The Elms Medical Centre

Quality Report

Hoole Rd
Chester
CH2 3NH
Tel: 01244351000
Website: www.elmsmedicalcentre.co.uk

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

Summary of findings

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Summary of findings

Overall summary

The Elms Medical Centre provided care and treatment from the main practice and a branch surgery at Blacon, Chester. We visited both locations as part of this inspection.

The service is registered with the Care Quality Commission to provide the following regulated activities:

Treatment of disease, disorder and injury, diagnostic and screening procedures, surgical procedures, family planning and maternity and midwifery services.

The patients we spoke with were very positive about the care provided. They told us the staff were kind and caring and treated them with respect.

The practice provided care and treatment in an environment which was clean and well organised. The building was well maintained and fit for purpose. Systems were in place to monitor patient safety.

The practice responded well to patient's needs and they undertook appropriate investigations of incidents.

Learning was disseminated to all staff, in order to improve care.

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 service was safe. There were systems in place to monitor patient safety. Effective systems were in place for safeguarding children and adults. It was clear that events were comprehensively reviewed and actions identified. Care and treatment was provided in an environment which was well maintained.

Are services effective?
The service was effective. Care and treatment was provided in line with evidence based practice and national agreed guidelines. Referrals to secondary care were timely. The performance of staff was appropriately assessed through appraisal and the practice undertook regular monitoring by clinical audits.

Are services caring?
The service was caring. All patients we spoke with during the inspection were positive about the practice. We saw patients were addressed in a professional but friendly manner. Staff showed patience when dealing with patients on the telephone, booking in or attending the reception desk

Are services responsive to people's needs?
The service was responsive. Patients were given the opportunity to give feedback about the service they received. The practice had appropriate systems in place to acknowledge, investigate, report and respond to any concern or complaint.

Are services well-led?
Some aspects of the service were well led. Staff felt there was a strong focus on patient care and that leadership was good. However staff were not consistently able to explain the future strategy for the practice. Staff were not always clear about their responsibilities when in lead roles.

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 was in the process of allocating a named GP for all patients over 75 years of age, to improve the continuity of care for older people. In addition to the emergency appointments, daily overflow surgeries were available. There were daily overflow surgeries available which were primarily aimed at providing easy access for older patients.

People with long-term conditions
Systems were in place to monitor patients with long term medical conditions. Patients were recalled for reviews in a timely manner.

Mothers, babies, children and young people
Suitable arrangements were in place for the safeguarding of children. Expectant mothers and babies had access to care, treatment and support from midwives and health visitors. The practice was proactively encouraging young people to self test for sexually transmitted diseases.

The working-age population and those recently retired
The practice provided extended hours for patients who worked. This meant appointments could be accessed at a time to suit most patients.

People in vulnerable circumstances who may have poor access to primary care
Safeguarding arrangements were effective in identifying patients in vulnerable circumstances who may be at risk. The practice was working to ensure patients whose first language was not English had access to information in other languages. Instructions in Polish had been added to the electronic checking-in system.

An 'at risk register' was maintained and monitored by the lead GP.

People experiencing poor mental health
The practice did not include information about assessment of mental capacity in their consent policy, however when we spoke with the GPs and staff, it was clear where patients lacked capacity to consent, the practice acted in accordance with legal requirements.

Summary of findings

What people who use the service say

We spoke with 12 patients who were visiting the practice during the inspection. We also spoke with two members of the Patient Participation Group (PPG) by telephone.

The comments from all the patients we spoke with about the care and treatment provided were positive. Patients told us they thought they received enough information about their treatment and what options were available.

Patients said staff were caring and that they were treated with dignity and respect. We were told their privacy was also maintained during any consultation.

We received negative comments about the telephone booking system. Patients told us they experienced long waits, trying to get through to the practice to make appointments.

The national patient survey in 2013 also revealed similar comments about access to the practice appointment system.

Areas for improvement

Action the service COULD take to improve

Out of date medication was found at the branch surgery Blacon Clinic.

The storage arrangements for the cleaning materials used by the external contractors were inadequate and data sheets to inform cleaning staff of the potential hazards of substances in use were not available.

The consent policy guidance made no reference to the assessment of the mental capacity of patients.

There was no hearing loop to assist the hard of hearing in the reception

There was no clear vision and strategy for the future of the practice amongst staff.

The Elms Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and the team included: a GP, a practice manager, a CQC Inspector and an Expert by Experience.

Background to The Elms Medical Centre

The Elms Medical Centre provides primary medical care and treatment for 10,015 patients who live in Chester. 11% of patients registered are over 70 years of age, with 22%, the majority, of patients 50 to 69 years .

The main practice is based close to the city centre, with easy access by public transport and main roads. There are two treatment rooms and five consultation rooms. The practice has a branch surgery Blacon Clinic, in the Blacon district of Chester. This is situated in temporary premises within a church hall.

Staff with in the practice consists of: Four GP partners, three salaried GPs, one nurse practitioner, four practice nurses, one healthcare assistant and administration and reception staff.

Out of hours services are provided at the local NHS hospital, The Countess of Chester.

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

Before visiting, we reviewed a range of information we hold about the service, along with information submitted by the practice. We also asked other organisations to share what they knew about the service. The information reviewed did

Detailed findings

not raise any significant risk across any of the five key question areas. We carried out an announced visit on 2 June 2014. We spent a total of nine hours at the practice, in addition to two hours at the branch surgery.

During our visit we spoke with a range of staff which included three GP's, the Practice Manager, Deputy Manager, Nurse Practitioner, two Practice Nurses, four Administration and three Reception staff. We spoke with 12 patients who were using the service on the day of the visit and we contacted two members of the Patient Participation Group (PPG)by telephone.

We saw how people were being treated and also spoke with carers and/or family members. Care Quality Commission comment cards had been available for patients to complete for a number of days prior to the inspection and on the day. We received three completed cards.

Are services safe?

Summary of findings

The service was safe. There were systems in place to monitor patient safety. Effective systems were in place for safeguarding children and adults. It was clear that events were comprehensively reviewed and actions identified. Care and treatment was provided in an environment which was well maintained.

Our findings

Safe patient care

There were systems in place to monitor patient safety. Information from data sources reviewed indicated the practice had a good track record for maintaining patient safety. There were arrangements in place to report any safety concern and the practice was able to use a range of sources to identify events that might affect patient safety. These included complaints, audits and patient surveys.

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

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

Learning from incidents

There was a detailed policy and procedure in place which gave staff guidance on the management of any event, this included; recognising, reporting, analysing and identifying learning following any event. Regular significant event analysis meetings were undertaken and attended by all GP's and the practice manager. From review of the meeting minutes it was clear that events were comprehensively reviewed and actions identified. These were undertaken to avoid any reoccurrence. Learning and actions required were then disseminated at clinical meetings held twice a month and monthly nursing meetings. The practice had no summary log for each quarter of the year, as all events were filed individually. This made it difficult to ascertain any themes from significant events. The practice manager and deputy both confirmed that work to produce this was in progress.

External safety alerts were managed appropriately. The practice manager was responsible for sharing alerts and in

their absence, the deputy. The practice manager described to us the processes they followed when the service received safety alerts from external sources such as the Medicines and Healthcare Regulatory Agency (MHRA). Staff confirmed how any actions required were shared.

Safeguarding

Staff had received annual training in safeguarding children and vulnerable adults. There was a nominated GP lead for both child and adult safeguarding. The lead GP, along with the other GP's had undertaken level 3 child safeguarding training as recommended by professional guidance. The practice had clear systems in place to support staff to recognise, report and manage any safeguarding concerns. There were robust policies and procedures in place to protect both adults and children. We saw in each treatment and consultation room there were flow charts to assist staff in escalating any concerns, with a range of local authority and support agency contact details.

The electronic patient record system had alerts to identify when children were subject to a child protection plan or were looked after by the local authority. Vulnerable patients and families were also flagged.

There were regular meetings with health visitors linked to the practice and information was shared appropriately. The lead GP was able to explain how the practice had reviewed information sharing procedures following a serious case review. We noted the lead GP attended regular multi-disciplinary safeguarding meetings with midwives, and other health and social care professionals. Reports were submitted to child protection conferences when requested. However we were told, attendance at meetings was difficult as invitations were often at very short notice.

Monitoring safety and responding to risk

Staffing levels on the day of the visit were adequate to support the needs of the patients. A detailed rota system for GP's, nursing and administration staff was in place. This helped to manage and recognise any potential staff shortfall. GP's and staff were also rostered to work at the Blacon Clinic. Most staff at the practice worked part time. This allowed flexibility to respond to staff sickness and absence within the existing staffing establishment. We were told that in the event of absence for a lengthy period the practice maintained clinical staffing levels by using locums

The practice had arrangements in place to carry out regular checks to monitor fire and other health and safety requirements to ensure the practice was safe and fit for purpose. At the Blacon Clinic staff had responded well to the limitations of space as far as practicable, within the premises.

There were systems in place to deal with medical emergencies. We saw certificates demonstrating that staff were trained in basic life support (BLS).

Medicines management

GP's and other clinical staff had up to date policy and procedure guidance for the management of medicines. British National Formularies were available and were current. This is a joint publication by the British Medical Association and the Royal Pharmaceutical Society, which provides prescribing information about medicines, their use and contra-indications.

Management of medicines was the responsibility of two administration medicines managers and one GP, who was the prescribing lead. There was an effective system to monitor medications when patients were discharged from hospital. This ensured any required changes to prescribed medication were noted and actioned quickly. Patients also received phone calls from the practice to explain those changes in medication.

Medication was stored securely. In order to ensure maximum effectiveness some medications and vaccines were stored, as required, in medicines fridges. We saw daily temperature checks were carried out and staff had guidance in place to follow, when temperatures were found to be out of range. The practice had appropriate arrangements in place which ensured medicines and vaccines transported between The Elms and Blacon Clinic, remained at the correct temperature during transportation. There were systems in place to monitor the quantity of medication held and ensure there were adequate supplies.

There were systems in place to check that stocks of medication held on site and in Doctors on-call bags were within expiry date. Monitoring was effective at The Elms but at Blacon Clinic we found adrenaline in one of the two emergency boxes which was out of date. Adrenaline is used for the emergency treatment of severe allergic reactions. The box with the out of date drug was kept in a multi use cupboard which potentially, was not easily

identified in an emergency. We spoke with the practice manager who assured us they would have emergency drugs situated in one place, which was accessible to all and could be identified and monitored more effectively.

Cleanliness and infection control

The practice had comprehensive policies and procedures which provided guidance and instruction to staff on all aspects of infection prevention and control (IPC). There was an infection control team which comprised of two of the clinical staff. All staff had received training in infection control.

The practice was clean and organised on the day of the visit. We were told an external company was responsible for the cleaning, through a domestic services contract arranged by the local NHS Trust. We saw audits were undertaken to monitor the effectiveness of the service. We were told there had been some shortfalls identified, but the company had rectified these and this was being effectively reviewed.

The storage arrangements for the cleaning materials used by the external contractors were inadequate. At The Elms we saw the cleaner's cupboard was also used for storage of clinical waste. At both The Elms and Blacon Clinic not all infection control arrangements were in line with best practice. In Blacon cleaning fluids were not securely stored and were accessible to members of the public, creating a potential hazard. We also noted that data sheets to inform cleaning staff of the potential hazards were not available. The practice manager said data hazard sheets were supplied by the cleaning company but they would ensure they would be readily available for staff on both sites.

The practice did not audit whether staff followed the IPC policies; for example, when hand washing or disposing of clinical waste to ensure themselves infection risks were minimised.

Staffing and recruitment

We sampled the recruitment records of five members of staff. The sample included clinical and non-clinical members of the team. Overall the practice had effective recruitment procedures in place to ensure staff employed had the skill and experience necessary for their roles and responsibilities. We saw interview records, identity checks, and references obtained prior to employment. Checks were made to ensure that people were physically and mentally fit for the work.

We saw the practice had an effective system for checking the registration of nurses with the Nursing and Midwifery Council (NMC). A list of renewal dates was maintained and copies of the NMC registration checking page were kept filed. The practice however did not replicate this system for the GP's. The practice manager assured us that they would replicate the same system for the GP's in order to have a better oversight when renewals were due. We saw both nurses and GP's were members of the Medical Defence Union (MDU) and each had up to date indemnity insurance.

Dealing with Emergencies

The practice had a business continuity plan in place, however this did not indicate the date of implementation or date of review. The practice manager explained the plan was reviewed annually or as required. A recent example was the provision of emergency mobile phones had been reviewed due issues with the telephones lines into the practice.

The plan had been agreed by the local Clinical Commissioning Group (CCG) and other relevant organisations. This meant the practice had comprehensive procedures in place in the event of any emergency that would stop the routine function of the practice.

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

Equipment

General equipment around the practice was clean and maintained in good working order. We saw evidence of annual portable appliance testing (PAT) and there were maintenance and service contacts in place.

Emergency equipment was available and staff were familiar with the location of emergency drugs, oxygen and defibrillator. We saw emergency equipment had been checked to ensure it was functioning correctly.

A self monitoring blood pressure machine had recently been installed at The Elms for patients to carry out self-checks. Explanation of how to use the equipment was displayed and people were advised that they could request the assistance of practice staff for further help if required.

Are services effective?

(for example, treatment is effective)

Summary of findings

The service was effective. Care and treatment was provided in line with evidence based practice and national agreed guidelines. Referrals to secondary care were timely. The performance of staff was appropriately assessed through appraisal and the practice undertook regular monitoring by clinical audits.

Our findings

Promoting best practice

All clinical guidelines were available on the shared electronic system. Care and treatment was provided in line with evidence based practice and national agreed guidelines. Lead GP's were nominated for chronic disease management and other clinical lead roles. Each GP lead was responsible for reviewing National Clinical Institute for Health and Clinical Excellence (NICE) guidance on clinical treatments were up to date for their specific lead area. They were also responsible for ensuring information was disseminated to GP partners and clinical staff.

The practice held regular clinical meetings to discuss clinical issues and to ensure best practice guidance had been followed. Quarterly primary care meetings were undertaken with other external lead professionals which ensured shared learning and best practice. A range of journals and a number of current medical text books and publications were available.

We discussed care planning with the practice manager and nurse practitioner and we were able to establish effective care plans were in place for patients with complex needs.

Management, monitoring and improving outcomes for people

The practice had established good working relationships with the Clinical Commissioning Group (CCG). This had resulted in better understanding and implementation of clinical care pathways for patients.

We saw there were appropriate referrals made for care and treatment in hospitals or the community and that these were undertaken in a timely manner. The practice utilised the national "choose and book " system. This meant that patients were able to receive the right treatment within acceptable time frames. The practice had done work to recognise and refer effectively, patients who required treatments for cancer.

A number of additional clinics had been implemented to improve care for patients with chronic diseases. Lead GP's and nursing staff leads contributed to the efficient management of care pathways and treatment. The practice effectively signposted patients to additional support groups. These included help with chronic diseases and dementia..

Are services effective?

(for example, treatment is effective)

We saw that new patients joining the practice were requested to complete a health and well being questionnaire. We noted patients were asked about matters such as their medical history, current medication, allergies, chronic diseases and family history. Information about social and lifestyle issues such as smoking, alcohol use and carer support was also requested. New patient consultations were requested

Staffing

The practice had a comprehensive system in place for identifying skills needs for all grades. The nursing team had undergone training and shared skills which enabled them to run a variety of clinics. For example, smoking cessation, chronic disease management and advice, dressings, suture removal, ear syringing, injections, blood pressure checks, holiday vaccinations, cervical smears, well woman and well man checks.

New staff who joined the practice were required to complete the practice induction programme. This included introduction to policies and procedures and opportunity to shadow more experienced colleagues carrying out their role. When we spoke with staff about their induction, they were very positive about the programme. They told us they had been well supported and supervised throughout their induction as they familiarised themselves and gained confidence in their role.

Nursing, healthcare and non-clinical staff had formal annual appraisals with their respective line managers. We sampled appraisal records of three staff. Examples of discussions included their job role, learning goals, training and development needs, record of attendance at practice meetings and response to management communications and staff notices. GPs followed the national programme of appraisal and future revalidation requirements by their professional body, the General Medical Council.

Staff we spoke with confirmed they felt adequately supported by their line managers. They told us they were readily available if there were any matters they wished to discuss with them. Staff said that GP's were approachable and they felt very much part of a team.

Working with other services

We saw the practice had established integrated working links with the local palliative care team. There was a lead GP for end of life care. We found the practice maintained a palliative care register which was shared with the out of hours service. This ensured that patients were receiving the most effective care and treatment as they approached end of life.

We found the practice worked well with district nurses, health visitors and midwives providing care for patients. There were arrangements in place to ensure the flow of information between the practice and other healthcare professionals. Links had been made with Vintage Blacon , a charity organisation focused in providing support for the elderly suffering from dementia. The practice was raising awareness of the group with patients.

The GP's also provided care and treatment at a near by residential care home, with routine visits made each Friday and call outs when required in any emergency.

Health, promotion and prevention

The practice had a wide range of information for patients. Numerous notice boards displayed information on various health and well being topics. We saw that the practice had an on-going initiative encouraging people to self-test for Chlamydia. Information posters were displayed in the waiting area and public toilets. We saw self-test kits and instructions on use were available for people to use.

Monthly newsletters were produced which highlighted current events and initiatives. The practice website also contained guidance and information for patients. We saw that there was general guidance available promoting good health and information about specific conditions, for example, diabetes and cancer.

The practice nurses explained that health promotion was discussed with every new patient and when patients attended clinics.

The practice was also promoting a carer's health and well being event. This was being organised by the local NHS community trust to provide guidance on healthy eating, health advice and health check ups for people who were caring for a relative or friend on a short or long term basis.

There were appropriate screening programmes on-going to detect as soon as possible any developing medical condition. Vaccinations programmes were also undertaken. Child immunisations were undertaken at routine child health clinics at both the main surgery and the branch at Blacon.

Are services caring?

Summary of findings

The service was caring. All patients we spoke with during the inspection were positive about the practice. We saw patients were addressed in a professional but friendly manner. Staff showed patience when dealing with patients on the telephone, booking in or attending the reception desk.

Our findings

Respect, dignity, compassion and empathy

The practice had a chaperoning policy in place. We saw notices displayed in the practice informing patients of the availability of a chaperone during their consultation if they wished. The healthcare assistant and reception staff had received training in acting as a chaperone. Staff we spoke were able to demonstrate a clear understanding of the role of a chaperone and the procedure to be followed.

Consulting and treatment rooms were lockable to ensure privacy during appointments. An emergency call system was in place whereby clinical staff could call for colleague assistance if required from each consulting and treatment room.

Patients were appropriately signposted to organisations that might provide additional support and guidance. For example, in dealing with child bereavement and Alzheimer's disease

When we spoke with patients comments included: “Staff here are very caring”, “I have only just registered here but I am very happy with the way the staff treat people”, “Staff are always very helpful and pleasant even when they are very busy” and “I am more than happy with the way the staff deal with me and my family, we have always been treated with the upmost respect”.

Another patient told us they were very pleased with the amount of support received during a long illness of a relative. They said the GP and staff treated them with understanding and compassion

Involvement in decisions and consent

Patients said they did not feel rushed during appointments. During consultations they felt they could ask anything and it was explained in an appropriate manner. Patients felt they were told about treatment options and we able to make informed choices.

In the 2013 GP Patient Survey The Elms was judged “better than expected” for staff involving patients in decisions about their care. The survey also found that patients again judged the practice “better than expected” when asked if they had confidence and trust in their GP.

The practice had a detailed consent policy in place which included guidance on the types of consent, when consent was needed and on taking consent from young people

Are services caring?

under 18 years of age. It made reference to Gillick Competency. This is when a person under 18 years of age shows sufficient understanding and intelligence to enable them to understand fully what care or treatment is being proposed. However the policy guidance made no reference to the assessment of the mental capacity of patients. One GP explained the action they would take when a patient was considered to be lacking capacity to make a decision. The Mental Capacity Act (MCA) states if a person lacks mental capacity to make a particular decision then whoever is making that decision or taking any action on that person's behalf must do this in the person's best interests.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The service was responsive. Patients were given the opportunity to give feedback about the service they received. The practice had appropriate systems in place to acknowledge, investigate, report and respond to any concern or complaint.

Our findings

Responding to and meeting people's needs

There was an automated self check in system available in the reception area. We saw this offered patients a choice of instructions in English and Polish. Staff told us they were able to access interpreter services for a patient during their consultation if required. Staff gave examples of having accessed the services to obtain interpreters in sign language for patients. We were told that it was possible to arrange for the same interpreter to accompany a patient at consecutive appointments.

We found there was no hearing loop to assist the hard of hearing in the reception. We saw reception staff trying their best to make themselves understood, but they had to raise their voice and privacy could have been compromised.

Both male and female GPs were available at the practice. Patients were able to choose to make an appointment with a GP of their choice if they wished but were likely to have to wait longer for an appointment if they did so. A leaflet, "Making the most of your appointment" was available. This gave patients useful tips to ensure their appointment was as effective as possible. For example, it explained the roles of clinical personnel within the practice to guide people to booking appointments with the right person.

In addition to the emergency appointments, daily overflow surgeries were available . These were primarily aimed at elderly and younger children with urgent needs.

The practice had a good understanding of the needs of the patients registered. Vulnerable families were recognised and additional support provided when needed.

Access to the service

We were told that the practice held a number of appointments with each GP open on a daily basis to accommodate emergencies. Extended hours were also available through the out of hours service at the local hospital. This meant that patients who worked could access appointments before or after work.

At the time of our inspection the Blacon branch was housed in a church hall as a temporary measure whilst a new building was under construction. We saw that dedicated consulting and treatment rooms had been created. These were fully equipped for the purpose for which they were intended and offered privacy for patients.

Are services responsive to people's needs?

(for example, to feedback?)

The practice encouraged people to provide mobile telephone numbers where possible so that they could send text messages with information about appointments. If patients did not attend for appointments at clinics for reviews such as management of chronic conditions or child vaccinations, this was recorded on the computer records. This triggered issue of a reminder letter to follow up on non-attendance.

Getting through to the practice to make an appointment was reported by patients as being a concern. The practice had recently experienced an issue with loss of telephone lines and had reviewed the business continuity plan as a result. The practice did not have a telephone queuing system and so patients were left with an engaged tone for a considerable time. This meant the practice had no way of calculating just how many patients gave up and sought alternative treatment at the accident and emergency department or the extended hours service.

Concerns and complaints

The practice had a comprehensive complaints policy and procedure in place. We reviewed the complaints log and found complaints were managed appropriately, within expected timeframes. We saw as a result of a complaint the practice took action, wherever possible to avoid a reoccurrence. We noted verbal complaints were also recorded following recommendations from the Medical Defence Union.

When we spoke with staff they were able to explain how they would handle any complaint raised and informed us that they would always try to resolve any issue before the need to formalise the complaint.

Complaints were discussed at significant event analysis meetings, clinical and practice meetings. This meant all staff were aware of the issues raised and what action was needed to be taken.

There was sufficient information for patients within the practice and on the practice website explaining how to make any comment or raise a complaint. Information for advocacy and other support agencies for help during the complaint process was also available for patients.

Are services well-led?

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

Summary of findings

Some aspects of the service were well led. Staff felt there was a strong focus on patient care and that leadership was good. However staff were not consistently able to explain the future strategy for the practice. Staff were not always clear about their responsibilities when in lead roles.

Our findings

Leadership and culture

From discussions with staff it was clear that there was a culture within the practice of striving to provide quality care and promote good health outcomes for patients. However there was no clear vision and strategy for the future and staff were unclear as to the plans for the future, particularly as the practice was due to move into a new health centre, which would be shared with other healthcare providers. We saw there was a good relationship between clinical and non-clinical staff. Staff told us the culture within the practice was supportive and with a strong focus on patient care. Staff also told us they felt leadership was visible. Not all staff were clear about their roles and responsibilities, especially in lead roles.

Governance arrangements

Key leads from clinical and administration staff had been identified for each area of governance and risk. These included: safeguarding, medicines management, complaints, end of life and significant events.

Clinical and practice meetings were held, along with monthly nursing staff meetings. At these meetings review of incidents, risks and other quality issues were discussed and actioned.

Finance meetings, with the practice manager and partners were held. Quality issues and local enhanced services were regularly discussed.

Systems to monitor and improve quality and improvement

There was evidence clinical audits had been undertaken and that these were used to influence and improve care and treatments of patients. For example; an audit had been undertaken following National Institute of Health and Clinical Excellence (NICE) guidance in respect of identifying patients with arterial disease (problems with circulation) who were not on anti platelet therapy. Antiplatelet treatment prevents the formation of blood clots. A register of patients was reviewed and as a result the practice was able to identify patients not on the recommended treatments, record any contraindications and implement the required treatment. A second audit was planned to review the outcomes of the treatments prescribed.

One of the GP' s led the relationship with the local Clinical Commissioning Group (CCG) and attended meetings to

Are services well-led?

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

represent the practice. There were processes in place to provide systematic assurance that high quality care was being delivered. The provider submitted clinical data through the Quality Outcomes Framework (QoF) and worked closely with the CCG. The QoF is a range of clinical outcomes by which GP practices can gain financial incentives if achieving at a certain level. The latest reports from the QoF demonstrated a high level of achievement across all the domains, these included clinical outcomes, patients experience and quality.

Patient experience and involvement

Both in the practices and on the website we saw there were a number of patient surveys on-going. For example, an asthma survey, physical activity and smoking questionnaires. The deputy practice manager explained they regularly promoted patient surveys on a variety of subjects with a view to ensuring the patient information they held, was up to date irrespective of whether or not a patient regularly visited the practice.

A practice information leaflet for patients was readily available. This was comprehensive, giving information about each GP, how to access appointments, information regarding the practice nurses role and clinics undertaken. How to make a complaint, compliment or comment was also included.

Patient surveys were undertaken in order to gain feedback at regular intervals on patient experience. The last survey demonstrated 44% rated the practice as excellent, 27% as very good 17% as good and only 6% as fair. The result mostly equalled or were higher than the national average score based on practices of similar patient list size.

A Patient Participation Group had been in existence for sometime but had been chaired by the practice manager and a GP. Recently joint chairs had been appointed from the patient representatives. We spoke with two members of the group by telephone. They had a good understanding of the purpose of the group and felt they were able to raise issues with the practice in a constructive way, to improve the service for patients. They said the membership was increasing and initiatives to continue to raise the profile of the group were planned. The move to the new premises was discussed and one of the joint chairs told us they intended to contact the bus company to increase the services to the new health centre, as access using public transport, was one of the major concerns from patients about the move.

Staff engagement and involvement

Staff told us that they received management communications and staff notices by email. They were required to acknowledge that these had been received and understood. We were told the communications were then discussed at appraisals or before if urgent action was needed.

The practice had a policy in place regarding whistleblowing. Whistleblowing is when a worker reports a concern about another staff member. Staff we spoke with were aware of the policy and of the procedure they should follow if they had such a concern. Staff told us they felt they would be supported through this process if necessary.

Practice meetings were held and nursing staff were invited, along with the practice manager and GP's. Non-clinical staff told us that historically there had been a formal staff meeting for them each month but this had lapsed. We were told that any issues were informally discussed during training days

Learning and improvement

We saw evidence of appraisals and staff said they were encouraged to discuss any issue, in addition to identifying training needs and discussing performance within their roles. We noted the practice manager had not had a recent appraisal since returning from maternity leave. We discussed this with the GP's who assured us that that would be undertaken as soon as possible.

Educational days for the clinicians and practice education days for all other staff were planned throughout the year. Training was undertaken by an external primary medical education service or by attendance at the CCG organised training events.

We found the practice manager maintained a training matrix for clinical and non clinical staff. Training needs were identified by a training needs analysis. Staff confirmed training opportunities were good. Staff we spoke with on the day of the inspection were very positive about the amount and availability of training, both for mandatory topics and personal development. We did find that nurses appointed a leads for Infection Prevention and Control (IPC) had not undertaken any additional training to support them in their role. We discussed this with the manager who assured us additional training would be sourced to support staff

Are services well-led?

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

Identification and management of risk

Environmental risks were identified appropriately through governance systems within the practice. Risk assessments were in place and were reviewed as required.

Policies and procedures were in place to support staff in their role and to provide guidance on how to identify and manage risk. For clinical areas lead GP's were appointed and were responsible for monitoring the risks associated with their area of responsibility.

The practice had no formal written plan for the sustainability of care in relation to the move to the new location. The GP's informed us they were now at the stage of addressing this and involving the practice manager in developing an operational plan to ensure the smooth transition of care and treatment into the new centre.