Conway Medical Centre

Quality Report

49 Westbourne Road
Luton
Bedfordshire
LU4 8JD
Tel: 01582 429953
Website: www.conwaymedicalcentre.nhs.uk

Date of inspection visit: 19 November 2014
Date of publication: 31/03/2015

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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Conway Medical Centre on 19 November 2014. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe well-led, effective, caring and responsive services. It was also good for providing services for older people, people with long term conditions, working age people and those recently retired people in vulnerable circumstance and people experiencing poor mental health. The practice was outstanding for the service it provided to families children and young people.

Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Complaints and comments were responded to appropriately.
- Patients said they could make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice was properly equipped to treat patients and meet their needs
- There was a clear leadership structure and staff felt supported by management. The practice sought feedback from staff and patients, which it acted on.

We saw one area of outstanding practice:

- The practice had developed considerable expertise in treating young people who were very ill with inherited

Summary of findings

conditions arising from this community. They provided specific, individually tailored care plans for these young patients that were overseen as part of the multi-disciplinary team arrangements. In addition the practice had participated in a 'rapid response pathway' pilot carried out locally that enabled direct access to the Paediatric Assessment Unit of the local hospital trust for children who were acutely ill. This pilot had led to this service being commissioned by the Clinical Commissioning Group for the current year.

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

Importantly the provider should:

- Carry out an infection control audit and introduce regular checks to monitor the effectiveness of the cleaning contractor's work.
- Check that its recruitment process produces enough documentary evidence to demonstrate its diligence in recruiting staff who are safe.
- Implement a short-term system to clear the backlog of records waiting to be filed electronically so that information about every patient is up-to-date.
- Update the information it has available about complaints to ensure patients are fully aware of their options for making a complaint.
- Sustain its efforts to set up and maintain an active patient participation group so that patients are able to formally contribute to the development of 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 was safe and is rated as good.

Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and significant events. 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 although an infection control audit had not been recently carried out. There were enough staff to keep patients safe although written references were not available in files of recruited staff. The practice had robust safeguarding procedures in place. Medicines were managed appropriately and the practice could respond effectively to medical emergencies. The practice was equipped to maintain a safe service if a major event occurred.

Are services effective?

Good

The practice is effective and is rated as good.

Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence 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 appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams and patients with complex needs or receiving end-of-life care had individually tailored care plans. There were effective arrangements for working with other organisations and sharing information.

Are services caring?

Good

The practice is caring and is rated as good.

National Patient Survey data showed that patients rated the practice similarly to other practices for several aspects of care but lower in other aspects. However, 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. Staff treated patients with kindness and respect, and maintained confidentiality. The practice was attuned to the needs of its

Summary of findings

population, particularly the younger population, arising from its experience of providing healthcare in such a diverse community with particular problems. The practice was proud of the way it had provided continuity of care for families over a long period of time.

Are services responsive to people's needs?

Good

The practice is responsive to people's needs and is rated as good.

The practice understood the needs of its diverse local population well. This was as a result of their experience of providing family healthcare in the community over many years and of their research into the particular problems in the community. The practice had engaged with the Clinical Commissioning Group (CCG) to prioritise their services where these were identified such as their participation in a rapid response pathway pilot for acutely ill children. The practice had developed an expertise in managing inherited conditions in younger members of its population, particularly where those conditions were terminal. Patients said they had not experienced problems making appointments with a GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was equipped to treat patients and meet their needs. Information about how to complain was available although some information was incomplete. The practice listened to and learned from complaints and comments.

Are services well-led?

Good

The practice is well-led and is rated as good.

It had a mission statement putting patients' needs first that was shared by all staff through an open and transparent culture. 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 weekly clinical management meetings. There were systems in place to monitor and improve quality and identify risk. The practice acted on feedback from staff and patients but here was no mechanism in place for formally receiving feedback through a patient participation group. GPs at the practice had special interests in different conditions and this added to the practice's overall shared knowledge base. The practice was a training practice and had supported trainee GPs to become qualified.

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 those who were at higher risk of attending hospital. Patients over 75 years of age had a named GP. The practice 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. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. 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

Outstanding

The practice is rated as outstanding 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 had a high number of A&E attendances. Immunisation rates were similar to expected for all standard childhood immunisations. Children and young people were treated in an age-appropriate way and were recognised as individuals. The premises were suitable for children and babies. The practice worked jointly with midwives, health visitors and school nurses.

The practice was attuned to the needs of their younger population, brought about by many years' experience of serving this community as a general practice and through comparative studies with similar populations with similar ethnicity, employment rates, deprivation and age range. The practice had developed expertise in particular needs related to the higher than expected mortality rate of children and young people and the survival into adulthood of some children

Summary of findings

with serious inherited conditions arising from consanguineous marriages. The care of these patients was managed with individual care plans through the practice's monthly multi-disciplinary team meetings with the community nursing and health visiting team.

The practice had been part of a successful 'rapid response pathway' pilot carried out locally; a programme that enabled direct access to the Paediatric Assessment Unit of the local hospital trust for children who were acutely ill. The outcome of the pilot programme had affected the commissioning intentions of the Clinical Commissioning Group for this type of approach for the current year.

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. The practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care such as telephone consultations by appointment. The practice was proactive in offering a full range of health promotion and screening that reflects the needs for this age group, including health checks for patients over 40.

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. It had carried out annual health checks for people with a learning disability and all of these patients had received a follow-up. It offered longer appointments for people with a learning disability. People who did not reside in the area could access healthcare through temporary registration as when treatment was deemed as immediately necessary.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told 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). 93% of the

Summary of findings

patients experiencing poor mental health had received an annual physical health check. 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 had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health. 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 spoke with 10 patients on the day of our inspection, reviewed 26 comment cards that had been collected from patients in advance of our visit and looked at data form the 2014 patient survey.

Data from the 2014 National Patient Survey, showed that a higher number of patients than average felt that other patients could not overhear in the reception area and who felt they were treated with care and concern by the doctor and the nursing staff.

The survey also showed that patients felt the GP and the nurses were good at giving them enough time, good at listening to them and good at explaining test results to them and good at involving them in decisions about their care. These satisfaction rates were similar to the average for both the local Clinical Commissioning Group (CCG) area and for England in general as were the satisfaction rates about patients experience of making an appointment.

The survey showed that the practice had lower than expected satisfaction rates for patients who stated they would recommend the practice, for those who felt the practice was good or very good overall and those who felt they had to wait too long to be seen.

However, the experiences of the survey respondents were not reflective of the positive experiences of people we spoke with and those reported on comment cards. All of the cards reported wholly positive experiences of patients. Some of the cards referred to doctors and staff by name, singling out individual examples of kindness, care and compassion. There were no concerns or critical comments about the appointment system on 25 of the 26 comment cards we received.

Our interviews with patients on the day of our visit showed that patients were very satisfied with their level of involvement.

Some patients told us they felt in control. Patients said that their diagnoses were explained well by their GP and that they had opportunities to ask questions to enable them to make informed decisions. Further, a significant number of the 26 comment cards we reviewed reported that patients felt listened to.

Patients told us that they were treated with kindness, respect and dignity by all the staff at the practice. All of the patients we spoke with reported that their GP and the nurses were courteous, considerate and compassionate.

Areas for improvement

Action the service SHOULD take to improve

The practice should carry out an infection control audit and introduce regular checks to monitor the effectiveness of the cleaning contractor's work.

The practice should check that its recruitment process produces enough documentary evidence to demonstrate its diligence in recruiting staff who are safe.

The practice should implement a short-term system to clear the backlog of records waiting to be filed electronically so that information about every patient is up-to-date.

The practice should update the information it has available about complaints to ensure patients are fully aware of their options for making a complaint.

The practice should sustain its efforts to set up and maintain an active PPG so that patients are able to formally contribute to the development of the practice.

Outstanding practice

The practice was attuned to the needs of their younger population, brought about by many years' experience of serving this community as a general practice and through comparative studies with similar populations with similar

ethnicity, employment rates, deprivation and age range. The practice had developed expertise in particular needs related to the higher than expected mortality rate of children and young people and the survival into adulthood of some children with serious inherited conditions arising from consanguineous marriages. The care of these patients was managed with individual care plans through the practices' monthly multi-disciplinary team meetings with the community nursing and health visiting team.

The practice had been part of a successful 'rapid response pathway' pilot carried out locally; a programme that enabled direct access to the Paediatric Assessment Unit of the local hospital trust for children who were acutely ill. The outcome of the pilot programme had affected the commissioning intentions of the Clinical Commissioning Group for this type of approach for the current year.

Conway Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection was led by a CQC Inspector, supported by a GP specialist adviser, a Practice Manager specialist adviser and an interpreter in several Asian languages.

Background to Conway Medical Centre

Conway Medical Centre is a community general practice that provides primary medical care for just over 8,000 patients who live in a densely populated area in the town of Luton. The patient population is over 95% British Asian or South Asian heritage with several different languages other than English being spoken as people's first language.

There is a significantly higher than average percentage of patients aged under 39 years as compared with the rest of England. There is a significantly lower percentage of patients older than this. The practice is in an area considered to be in the lower 30% of deprived areas in England.

Conway Medical Centre has five GPs, three of whom are partners in the practice and two of whom are female doctors. There are two practice nurses and three healthcare assistants who run a variety of clinics as well as members of the community midwife and health visiting team who operate regular clinics from the practice location.

There is a practice manager and a team of non-clinical, administrative and reception staff who share a range of roles, some of whom are employed on flexible working arrangements.

The practice provides a range of clinics and services, which are detailed in this report, and operates generally between the hours of 8.30am and 6.30pm, Monday to Friday. Outside of these hours, primary medical services are accessed through the NHS 111 service.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme in accordance with our regulatory functions. This inspection was planned to check whether the provider was 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.

This provider had not been inspected before and that was why we included them in this round of inspections in the Nene Clinical Commissioning Group (CCG) area.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

We conduct our inspections of primary medical services, such as Conway Medical Centre, by examining a range of information and by visiting the practice to talk with patients and staff. Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew about the service.

Detailed findings

We carried out an announced visit on 19 November 2014. During our visit we spoke with three of the GPs, the practice manager, members of the nursing team, administration staff and a GP registrar (an experienced doctor undergoing training to become a GP).

We spoke with 10 patients using the service on the day of our visit. We observed a number of different interactions between staff and patients and looked at the practice's policies and other general documents. We also reviewed 26 CQC comment cards completed by patients using the service prior to the day of our visit day where they shared their views and experiences.

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?

We also look at how well services are provided for specific groups of people and what care is expected for them. Those population groups are:

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Good

Are services safe?

Our findings

Safe track record

We found evidence that Conway Medical Centre was consistently safe over time. The practice had clear and simple policies and procedures in place relating to escalating safety incidents such as significant events, allegations or suspicions of abuse, complaints and safety alerts. This was supported by an open and transparent culture among the staff about keeping people safe. Staff were aware of their responsibilities and showed a good understanding of procedures.

We looked at the records of practice meetings for the 12 months preceding our visit. We saw that significant events and safety incidents were discussed between the GPs, practice nurses and the practice manager at weekly clinical team meetings. Where any action was required to ensure patients were safe then this was taken quickly and robustly. For instance, we learned of one incident where a child was thought to have suffered a non-accidental injury and the practice team had responded quickly and in accordance the local procedures. This had also led to improved access for such vulnerable patients through the introduction of dedicated appointment slots to see the GP on the day if required.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording, analysing and learning from significant events, incidents and accidents, complaints and other untoward events; a process known as significant event analysis (SEA). For example, we looked at the record of a SEA that had taken place in the week prior to our inspection. This had resulted in improvements made to the arrangements for communicating with a patient and a local pharmacy about the dispensing of a particular medicine.

All staff were empowered to report incidents and events and could determine whether an event was deemed to be significant and thus required further investigation or discussion at the weekly clinical team meeting. Staff reported any concerns or events in a book that was kept in reception. During our discussions with staff we learned of occasions when this process had been used.

Outcomes and any learning arising from SEAs were communicated to staff during staff meetings that occurred three times each year together with any other patient safety or medicine alerts. The records of these clinical meetings were readily available to staff in a binder in an office near reception and staff were encouraged to read these. We noted events that had been written in the staff record book that were followed up in the records of the meetings. However, there was no other formal means of disseminating learning to the staff team such as, for example, staff briefings or team emails.

Reliable safety systems and processes including safeguarding

The practice had policies and systems in place to manage and review risks to vulnerable children, young people and vulnerable adults. There was a named GP lead for safeguarding and that the staff were aware of the name of the lead GP. All staff had received training in keeping people safe and recognising abuse that was appropriate to their role. This included the GPs who were trained to the recommended, more advanced level. The lead GP was also the practice's 'Caldicott Guardian', a person who is responsible for ensuring the confidentiality of patient's personal information. As such, they took an active role in local safeguarding meetings and facilitated the flow of information to other agencies about patients who might be at risk.

Effective safeguarding policies and procedures were in place and were fully understood and consistently implemented by staff. We saw that information about the local authority's safeguarding process was readily available. Staff we spoke with knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities about documenting safeguarding concerns and how to contact the relevant agencies during and out-of-hours. This was evident, for example, in the incident relating to a suspected non-accidental injury to a child reported above.

The practice computer system was equipped with a facility to alert staff to any patients who might be vulnerable, such as children subject of a child protection plan or children who were in the care of the local authority.

Medicines management

We spoke with a practice nurse and the practice manager and checked medicines stored in the treatment rooms and refrigerators. Medicines were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that temperature sensitive medicines, such as childhood, flu or travel vaccines, were kept at the required

temperatures. Refrigerator temperatures were monitored daily using the minimum, maximum and actual measurements allowing the staff to be assured that they remained safe to use. Vaccines were rotated in the refrigerator so that they were used in date order.

Medicine stocks were monitored by the practice manager who ensured that the practice was adequately stocked with. For example, the emergency medicines were kept in a box and checked fortnightly to ensure the medicines remained 'in date' and safe to use. The practice did not stock any medicines categorised as controlled drugs.

The practice nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that the nurses had received appropriate training to administer vaccines. One of the nursing team was also qualified to review and to prescribe medicines.

There was a safe system in place for managing repeat prescriptions. Prescriptions could be ordered by hand, by post, through the local pharmacy or by using the practice's online system and we saw that there was a safe system in place for receiving, checking, authorising and re-issuing prescriptions.

Cleanliness and infection control

The practice was clean and tidy on the day of our inspection. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness. The practice was cleaned by an independent cleaning contractor whose staff followed a cleaning schedule, with daily and weekly tasks, that was posted on a cleaning rota in the staff kitchen. Any request for additional cleaning services or any issues that needed to be brought to the attention of the cleaning staff were recorded in the staff message book. The cleaning staff belonged to a recognised and established clinical cleaning contractor. However, there was no other means of checking whether the cleaning was effective or thorough or carried out to required standards, such as a log of regular checks or internal inspection.

We saw that all staff had attended infection control training at another nearby practice earlier in the year and. Staff also received regular inputs on infection control related topics during their practice learning sessions, such the use of personal protective equipment and hand-hygiene. One of the practice nurses had the lead responsibility for infection control. They had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training at the staff learning sessions.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to implement measures to control the risks of a healthcare associated infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Notices about hand-hygiene techniques were displayed in treatment rooms and toilets. Hand-washing sinks with elbow taps, hand gel and hand towel dispensers were available in treatment rooms.

The practice's clinical waste, including used, sharp instruments was collected in appropriate waste containers and disposed of regularly.

The practice had carried out a minor operations infection control audit earlier in the year using data from patient records. However, we noted that the practice had not carried out a comprehensive infection control audit since 2008, such as is recommended in guidance issued by the Department of Health. The premises were generally clean and we observed and were told about safe infection control practices. However, the absence of a comprehensive infection control audit and of a regular cleaning monitoring regime showed that the practice could not be assured they had identified and controlled any risks to patients or staff.

Equipment

Staff we spoke with told us they had appropriate equipment to enable them to carry out their work. We saw logs showing that all items of equipment, for example the electro-cardiogram (ECG) machine, spirometer (a lung capacity testing machine) and emergency oxygen cylinder, were checked fortnightly to ensure they were in working order. Other items, such as blood glucose monitors, were sent to the local hospital trust for calibration. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date.

The practice was a large, older converted house and so space was very limited. For example, the main waiting area on the ground floor was cramped and overflowing to the extent that some patients had to stand whilst awaiting their

Good

Are services safe?

appointment at certain times of the morning. Nonetheless, the practice had configured its patient and staff areas to the most optimum layout available, such as additional seating areas close to treatment rooms.

Staffing and recruitment

We found evidence that there were sufficient numbers of appropriately skilled staff on duty at all times to ensure patients were treated safely. The practice had a clear overview of the needs of its patient population and had put in place an appropriate amount of scheduled appointments with sufficient appropriately skilled staff. For instance, the nurses had been trained in diabetes and other long term conditions, the healthcare assistants had been trained to carry out health checks and there were enough staff with this training to manage the needs of the patient population.

The practice had calculated it required 33 clinical sessions each week and these were staffed according to a rota for GPs, nurses and supporting administrative and reception staff. Staff told us that they always covered for each other during leave or sickness absence and they had been trained to carry out each other's roles. We learned that there had never been a need for agency staff and the use of locum GPs was rare.

The practice had a recruitment policy that was sent to us in advance of our inspection. The policy set out the standards followed when recruiting clinical and non-clinical staff. The four staff records we looked at during pour inspection contained evidence that some recruitment checks had been undertaken prior to employment, such as criminal records checks. We also learned that the identity of new staff was verified before they were offered employment and that the recruitment interview process was designed to examine the suitability of candidates for all roles. However, there was no documentary evidence in the staff files to show that identify checks had been carried out for administrative staff. Furthermore, our review of staff files and interviews with staff and the practice manager showed that some staff were employed on the basis of verbal recommendations from within the local community as opposed to formal written references.

Monitoring safety and responding to risk

We saw that the practice had procedures in place to deal with potential medical emergencies including a prominently displayed emergency response flow-chart that showed the differing responses for GPs, nurses or receptionists. There was also an emergency alarm bell that could be rung to alert other staff to the need for assistance. All staff had received training in basic life support and received update training annually. This included training on cardio-pulmonary resuscitation and on recognising anaphylactic shock associated with an allergic reaction to vaccines.

Staff had access to an automated external defibrillator, a device used to restart the heart in a medical emergency, as well as emergency oxygen. The practice carried a stock of medicines for use in the event of a medical emergency. These included medicines for use for people experiencing chest pain, a diabetic emergency or anaphylactic shock. The emergency medicines were checked fortnightly to ensure they were within their expiry dates along with checks on the equipment.

Staff at all levels could share immediate concerns about risks to individual patients with a clinician. Staff we spoke with said they were confident they could recognise patients who might have acute needs requiring a clinician's input as a priority. We also noted that there was a book in the administration office that all staff read when changing shifts. This was used to hand over information about any concerns, issues or risks form one shift to the next.

Arrangements to deal with emergencies and major incidents

There was a business continuity plan in place that enabled the practice to respond safely to the interruption of its service due to an event, major incident, unplanned staff sickness or significant adverse weather. The plan included relevant contact information for local services and commissioners to enable rapid contact to be made with relevant organisations. The document was kept under review and hard copies were located both on and off-site.

Identified risks and the means of managing them were included as part of a folder containing health and safety protocols. These included dealing with power failure, water leaks, fire drills, risks to accessing the practice and the car park.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We found evidence that the practice used recognised guidance and best practice standards in the assessment of patients' needs and the planning and delivery of their care and treatment. This included the use of best practice and clinical guidance described by the National Institute for Health and Care Excellence (NICE) and local guidance emanating from local commissioners of health services such as the Clinical Commissioning Group (CCG). For example, three of the GPs attended monthly learning events at the local hospital trust where new or emerging guidance was discussed. Thereafter, guidance was cascaded to the remainder of the clinical team during weekly clinical team meetings to ensure that all staff would benefit from the most recent updates and their understanding enhanced through peer discussion.

We learned that the GPs had their own areas of special interest or expertise, such as orthopaedics, gynaecology, dermatology and ear-nose-throat. As a result, the need for referrals onwards to other services was reduced as patients could receive specialist treatment 'in-house'. Nonetheless, whenever referrals to other services were required these were discussed at clinical meetings to ensure consistency of approach.

We noted that the practice had used a risk identification tool to identify patients that were most at risk of repeated hospital admissions and were managing their care through individually tailored, proactive care plans. Additionally, we reviewed the records of monthly multi-disciplinary (MDT) meetings held between the GPs, nurses, the community nursing team and health visitors. These records showed the practice had an active programme of monitoring the care and treatment of those patients who were receiving end-of-life care and those patients who were receiving care for complex conditions.

The practice had a diverse work force and we saw no evidence of discrimination in decision making about care and treatment decisions. Moreover, throughout our inspection the practice showed us that they had an acute understanding of the particular needs of their multi-ethnic community. They had taken account of the health needs emanating from this diverse community in the way they planned their services, such as the range of treatments offered to children with complex inherited conditions.

Management, monitoring and improving outcomes for people

We saw that the weekly clinical meeting played a key role in monitoring and improving outcomes for patients. For instance, the practice actively ran regular searches using their computer system and the quality and outcomes framework (QOF) to help them to manage their performance in the diagnosis and treatment of common chronic conditions and to assess their quality and productivity. We noted that national data, including data obtained from the QOF, showed that the practice was in line with expected standards and rates for identifying, registering, treating and prescribing for all conditions. The practice exceeded national expected standards in relation to registering and treating patients receiving end-of-life care, those with learning disabilities and those with coronary heart disease.

As well as QOF information, the clinical meetings considered significant events, complaints, medicine alerts and audits in order to inform the way the service was run. Our examination of a sample of the records of the clinical meetings for the year prior to our inspection showed numerous examples where this information had been discussed.

To support this, the practice had a culture of monitoring performance through clinical audits. A clinical audit is a performance assessment process that identifies the need for improvement or change, then measures performance once changes have been implemented in order to assess their effectiveness. One example of this was an audit into the rates at which patients did not attend appointments without cancelling them (DNA). The practice had historically introduced 'sit-and-wait' open clinics on Monday mornings to try and reduce the impact of lost appointments. The practice carried out an audit, using data from the beginning of 2014, into the rates of DNA to identify if other measures might be introduced. Text messaging to patients who did not attend their appointments was introduced, followed up by a letter advising them that repeated instances would result in them being removed from the list. A second, follow-up audit was carried out in October 2014 to assess the effectiveness of this initiative on DNA rates which showed that it had been partially effective in reducing the rate for patients of two of the three GPs involved in the audit.

Good

Are services effective?

(for example, treatment is effective)

We looked at six audits carried out in the six month period prior to our inspection. These included audits into the effectiveness of minor surgical procedures, the effectiveness of referrals for children with a urinary tract infections and the viability of cervical smear samples.

There was a policy in place for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GPs. The practice computer system alerted staff to relevant medicines alerts when the GPs or prescribing nurse were prescribing medicines. We saw evidence to confirm that the practice monitored their prescribing behaviour such as an audit into their prescribing of a particular anti-clotting medicine. In that case the practice established that their prescribing behaviour for this medicine was in line with the relevant NICE guidelines and that no further action was required.

Effective staffing

Practice staffing included clinical (GPs and nurses) and non-clinical roles (managerial and administrative staff). We looked at records and spoke with staff and found that for both clinical and non-clinical staff were appropriately trained and supported to carry out their roles effectively. For example, nursing staff had been trained in immunisations, asthma, diabetes and other long term conditions; healthcare assistants had received training in carrying health checks and taking blood samples.

As reported above, all of the GPs had their own areas of clinical expertise which they were leading on for the practice and this enhanced the service they were able to provide to their patient population. As a further example of this, we saw that one of the GPs was the lead clinician for palliative care with the CCG.

New staff received a comprehensive induction programme that introduced them to their role. Non-clinical staff were trained to carry out more than one role. We noted that all administrative staff could carry out reception duties to enable the practice to remain effective during peak times. We saw that all staff received regular training in subjects that are generally considered as key, such as annual basic life support training and annual safeguarding training.

All clinical staff were appraised annually and undertook continuing professional development in order to fulfil the revalidation requirements of their professional bodies such as the General Medical Council and the Nursing and Midwifery Council.

All other staff received an annual appraisal during which any training needs were identified. Non-clinical staff participated in the practice 'in-house' learning sessions known as protected learning time (PLT). During PLT sessions, staff undertook much of the training considered as key to their roles and in some instances this was delivered by specialist from within the practice, such the use of personal protective equipment and hand-hygiene delivered by one of the practice nurses. Staff we spoke with were clearly happy to work there and told us said they felt well supported by an approachable management team.

Working with colleagues and other services

We found that the practice engaged regularly with other health care providers in the area such as the district nursing team, the health visitors, the emergency department of the local hospital and the local ambulance service. All records of contact that patients had with other providers, including blood and other tests such as x-rays, were received by the GPs electronically. Thereafter they were reviewed and followed up within 24 hours by the GP who last or usually saw the patient. On those occasions when that GP was on leave the practice manager allocated the record of the contact to another GP for review that day.

The evolving needs of every patient receiving end-of-life care, as well as children at risk and patients with complex needs were discussed at monthly multi-disciplinary team (MDT) meetings. These meetings involved the GPs, nurses, practice manager, health visitors and the community nursing team. As patients neared the very end-of-life, their care plans and any documents that related to their decisions about resuscitation were sent to the ambulance service and the out-of-hours service to ensure that specific wishes about their death could be met.

Information sharing

The practice used an established electronic patient records management system (known as SystmOne) to provide staff with sufficient information about patients. All staff were trained to use this system. The system carried personal care and health records and was set up to enable alerts to be communicated about particular patients such as information about children known to be at risk. The

Good

Are services effective?

(for example, treatment is effective)

practice system was also the gateway to the 'choose and book' system which facilitated the management of referrals on to other services such as the hospital outpatients. This system was readily available and accessible to all staff.

The practice had begun to use the electronic Summary Care Record which enabled faster access to key clinical information about patients for healthcare staff when treating patients in an emergency or out of normal hours. We saw that patients who were sent to hospital for an emergency admission, a copy of their summary record was made available for them to take with them. One GP explained how this system worked using an example.

The system also enabled correspondence from other health care providers, such discharge letters or blood and other test results, to be held electronically to reduce the need of paper held records. The system also allowed for hard copy correspondence to be 'scanned in' and held on patients' records although those occasions when were infrequent. We noted, however, that there was a considerable backlog of scanned records waiting on the system to be filed. One of the GPs explained that this backlog was artificially high since the practice was in the process of converting archived paper records for viewing electronically.

Consent to care and treatment

We found that people's consent to care and treatment was always sought in line with relevant guidance and the practice's clear consent policy. Clinical staff we spoke with understood the processes involved for obtaining consent from patients. This was the case whether consent was implied, such as for a routine consultation, or obtained explicitly in writing for particular treatments, such as minor surgical procedures.

We found that staff had been trained in the application of the Mental Capacity Act 2005. Staff understood the process and reasons for making decisions in patients' best interests where their capacity to consent was impaired, such as decisions about resuscitation in a medical emergency. We also saw that the practice applied well established criteria used by each clinician to assess the competence of young people under 16 to make decisions in their own right about their care and treatment without the agreement of someone with parental responsibility. However, this was a very rare occurrence in this patient population group.

Patients we spoke with on the day of our inspection told us that they were involved in making decisions about their care and treatment and that they were given sufficient information to make decisions about it. We saw that patients with a learning disability and those with dementia were supported to make decisions through the use of care plans that they had agreed to.

The population served by the practice was hugely diverse with a number of different, predominantly South Asian, languages and cultures represented and where around 95% of the patient group had South Asian heritage. As a result, many of the older patients from this community could not speak English or had limited understanding of the health and medical options. In many cases, such patients chose to be accompanied by younger relatives to interpret and aid their understanding during consultations in preference to using official translators. In addition, much of the communication with patients that took place outside of consultations, such as telephone calls, making appointments and discussing diagnostic tests was also made with patients' relatives. As this was such a frequent occurrence, the practice had developed a specific policy for engaging with relatives. This involved obtaining written consent from the patient to enable the relative to be provided with information on their behalf and this was then kept on file. During our interviews with patients on the morning of our inspection, some of which were through our own interpreter, we confirmed that this was a prevailing arrangement that patients were satisfied with.

Health promotion and prevention

We saw that all new patients were asked to complete a general health questionnaire when they first registered and were invited into the surgery to see a nurse or healthcare assistant for a health check and exploration of their medical history and lifestyle. All patients over 40, including those also over 75, received a NHS health check by healthcare assistants that had been trained to carry this out.

The practice ran health promotion clinics for long term conditions such as diabetes, asthma and heart disease and these were advertised in the practice information leaflet and on the practice web-site. Clinics were also held for smoking cessation, blood pressure monitoring and weight

Good

Are services effective?

(for example, treatment is effective)

management. We saw that there was also plentiful information available about long tern conditions on the practice web-site as well as information about promoting family health.

The practice also provided a full range of childhood immunisations and nationally collected data showed that they were reaching generally similar or slightly higher rates in comparison with the rest of the CCG area. The same national data showed that the practice achieved expected take up rates for cervical smears and influenza vaccines, as well as for those patients living with dementia who had received a face-to-face review of their health needs.

As reported above, the practice used a risk identification tool to identify patients that were most at risk of repeated hospital admissions. The practice managed the care of these patients, as well as those receiving end-of-life care, through individually tailored, proactive shared care plans on a multi-agency basis. National data indicated that the practice had a higher than expected rate for patients on the palliative care register, showing that they had been particularly effective at identifying and planning for this group of patients. There was a similar picture for adult patients with learning disabilities and for those with coronary heart disease where the data indicated the practice was performing well.

The practice proactively identified patients who were also carers and offered them additional support. This was supported by a display in the reception area advising carers where they could get further support and a discrete page on the practice web-site. However, we learned that the need to refer carers to additional support through the practice was lower than expected. This was because the particular patient population served by the practice commonly looked after older people within extended family.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with 10 patients on the day of our inspection, reviewed 26 comment cards that had been collected from patients in advance of our visit, looked at data form the 2014 patient survey and carried out observations throughout our inspection.

Patients told us that they were treated with kindness, respect and dignity by all the staff at the practice. All of the patients we spoke with reported that their GP and the nurses were courteous, considerate and compassionate. Most patients also told us that all the reception staff were polite and had a pleasant manner with patients. This was borne out during our observations in the reception and administration areas when we listened to reception staff speaking with patients over the telephone and observed their interaction with patients at the desk.

A notice asked patients to wait behind a line until called forward in order to respect the privacy of patients already talking to reception staff. The line was clearly marked some two meters away for the reception desk. Staff told us that patients could be taken to another area near the reception if they wanted to speak in private to a receptionist but that this was no often. We noted, however, that the request for patients to wait behind the line was observed each time and reception staff spoke discreetly with patients at the desk. In the absence of a separate interview room and given the cramped reception area, we considered that this arrangement worked as well as could be expected in respecting patients' privacy. Data from the 2014 National Patient Survey, carried out on behalf of the NHS, showed that a higher number of patients than average felt that other patients could not overhear in the reception area. This would suggest that the privacy measures had been effective.

None of the comment cards we reviewed indicated any negative or critical opinions about the care, dignity and respect offered by the staff. All of the cards reported wholly positive experiences of patients. Some of the cards referred to doctors and staff by name, singling out individual examples of kindness, care and compassion.

Further data from the 2014 National Patient Survey showed that 54% of patients stated they would recommend the practice whilst 68% stated that they felt the practice was good or very good. These were among the lower range of ratings as compared with other GPs both nationally and within the Clinical Commissioning Group (CCG) area. 62% of patients reported that the reception staff were helpful and this, too, was lower than expected. However, the experiences of the survey respondents were not reflective of the wholly positive experiences of people we spoke with and those reported on comment cards. The survey showed satisfaction rates for patients who thought they were treated with care and concern by the nursing staff (75%) and by their doctor (71%). These were similar to the national average and the CCG area.

We saw that there was a chaperone policy in operation and a notice was displayed in reception that invited patients to ask if they required such a facility. A chaperone is a person who might be present during a consultation when an intimate examination is taking place to ensure that patients' rights to privacy are protected. Female patients we spoke with confirmed that they had either been offered a chaperone or that a chaperone had been present during an examination by a male doctor. All members of staff including reception staff could carry out the role of chaperone. Whilst there had been no formal training for the role, staff had been briefed about it and understood the role well.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

We found that patients were involved in decisions about their treatment. The National Patient Survey 2014 showed that, on average, 81% of patients felt the GP was good giving them enough time, good at listening to them and good at explaining test results to them. The survey showed that 71% of patients felt that the GP was good at involving them in decisions about their care. These satisfaction rates were similar to the average for both the local CCG area and for England in general. The corresponding figures for the nursing staff were also similar to the England and CCG average with 83% reporting that the nurses gave them enough time, listened to them and explained test results, whilst 77% felt the nurses involved them in care decisions.

Our interviews with patients on the day of our visit showed that patients were very satisfied with their level of involvement. Some patients told us they felt in control.

Good

Are services caring?

Patients said that their diagnoses were explained well by their GP and that they had opportunities to ask questions to enable them to make informed decisions. Further, a significant number of the 26 comment cards we reviewed reported that patients felt listened to.

We found that patients who were referred onwards to hospital or other services were involved in the process. We saw that patients could make a choice about where and when to receive follow-up treatment from hospital providers by the use of the 'choose and book' system.

The practice had access to translating and interpreting services for patients who had limited understanding of English to enable them to fully understand their care and treatment. Around 95% of the patient population had South Asian heritage, which itself was also multi-ethnic and with a diverse range of cultures and languages. As such there was a diverse range of languages spoken by many patients, some of whom had a limited understanding of English, particularly older women. Those languages included Urdu, Bengali, Punjabi, Hindi or Gujarati. The diversity of the patient population was reflected in the make-up of the staff at the practice. Most of the staff spoke at least one other language so that the practice could communicate with people whose first language was not English. Although the practice sometimes used interpreters, the range of languages spoken by the staff meant that the need for an interpreter was much lower than expected. In addition, as we have reported above, the practice took steps to obtain written consent from patients to enable them to communicate with their relatives. This showed that the practice made the most of opportunities to ensure patients understood and were involved in their care and treatment planning.

Patient / carer support to cope emotionally with care and treatment

Patients and others close to them received the support they needed to cope emotionally with their care and treatment, including those that were recently bereaved. For example, staff we spoke with told us they were always made aware of the names of the patients who had recently deceased. This ensured that relatives of patients who had died were greeted appropriately and enquiries made to establish whether they required any additional support. Notices in the waiting area sign-posted patients to support services from local services, such as a children's centre, and local branches of national services such as Age UK.

Relatives of patients who had died were called by the practice in order to assess their emotional and support needs and to offer a referral to local counselling or bereavement support services.

The care plans of people receiving end-of-life care, those patients who were most at risk of unscheduled hospital admissions and patients with particular complex health needs including children were discussed at monthly multi-disciplinary team (MDT) meetings. This ensured that the practice could regularly and actively monitor the evolving needs of these groups of patients.

As we have reported above, the practice actively took steps to identify patients who were carers and offered them additional support. This was supported by a display in the reception area advising carers where they could get further support and a discrete page on the practice web-site. However, we learned that the need to refer carers to additional support through the practice was lower than expected. This was because the particular patient population served by the practice commonly looked after older people within extended family.

The practice were attuned to the needs of their population and had recognised that there was a high mortality rate for younger people from inherited conditions arising from consanguineous marriages. We learned from our interviews with the practice manager and the GPs that they had acquired considerable experience in managing the terminal phase of many of these illnesses in children and younger adults and this was reflected in the discussions of the MDT meetings.

The practice were proud of their approach to providing continuity of care for families in their community, many of whom had several generations registered with the practice. This was borne out in our discussions with patients over a wide age range on the day of our inspection. We frequently received positive comments from patients about the knowledge the practice had of their health needs, those of their families and the support they had been given over the years.

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 patient'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 in the way services were delivered. For example, the practice monitored its doctor consultation rate and its rates for patients who did not attend appointments. As a result, the practice had a clear understanding of the nature of the illnesses presented by patients who attended and re-attended and the reasons for patients' non-attendance. In turn the practice understood clearly which types of services it was likely to have to provide over time. As appointments were only bookable two weeks in advance, the practice could respond dynamically to risks brought about by fluctuating or seasonal demand by adjusting its staff rota and appointments schedule.

As we have previously stated, the practice was attuned to the needs of their younger population, brought about by many years' experience of serving this community as a general practice. The practice had built on this experience and taken further steps to understand the needs of their population by comparative studies with similar populations with similar ethnicity, employment rates, deprivation and age range. The practice presented information and research to us that they had used to aid this understanding. As a result of this experience and this level of understanding the practice had developed expertise in particular needs related to the higher than expected mortality rate of children and young people and the survival into adulthood of some children with serious inherited conditions arising from consanguineous marriages. The care of these patients was also managed with individual care plans through the practices' monthly multi-disciplinary team meetings with the community nursing and health visiting team.

The practice had been part of a successful 'rapid response pathway' pilot carried out locally; a programme that enabled direct access to the Paediatric Assessment Unit of the local hospital trust for children who were acutely ill. The outcome of the pilot programme had affected the commissioning intentions of the Clinical Commissioning Group (CCG) for this type of approach for the current year.

The practice played an active part in the local CCG with one of the GPs having lead responsibility for palliative care. The practice participated in meetings with the seven other practices in a local cluster where local needs were discussed and prioritised.

The practice had well established clinics for long term conditions such as asthma and chronic lung disorders and used spirometry, a lung capacity test, as part of its service to assess the evolving needs of this group of patients. The practice had recognised that its particular population had a higher than average prevalence for diabetes and had ensured that there were sufficient resources allocated for reviewing patients with this condition. The practice also promoted independence and encouraged self-care for these patients through the provision of printed information about healthy living and opportunistic smoking cessation advice.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, the practice tried to ensure that women patients understood the importance of receiving a cervical smear test by telephoning them individually.

Additionally, although the practice had access to an interpreting service, there was a limited requirement for them. This was because the practice could communicate with all of their patients with different languages because the staff spoke six different languages between them. The practice web-site also had a translation facility.

The practice had up-to-date polices on bullying, harassment and discrimination and these were accessible to staff with all the other practice polices to staff in hard copy format in a folder in the administration office.

The practice was in an older, converted house. However, there was a ramp access to the practice for patients with wheelchairs or pushchairs and a doorbell for patients to ring for assistance if they had a disability that inhibited them from gaining access. Patients who could not manage the stairs were offered appointments on the ground floor.

Longer appointments were available for patients who had complex needs or who required translation facilities and for those who had difficulty getting in and out of surgery quickly.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The waiting area was very cramped and was not conducive to the movement of larger wheelchairs or pushchairs. The practice was aware of the shortcomings in relation to the building and had plans to relocate.

Patients who did not ordinarily reside in the area could see a GP on the basis of their treatment being immediately necessary. However, there was no facility to take on new patients unless they were either new births to existing patients or relatives of existing patients who had recently come to the area.

Access to the service

The practice offered most appointments that could be booked on the day or up to two weeks in advance for both GPs and nurses. There were also five appointments for each doctor for each day that could be booked in advance with no time limit. Patients who had an urgent medical need could come to the surgery at 11am and 'sit and wait' to see the next available GP. Appointments were only available if booked over the telephone.

The practice offered shorter, telephone consultation slots between 12pm and 1pm every day but these, too, were available for booking in advance over the telephone. Patients who were too ill to come to the surgery or who were housebound were offered home visits and these were booked over the telephone between 8.30am and 10.30am.

The practice had a walk-in surgery every Monday morning so that patients could attend without an appointment. Patients we spoke with told us that they thought the open surgery on Monday morning was beneficial and that they had never had any problems getting to see a doctor.

Practice opening times were 8.30am to 6.30pm. Out of practice opening times patients were directed to the NHS 111 service. The practice did not offer extended opening hours outside of normal surgery times.

The 2014 National Patient Survey results showed that patient satisfaction with the practice's opening hours and their experience of making an appointment was similar to other practices in England in the CCG area. A recurring observation from patients was that the surgeries were often running late. This was reflected in the National Patient Survey. This showed that only 30% of patients said they waited less than 15 minutes from the time of their appointment and only 20% felt they did not have to wait too long to be seen, These were lower than the expected rates for practices in England.

There were no concerns or critical comments about the appointment system on 25 of the 26 comment cards we received. Several patients commented positively about appointment availability. Patients could generally see the GP of their choice, including their choice of male or female GP although the patients we spoke with on the day of our inspection acknowledged that they sometimes had to wait a few days to do so.

Listening to and learning from concerns and complaints

The practice listened to concerns and responded to complaints to improve the quality of care. The practice had a system in place for handling complaints and concerns according to a policy that was in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated responsible person who handled all complaints in the practice. There was information on the practice web-site although this was limited to referring people to the practice manager.

Further information was available in leaflet form in the reception area and in a notice on the notice board advising patients how to complain. However, there was no other information about how to complain to bodies other than the practice.

We reviewed complaints and comments from patients received over the last two years. This included comments that had been left in the practice suggestion box that was in reception. We were told that learning from complaints was discussed at the full practice meetings that took place three times each year and we saw examples of this in the records of those meetings.

We noted that the practice also took account of the findings of reviews and reports carried out. For example, as the result of a review by Healthwatch in 2013, we saw that the practice had implemented a 'privacy line' to promote confidentiality at the reception desk.

Staff told us they were encouraged to raise any concerns they have and were aware of the practice's whistleblowing policy.

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

Conway Medical Centre's 'Mission statement' to '…provide the best possible healthcare within the means of the practice' was prominently shown at the front of the practice information leaflet. This leaflet was available from reception although there was no such statement available on the practice web-site. The practice also had 'Patients' Charter' leaflet which was given to all new patients and which was also available in reception. The charter stated that the practice had an emphasis on quality and the provision of healthcare that met patients' needs. From our observations of interaction between staff and patients and our interviews with the management team and the staff, we found that these values were evident in a caring culture and a general attitude of putting patients' needs first. This was also demonstrated in the way that the practice had understood the needs of its population and had tailored its services to meet those needs.

The practice had acknowledged that the premises it occupied was too small for the size and demands of its patient population. There was no additional funding available to the practice and so the practice business plan included an intention to explore options to rent a purpose built property at its own cost. However, this plan was still in its infancy and no firm commitments had yet been made at the time of our inspection.

Governance arrangements

The practice had a clear governance structure designed to provide assurance to patients and the local clinical commissioning group (CCG) that the service was operating safely and effectively. The practice's weekly clinical management meetings provided clear direction and structure. There were clearly identified lead roles for areas such as safeguarding, palliative care, minor surgery and doctor training. These responsibilities were shared between the GP partners. The practice had also identified areas of responsibility for other practice staff members. For example, one of the nursing team had lead responsibility for infection control.

Decision making and communication across the workforce was structured around key, scheduled meetings. For example, the weekly clinical management meeting had overall oversight of the business of the practice whilst monthly multi-disciplinary team meeting managed the care plans of patients at risk. Staff received updates and key information through protected learning time (PLT) sessions. PLT sessions took place three times each year.

The practice used a number of processes to monitor quality, performance and risks. For example, the practice actively ran regular searches through the quality and outcomes framework (QOF) to help them to manage their performance and to assess their quality and productivity. The QOF data and other NHS data sources for this practice showed it was performing in line with national standards and similar to expected for other practices in the CCG.

As we have reported earlier, the practice also actively used the findings of significant event analyses and clinical audits to understand and manage any risks to their service through the weekly clinical meetings.

There were clear policies for each aspect of the practice's business accessible to staff in hard copy form and these were subject of periodic review to ensure they were up-to-date. We noted that the practice polices were clearly written and simple to understand. Staff were made aware of key policies during induction and could get access to clear instructions or protocols that set out how their work was to be performed.

Leadership, openness and transparency

We found that the leadership style and culture reflected the practice mission statement of providing the best possible healthcare within its means. The partners and the practice manager were open, highly visible and approachable and we learned that an 'open-door' policy existed for all staff to raise issues whenever they wished. The practice also operated a 'blame free' policy. This enabled any issues to be reported and discussed properly at clinical team meetings and with an emphasis on learning.

The practice manager explained that there was a low turnover of staff in all roles and that the workforce was stable. We noted that staff were positive and caring in their attitudes towards patients and each other and presented as a happy workforce. The practice had been managed for many years by senior GPs who were related. This had helped to engender a sense of family among the staff team. They told us they felt supported and valued and felt like part of a family. We considered this to be evidence of the effectiveness of the open and transparent leadership approach adopted by the practice.

Are services well-led?

Good

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

There were robust policies in place that also had the practical effect of supporting staff. For example, we noted that there was a zero tolerance policy in place in relation to abuse or violence towards staff and this was overtly publicised in the practice and on the web-site. This demonstrated that staff safety and wellbeing was treated a priority by the practice.

Seeking and acting on feedback from patients, public and staff

For around the previous four years the practice had not had an active patient participation group (PPG), a group made up of patient's representatives and staff with the purpose of consulting and providing feedback in order to improve quality and standards. We learned that the previous PPG had bene poorly attended and had not resulted in meaningful discussion about improvement. The practice had begun a recruitment campaign to try and reinvigorate the PPG through advertising in the reception and on the web-site. At the time of our inspection this had only just begun and so we were unable to say how effective it had been.

As we have reported earlier, the practice listened to and learned from complaints and comments made by patients and we saw examples of when this had taken place.

The practice monitored feedback from patients in other ways such as a comments box and a review of the national patient survey. We saw that the practice had produced an action plan from the findings of the 2012 and 2013 patient surveys in order to address shortcomings. We noted that the action plan had shown an increase in satisfaction rates between the two surveys from 40% to 62% as a result of an action to ensure staff answered the telephone in three to four rings. We looked at a review of the location carried out by Healthwatch in 2013 and saw that the practice had responded to feedback about the availability of appointments by introducing telephone consultations.

Staff told us that the open door policy meant that they felt able to make suggestions although there was no evidence available of when this had been done.

Management lead through learning and improvement

The practice ensured its staff were multi-skilled and had learned to carry out a range of roles. This applied to clinical and non-clinical staff and enabled the practice to maintain its services at all times. This was supported by a proactive approach to training and staff development as evidenced by the supportive appraisal system and opportunities for learning through PLT sessions.

The practice also had a learning culture that enabled the service to continuously improve through the analysis of events and incidents and the use of clinical audits. Staff at all levels were encouraged to escalate issues that might result in improvements or better ways of working.

The GPs at the practice each had special interests; for example, in gynaecology, dermatology and minor surgery. This enabled the practice to acquire and maintain a knowledge base of a range of conditions managed in general practice. The practice was also a GP teaching practice and was proud of its success in helping trainee GPs to qualify. The practice manager showed us data showing that the practice had achieved a high pass rate for GP registrars that had placements with the practice in the Member of the Royal College of GPs (MRCGP) examinations.