between 1pm – 5pm each working day. Repeat prescriptions could be ordered on the telephone line, via reception staff or online, although the online service was rarely used.

Reception staff had access to printing repeat prescriptions for a restricted number of medicines. The practice used a virtual message board system for queries and authorisation of certain medicines. Repeat prescriptions were reviewed every six months by the doctor.

A healthcare assistant completed audits, monitored recalls and safe disposals of unwanted certain medicines including warfarin. The audits were up to date and clear.

Are services safe?

The practice had close links with the pharmacy that operated within the medical complex. Patients were able to get their medicines easily with the pharmacy in close proximity. We looked at the medicines that were on site for example, adrenaline – usually used in anaphylactic shock – which was held in a locked cupboard and in date. This could cause problems if there was an anaphylactic emergency, as there was a dedicated place for the key which was in a different vicinity to the locked cabinet. There were two fridges in the practice which were both locked. On the front of each fridge was a list of medicines and the temperatures they should be stored at which was checked daily. All medicines were stored correctly and vaccinations were in date. A nurse stated that expiry dates were not checked as the medicines were used frequently and stock was kept to a minimum.

An audit of the record keeping for medicines management had not yet been carried out. This included the issuing of prescription pads with the exception of the healthcare assistant whose audit was complete. The practice was looking to improve this area by putting in place a system of auditing and monitoring medicines and prescription pads.

We saw that medical alerts and the National Institute of Health and Care Excellence (NICE) guidance came into the practice via each individual GP, who discussed them informally with the practice manager. The CCG pharmacist member then did independent research and informed the practice manager of any action required.

Cleanliness & Infection Control

We saw all areas of the practice had a high standard of cleanliness and the building was well maintained. Several patients we spoke with and those that completed the Care Quality Commission (CQC) comment cards stated that all facilities and rooms were clean.

There were no documented issues of infection control concerns. Speaking to members of staff, it was unclear as to who was the lead in infection control.

Soap, water and hand sanitising liquids were provided within all consulting rooms. The wall mounted dispensers had embossed into them written and pictorial information which promoted good hand hygiene.

There were sufficient quantities of gloves and aprons and the consulting couches had paper rolls protecting them.

We spoke with staff who told us they were trained in infection control. We saw evidence of audits for cleaning, infection prevention and control. We saw clinical and other waste was managed appropriately.

Staffing & Recruitment

The practice had a comprehensive and up-to-date recruitment policy in place. The policy detailed all the pre-employment checks to be undertaken on a successful applicant before that person could start work. We looked at recruitment files and we saw that the recruitment policy had been fully followed in line with the current legislation.

As other practices have joined Issa Medical Centre their staff records have been transferred over. The practice had ensured key data was in place in staff files and had a process of standardisation for further recruitment in keeping with its policies.

Dealing with Emergencies

We saw an updated business continuity plan. However, some staff we spoke with did not know whether there was a business continuity plan in place to deal with emergencies that might interrupt the running of the service such as power cuts in adverse weather conditions. More experienced staff who had been with the practice for some time knew that there was an emergency mobile telephone if the main telephone lines were inaccessible in such conditions.

All staff were trained to a minimum of basic life support to ensure patients had emergency care if needed.

Fire alarm testing, which was to be completed monthly, had not happened within the last three months.

Equipment

Emergency equipment including a defibrillator and oxygen was readily available for use in an emergency. We saw that there were processes in place to regularly check and calibrate equipment. We saw a system in place to regularly check the equipment used in clinical areas. Staff were aware of the processes in place to report faulty or broken equipment.

Are services effective?

(for example, treatment is effective)

Our findings

The practice was effective. Clinicians were trained and opportunities had been made available for staff to have update training as necessary and records of this were kept including certificated updates for clinician's skills. The GPs used structured audits and evaluations to help them to maintain and improve clinical outcomes for patients using a cycle of continuous improvement. As a teaching practice trainee doctors were supported and evaluated regularly.

All staff had regular supervision and an annual assessment of their performance was recorded in order to identify strengths and where any developmental or training needs were highlighted for the upcoming year.

Promoting Best Practice

The clinical staff in the practice had received training to ensure they could recognise and respond to people's needs using best practice guidelines.

Clinicians we spoke with demonstrated their knowledge of patient assessments and explained to us how care was delivered in line with current published best practice.

Clinicians were clear about how to obtain consent, particularly if mental capacity was an issue within the meaning of the Mental Capacity Act 2005.

We saw audits that evidenced that prescribing was appropriate and was reviewed and monitored.

End of life care protocols were in place.

We saw prompt referrals were made to other health and social care services by the practice. The practice could demonstrate that they regularly monitored referrals to ensure they were prompt and had been received. All referrals were sent to the other services on the same day. This ensured that best practice was followed by improving timely access to services.

There was a multi-agency, multi-disciplinary approach to working at the practice which meant that all aspects of patient care was well co-ordinated and responsive to patient need. We found the clinicians adhered to the requirements of the Mental Capacity Act 2005 and the Children Act 1989 and 2004. Capacity assessments and Gillick competency assessments of children and young people, which check whether children and young people have the maturity to make decisions about their treatment, were an integral part of clinical staff practices.

Management, monitoring and improving outcomes for people

We saw evidence that audits were undertaken within the practice. The practice manager completed and circulated a monthly activity report with a number of comparators such as number of referrals made. These activities were compared to the previous month's activity report and could be compared to previous years. This assisted the practice in its forward planning for the treatment care and provision needed for their patients.

The practice held regular meetings to monitor the practice's performance. The monthly data the practice manager provided was also used for discussion at the Patient Participation Group (PPG) meetings and clinical meetings held at the practice. We were also told that each month a secondary care (that is hospital) consultant comes to the practice for clinical speciality meetings. This ensured that there was regular monitoring to ensure best care was provided and continuous learning and education.

We looked at how the practice utilised the Quality Outcome Framework (QOF). The QOF is a system to remunerate general practices for providing good quality care to their patients and to help fund work to improve the quality of healthcare delivered. The practice has held meetings in the past but they have not discussed the QOF during meetings recently.

Patients told us they were happy and the doctors and nurses at the practice managed their conditions well. They found if changes were needed they were fully discussed with them and choices were offered to best suit their needs and conditions.

Staffing

GPs and Nurses were in receipt of supervision of their practice at least annually There were systems in place to check the registration of doctors and nurses with the relevant professional body.

From discussion with staff we were told, the practice had developed a comprehensive induction policy and

Are services effective?

(for example, treatment is effective)

identified a period of induction for all new staff. The induction covered a wide range of training such as dignity and privacy, equality and diversity, as well as mandatory training and a relevant medical centre induction.

All appraisals for the GPs and senior staff had been completed within the last 12 months. Other staff appraisals had recently lapsed. Speaking to the staff during the inspection, they said this would be rectified over the next few weeks.

Working with other services

The practice had strong relationships with other community services including Age UK. Age UK is a charity dedicated to supporting young people to start in the caring profession providing the best care for the over 60's. We saw a letter from a training instructor that collaborated with the medical centre stating that they enjoyed the mutually beneficial collaborative partnership with ISSA Medical Centre and that the feedback from the learners had been positive. Both parties said that they have improved relationships with other agencies and the community as a result. The practice had also been able to recruit many of the volunteers into positions as the medical centre has grown. Age UK and the volunteers have been very appreciative of this.

One patient stated that referrals to other services were quick. Each GP managed their patients' treatments autonomously, seeking advice and guidance when needed. If a referral was needed, they completed the referral form and sent it within minutes of the patient seeing them. All correspondence was sent on the same day. We saw evidence of the practice working closely, when necessary, with district nurses, health visitors, school nurses and Preston Primary Care service who was the Out of Hour's provider. Also, there was a system in place to ensure clinical staff received and monitored any out of hour's activities or notes, or communications received from other professionals.

Health Promotion & Prevention

Staff spoke to patients to gather information on the types of needs patient's presented with and understood the number of heath conditions being managed by the practice.

The practice provided information for a range of conditions and end of life care. Patients requiring end of life care were identified by a letter from the hospital. There was a lead clinician who ensured that a register of patients was kept up to date and that each patient had a dedicated GP. However, there was no formal process for a named GP and there were no formal care plans for these patients only the suggested plans created by the palliative care team.

There was limited information available for patients both in the waiting room and on the website, for example; there was no information on chlamydia screening or promotion of safe sexual health. The practice explained why there was no information of this type saying that was because of the non-sexual behaviour of teenagers and young people in this community. There was a good amount of information on diabetic testing and screening as there were a large number of patients with diabetes.

Are services caring?

Our findings

The practice was caring. We spoke with 16 patients during the inspection and received 29 completed Care Quality Commission (CQC) comment cards. Comments were very positive about the kindness shown by all staff and that they were treated with dignity and respect. All patients said they had confidence that their personal information was kept private at all times.

Respect, Dignity, Compassion & Empathy

We saw that staff interacted well with patients when they arrived at the practice. They were polite, welcoming, professional and sensitive to the different needs of patients. The reception desk always had at least one member of staff available. We also observed staff dealing with patients on the telephone and they responded in an equally calm professional manner.

We saw the practice had confidentiality and chaperone policies in place and staff were aware of these. We saw that some staff had undergone chaperone training and were aware of their roles and responsibilities when supporting patients. We saw information displayed explaining that patients could ask for a chaperone during examinations if they wanted one. They told us if a patient was distressed and wanted to speak in confidence they gave them the option to speak directly to the doctor or nurse in private. The staff we spoke with were aware of the importance of maintaining people's privacy and dignity.

Patients we spoke with and those that completed the Care Quality Commission (CQC) comment cards said that all staff treated them with respect and dignity.

We were told a variety of reception staff could speak in different languages so that patients could speak in their first language if they struggled with English. If a language was not spoken by the reception staff, a telephone service was available for use. One patient we spoke to said that this service was excellent and the staff did not rush them whilst they took their time to understand.

Involvement in decisions and consent

We found the healthcare professionals at the practice adhered to the requirements of the Mental Capacity Act 2005 and the Children Act 1989 and 2004. This included capacity assessments and Gillick competency assessments of children and young people, which check whether children and young people have the maturity to make decisions about their treatment.

We spoke with patients during our visit and received 29 completed Care Quality Commission (CQC) comment cards. Many said that they received a clear explanation of the treatment they received and staff were able to discuss alternative treatments and referrals. One patient said that the doctor offered care and treatment choices where possible and explained the best course of treatment compared to the alternative treatment methods.

Consent for procedures was given verbally.

We saw patients had access to a chaperone service when they underwent an examination. Information about chaperones was available on request from the reception.

The practice had a self-check in system which operated up to 60 languages in order to maintain a swift and efficient check in service which was easily understood by all patients.

Carers told us that they felt supported by the practice in making decisions.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

The practice was responsive. Patients spoke very positively about the practice. Parents and grandparents were very positive about the support they received in relation to the care of their children / grandchildren.

The practice had set up a patient participation group (PPG). This group was active and felt supported by the practice. Members of the PPG said that they were able to have a voice and that the practice listened to them as they contributed to the on-going development of the practice.

The practice had a complaints policy and complaints were responded to in a timely manner.

Responding to and meeting people's needs

There was a large car park of 50 parking spaces to the rear of the practice and the building was purpose built. The practice was easily accessible to patients with mobility difficulties. A lift was available for patient's use.

Reception staff could speak multiple languages for patients who did not understand English and access to a telephone interpretation line was available.

We looked at how responsive the practice was to making and reviewing referrals and saw that there were prompt and responsive systems in place to monitor and review this regularly. We saw that there was a process in place for referrals and for patients to accept or decline. The practice fostered a positive culture of choice in their own treatment.

A variety of services were available for people to use.

Access to the service

There were a wide variety of languages spoken by patients, the main languages being English, Bengali, Hindi, Punjabi, Urdu and Gujarati.

The practice had touch screens for use to ease patient sign in. We saw several patients use this facility during our observations. The system had up to 60 languages so all patients could access the sign in facility.

Appointments could be booked for up to two weeks in advance and there was a limited number of same day appointments that were provided on a first come first served basis.

Patients who were full time workers found getting an appointment difficult as the practice had no extended hours. The access to out of hour's services provided by the practice was limited to lunch times, where patients could get education for conditions and ailments, antibiotic prescribing and emergency appointments for those who were not able to be seen in the morning.

Patients we spoke with and two of the 29 comment cards mentioned they had difficulty in getting appointment. One patient said that they could never get through on the telephone in the morning and when they eventually got through; the appointments had been booked and they were asked to ring again the following day. The same patient said that they could not get an appointment for their ill child and therefore learnt to exaggerate the symptoms so that the child could be seen. The policy at the practice was for children to be seen on the same day as necessary.

Concerns & Complaints

There was a complaints policy and the practice was able to handle staff and patient concerns made correctly, effectively and in a timely manner. Those that did not use the correct complaints procedure however, found some difficulties, with many patients stating that they did not know how to make a formal complaint. The patients we spoke with who wanted to make a formal complaint said they had mentioned their complaint to a member of staff but had had no resolution to the verbal complaint made and did not know the correct procedure.

The practice had a complaints policy and was able to handle staff and patient concerns.

Concerns and complains were discussed every three months at the clinical meeting and resolutions were discussed with staff at their subsequent bimonthly meetings.

Are services well-led?

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

Our findings

The practice was well led and effectively responded to changes. The lead GP had provided strong and clear leadership and had implemented a clear and concise strategy for the practice. ISSA Medical Centre was a relatively new practice which had demonstrated a strategy of a growing medical centre as many patients had joined within the last 12 months.

Leadership & Culture

The practice was well led by the GP who had a clear vision and purpose for the medical centre. Under his leadership the practice had clearly built up strong links and connections with the local community health services to ensure high quality care for patients.

We were told that there were leads in areas such as safeguarding, diabetes, complaints and infection control but we found that staff gave conflicting names or did not know who the lead was.

Appraisals were clearly important in order to maintain the high quality care provided to patients and the ever changing demands of patients. The practice encouraged a positive learning environment ensuring that all staff had completed regular mandatory training and any courses to enhance their continual professional development (CPD) needs.

The clinical and non-clinical staff we spoke with took an active role in ensuring that a high level of service was provided on a daily basis.

The practice manager published a 'monthly activity report' detailing the numbers of appointments made, numbers of appointments where patients did not attend, number of referrals, telephone calls and prescriptions written. This was compared to the previous month's activity and circulated to appropriate staff in order to keep staff updated

Governance Arrangements

The practice monitored its performance against the national Quality Outcomes Framework (QOF).

The practice had a range of staff and patient volunteers called the Patient Participation Group (PPG) that met monthly to discuss training, performance and quality of the practice and completed analysis and review of data, such as referral numbers, new patients and appointment numbers. The discussions of the PPG contributed to the wider monitoring arrangements used by the management team forming part of the performance monitoring audit process which the practice had in place.

Systems to monitor and improve quality & improvement

The practice held staff meetings every two months to share common aims and visions for the practice as well as keep staff up to date with current practices and policies. Staff could also raise issues and concerns openly at these meetings. This information was then used in a clinical meeting the following month to discuss resolutions, and training needs could be identified for individual staff and whole staff training.

With the growing practice, policies and procedures inevitably needed to be updated regularly to deal with the growing demand. The practice manager provided staff with regular updates and new policies to ensure high standards of care and to ensure that staff were able to be patient focused. The constant updates could mean that some staff were uncertain on procedures due to a lack of consolidation.

The staff had receiving training and had undertaken a variety of very detailed clinical audits, which were made available to us for our information. This information could be used by the practice to ensure a cycle of continually improving care for patients.

Patient Experience & Involvement

A Patient Participation Group (PPG) was set up at the practice. A PPG is made up of a group of volunteer staff and patients who meet or communicate regularly to discuss the services on offer and how improvements can be made for the benefit of the local patient population and the practice. We saw on the practice web site that the minutes of the meetings were available. The minutes outlined issues that had arisen and their conclusions as well as future developments that ISSA medical centre was working on, including a time frame for implementation.

Members of the PPG recognised the importance of the group as it considered the views of patients who used the services and those close to them including carers. It did take a proactive approach to seek feedback and the members, on the whole, were satisfied with this process. We were told that the facilitation of the PPG meetings was

Are services well-led?

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

sometimes challenging as not everybody understood all discussions. We were told that this was because some participants sometimes continued discussions in their own language.

The practice made the local patient surveys available. The latest patient survey saw 91 patients make a response. The survey focused upon patients appointments. This included how easy it was to make an appointment, who the appointment was with, the preference when making appointments and being able to make their appointment more than two days in advance. The results showed that 87% thought it was easy to get an appointment and 69% arranged their appointment by telephone. Feedback also suggested 76% of patients said it was important to book an appointment more than two days in advance and only 52% were able to do this in the past six months.

Within the survey there were no questions asked in regards to their treatment from the medical staff or their patient experience and involvement in their own care.

We spoke with members of the PPG who spoke positively about the open forum style meeting in place and to discuss any issues that had arisen to ensure that the practice was aware of patient demands and continually learning to improve.

Staff engagement & Involvement

Staff meetings took place every two months. In these meetings policies and procedures were discussed and new policies introduced to all the staff as necessary. Information about complaints and resolutions were also shared here. Staff we spoke with found it difficult to express how valued they were in these meetings. From the minutes we saw, we found that staff engagement was minimal, with the meetings being led from senior staff.

Nurses attended monthly meetings and told us there were opportunities each day for discussion about any issue that arose to ensure that best practice guidelines were being followed.

Staff knew about the whistleblowing policy and knew how to use it. They were able to access the policy at any time.

Patient Participation Group (PPG) meetings were minuted and shared with staff. Staff and team meetings were held every two months where opportunities were made for staff to discuss issues and to find resolutions. Significant events audits (SEA) and complaints were shared with staff during these meetings.

Learning & Improvement

All staff had received essential and mandatory training relevant to their role. Training and development needs for individuals were linked to 'one to one' supervision meetings. Any training needs arising were recorded and linked with any key job role objectives. Training programmes were being developed to reflect the growth of the practice and that development formed part of an on-going strategy of practice development. GPs had undertaken their statutory revalidation as required by the General Medical Council (GMC).

Services were being developed at the medical centre, not only by virtue of other practices merging, but also with the introduction of new services on first floor of the practice. This included neurology and physiotherapy services and ear nose and throat services were anticipated in August 2014. As part of this development the practice had taken time to review, plan and implement improvements in performance in services offered.

Identification & Management of Risk

The practice had adopted a written risk assessment approach. A system was in place for the recording, investigation and learning from significant events. Clinicians were well versed in patients' lifestyle health risks and had implemented systems. For example in relation to smoking cessation, use of antibiotics and encouraging more women to attend for routine smear tests. The management of risks to the delivery of services at the practice was addressed by an up to date practice emergency contingency plan and health and safety arrangements were in place for the premises and users of the premises.

There were appropriate procedures in place to protect staff and patients from dangers associated with sharp equipment such as needles.