Castlegate Surgery

Quality Report

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

Summary of findings

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Summary of findings

Overall summary

Castlegate Surgery is located in the town of Cockermouth in Cumbria. The practice is situated within the newly built Cockermouth Community Hospital and provides services to approximately 10,500 patients. It is registered with the Care Quality Commission to provide the following regulated activities; diagnostic and screening procedures, family planning, maternity and midwifery services, surgical procedures and treatment of disease, disorder or injury.

We carried out an announced inspection on 29 April 2014. The inspection team included the lead inspector, a GP, a practice manager and an expert by experience.

During the inspection we spoke with patients and staff. We also reviewed completed CQC comments cards.

Feedback from patients was very positive. They told us they were happy with the practice and the premises. We saw the results of a patient survey which showed patients were consistently pleased with the service they received.

The practice had only moved into the community hospital premises in early 2014, and had previously been located in a temporary building following the floods of 2009. The new premises were purpose designed and built and were accessible to all.

The leadership team was very visible and staff found them approachable. There were excellent governance and clinical leadership measures in place.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Overall the service was safe. Systems were in place to keep patients safe and protect them from avoidable harm. The practice had clear systems in place to support staff to recognise, report and manage any safeguarding issues. There were robust arrangements to report any incidents or concerns. We found some staff recruitment checks were not up to date.

Are services effective?

Overall the service was effective. Care and treatment was delivered in line with current best practice. Staff were appropriately qualified and had opportunities to develop their skills and knowledge. The practice worked closely with other providers to co-ordinate care.

Are services caring?

Overall the service was caring. Patients we spoke with were very complimentary about the practice. They all told us the staff were caring and helpful. The practice's own patient survey also produced consistently positive results.

Are services responsive to people's needs?

Overall the service was responsive to people's needs. The practice offered telephone consultations or face to face appointments depending on each patient's preference or need. Patients had the option to book appointments over the telephone or on-line The premises were accessible to those with a physical disability. There was a clear complaints policy; staff and patients were aware of how to make and respond to any complaints.

Are services well-led?

Overall the service was very well led. There was a strong and visible leadership team, with a clear vision and purpose. There were clear lines of accountability and responsibility within the practice. Staff were committed to improving standards and encouraged good working relationships amongst the staff and other stakeholders.

Summary of findings

What people who use the service say

All the patients we spoke with during our inspection were very complimentary about the service they received. They told us they were happy with the practice and the premises. Patients said that staff treated them with respect and explained any necessary medication or treatment.

We reviewed four CQC comment cards which had been completed by patients. All four of the cards contained positive feedback about the practice.

We also looked at the results of the most recent patient survey, which was published in January 2014. Over 250 patients completed the survey during November 2013. Of those, 98% described their overall satisfaction with their visit as good or better.

Areas for improvement

Action the service COULD take to improve

Our inspection team identified the following areas for potential improvement:

- Not all clinical staff had up to date Disclosure and Barring Service (DBS) checks.
- There were no risk assessments to determine which staff groups should have DBS checks.
- There were no formal arrangements in place to deal with any foreseeable emergencies.
- New patients' medical records were not all summarised on a timely basis.

Good practice

Our inspection team highlighted the following areas of good practice:

- The aspects of clinical care that we looked at demonstrated the practice was outstanding.
- The practice had a strong leadership team.

Castlegate Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector. The inspector was accompanied by two specialist advisors (a GP and a practice manager) and an expert by experience (an expert by experience is somebody who has personal experience of using or caring for someone who uses a health, mental health and/or social care service).

Background to Castlegate Surgery

Castlegate Surgery is located in the town of Cockermouth in Cumbria. The practice is situated within the newly built Cockermouth Community Hospital. The practice only moved into the community hospital premises in early 2014, and had previously been located in a temporary building following the floods of 2009. There are nine GPs and two GP registrars, and a team of five nurses and healthcare assistants. The clinical staff are supported by a team of administrative staff, led by the practice manager.

The practice covers the town of Cockermouth and the surrounding rural areas. The service is responsible for providing primary care services for approximately 10,500 patients. The practice is open from Monday to Friday. Out of hours services are provided by Cumbria Health on Call (CHoC).

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?

Before visiting, we reviewed information we held about the service and asked other organisations to share what they knew about the service. We carried out an announced visit on 29 April 2014. During our visit we spoke with a range of staff (eight GPs and both registrars, two nurses, two healthcare assistants (HCAs), the practice manager, reception staff, administrative staff and the medicines management officer) and spoke with patients who used the service. We reviewed CQC comment cards where patients and members of the public shared their views and experiences of the service.

Are services safe?

Summary of findings

Overall the service was safe. Systems were in place to keep patients safe and protect them from avoidable harm. We saw evidence that following a serious incident, a thorough and rigorous investigation had taken place. Although recruitment checks were carried out on staff, some of the checks were not up to date.

Our findings

Safe patient care

The practice had a consistently good track record on safety. Information from the Quality and Outcomes Framework, which is a national performance measurement tool, showed that the practice appropriately identified and reported incidents. Where concerns arose they were addressed in a timely way. There were effective arrangements in place for reporting safety incidents. The staff we spoke with were all able to accurately describe the process they would follow if they witnessed such an incident.

The practice took a proactive approach to safeguarding, with a focus on early identification so that people were protected from harm.

Learning from incidents

The practice was open and transparent when there were near misses or when things went wrong. We saw there were monthly practice meetings to discuss any such events. We looked at the schedule of critical events for 2013-2014. The schedule detailed the events and any learning points and subsequent action taken. The provider had experienced a serious adverse event involving a patient's late diagnosis. This was subsequently reported to the Ombudsman. We saw evidence that a thorough and rigorous investigation had taken place. This had identified some key learning points, for example, around recall arrangements (ensuring that when advised by the clinician, patients booked and attended any follow-up appointments), which had been shared with staff.

Safeguarding

We saw the practice had safeguarding policies in place for both children and vulnerable adults. There were identified members of staff with clear roles to oversee safeguarding within the practice. This role included reviewing the procedures used in the practice and ensuring staff were up to date and well informed about protecting patients from potential abuse. The clinicians held quarterly meetings to discuss ongoing or new safeguarding issues. The staff we spoke with had a good knowledge and understanding of the safeguarding procedures and what action should be taken if abuse was witnessed or suspected.

Are services safe?

The practice had a system to highlight vulnerable patients on their computerised records system. This information would be flagged up on patient records when they attended any appointments so that staff were aware of any issues.

The patients we spoke with told us they felt safe at the practice. One patient said "I feel safe in every sense", another said "I feel safe when visiting the practice, there's no problems like that."

We asked the practice manager how any safeguarding concerns were identified for new patients. They told us the patient would have a registration medical with the practice nurse. In addition, any records from patient's former practices would be sent to the practice. During our inspection we found that the practice had 130 records for new patients which had not been reviewed and then summarised. The practice manager told us new patients had all attended a 'registration medical' with the practice nurse. However, if the patient did not mention any safeguarding concerns during this medical there was a risk such issues may not have been identified until the records were reviewed.

Monitoring safety and responding to risk

The provider did not have detailed plans in place to ensure business continuity in the event of any emergency, for example, power failure or flood. The local area had suffered from flooding in the past, which impacted on the former premises. The practice manager told us that they had only recently moved into the current premises and a plan had not yet been developed.

We looked at the arrangements in place to cope with changes in demand for the service, for example, seasonal variations. The practice manager told us that the area did not have a significant amount of tourists, and any that did request an appointment were seen. We found the practice had undertaken a detailed planning exercise when there had been a potential flu pandemic. We also saw adjustments to staffing and availability of appointments were made around public holidays, including increasing the number of acute appointments on the day after such holidays. This demonstrated the practice took a proactive approach to anticipating changes in demand.

The practice manager had agreed staffing levels with the provider. We looked at the staff rotas and saw these levels were maintained. The doctors told us they managed staffing levels and very rarely needed to use locum doctors.

Medicines management

We found that there were up to date medicines management policies in place. The staff we spoke with were familiar with them. Medicines were kept in a secure store, which could only be accessed by clinical and pharmacy staff. There were appropriately stocked medicine and equipment bags ready for doctors to take on home visits. We saw evidence that the bags were regularly checked to ensure that the contents were intact and in date. Arrangements for the storage and recording of controlled drugs, which are strong medicines that require extra administration checks, were followed.

The provider held medicines on site for use in an emergency or for administration during a consultation (for example, vaccinations). We checked a sample of drugs to ensure they were in date. Vaccines are required to be stored below a certain temperature. We asked the nursing staff how they ensured the vaccines were stored appropriately. They described the 'cold chain process' whereby the vaccines were delivered in a cool box then immediately transferred to a fridge. The temperature of the fridge was checked daily to ensure it was within the correct range.

Patients we spoke with told us they were given information about any prescribed medication. Comments included "The doctors and nurses are very good about explaining any medication, the doses and side effects and they tell me what each one is for" and "Staff explain everything about my medication and answer any questions I have."

Cleanliness and infection control

We looked around the practice and saw it was clean, tidy and well maintained. The waiting areas were bright and airy. We found the consultation rooms were in excellent condition and were laid out in line with good infection control practice. For example, disposable curtains were in place and sinks had elbow taps. This helped to protect patients from the risks of cross infection. Personal protective equipment (PPE) and hand hygiene gel was available throughout the practice. Hand washing

instructions were also displayed by hand basins and there was a supply of liquid soap and paper hand towels. This meant patients and staff were informed about good hand hygiene practice.

We saw there were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We asked the healthcare assistants about the procedures for accepting specimens of urine from patients. They showed us there was a box for patients to put their own specimens in. The staff then used PPE to empty the box and transfer the specimens. These actions meant staff were protected against the risk of health related infections during their work.

Staffing and recruitment

The practice manager advised that the practice did not have a formal recruitment policy in place. However, they described the process they had adopted; this was appropriate. There was a job description and person specification for each role and evidence of selection and grading at interview. All of the staff we spoke with confirmed they had completed a written application and attended a formal interview.

We looked at a sample of recruitment files. We saw recruitment checks had been undertaken, which included a check of the person's skills and experience through the curriculum vitae (CV), references and identification confirmation. The practice manager told us they checked clinical staff's registrations with their professional bodies such as the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) annually.

We found that police clearance checks (called Disclosure and Barring Service (DBS) checks) had been carried out for most, but not all clinical staff. The provider had not carried out a risk assessment as to whether it was necessary to carry out DBS checks for non-clinical staff.

Dealing with Emergencies

The practice had resuscitation equipment and medication available for managing medical emergencies. We saw all items including drugs were within the expiry date and regular equipment checks were undertaken. All of the staff we spoke with told us they had attended CPR (resuscitation) training within the last 12 months.

The fire alarms were tested on a weekly basis. The practice manager told us an evacuation drill had also recently been carried out.

Equipment

Staff had access to appropriate equipment to safely meet patients' needs. The consultation rooms were equipped with PPE, such as gloves and aprons. We found medical equipment including blood pressure monitoring machines, defibrillators, scales and thermometers had recently been checked and calibrated (adjusted, if necessary, to ensure accurate results for patients). This was carried out annually and we saw certificates from February 2014 which confirmed the checks.

The practice healthcare assistants were responsible for monitoring stock levels of medical supplies. We saw each of the consultation rooms had a trolley to store frequently used items. These trollies were replenished daily by the HCAs.

We saw electrical equipment was tested annually to ensure it was safe to use.

Are services effective?

(for example, treatment is effective)

Summary of findings

Overall the service was effective. Care and treatment was delivered in line with current best practice. Staff were appropriately qualified and had opportunities to develop their skills and knowledge. The practice worked closely with other providers to co-ordinate care.

Our findings

Promoting best practice

Care and treatment was delivered in line with recognised best practice standards and guidelines. One of the doctors had a lead role in developing clinical templates for use throughout the practice (e.g. for clinical conditions and diseases). We looked at a sample of the templates and found they were thorough, comprehensive and easy to use. The information collated from the templates was then reviewed as part of a clinical audit to determine whether there had been any unwarranted divergence from the clinical standards.

The practice had protocols in place when referring patients. For example, referrals were made within 24 hours of the initial appointment for patients with suspected cancer; this is in line with the NICE (national institute for health and care excellence) recommendations.

The arrangements for arranging the 'choose and book' (which gives patients of place, date and time for their appointment) were not clearly defined. When a patient was referred, the referring doctor sent a note to the administrative officer responsible for registering the patient. The officer then selected a choice of service, based on the information provided by the doctor. In some cases, where the notes did not clearly state which service and sub-category were required, it appeared that the officer made a clinical decision by selecting the service. We discussed this with one of the doctors. They told us the administrative officer would contact the doctor if they were not sure which service to select, therefore the decision would be made by the referring clinician.

We saw that healthcare professionals adhered to the requirements of the Mental Capacity Act 2005 and the Children Act 1989 and 2004. Capacity assessments and Gillick competency assessments of children and young people, which check whether children and young people have the maturity to make decisions about their treatment, were an integral part of clinical staff practices. We found that clinical staff understood how to make 'best interest' decisions for people who lacked capacity and sought appropriate approval for treatments such as vaccinations from children's legal guardian.

Are services effective?

(for example, treatment is effective)

Management, monitoring and improving outcomes for people

Delivery of care and treatment achieved positive outcomes for people. We reviewed the most recent QOF scores for the practice. The quality and outcomes framework (QOF) is part of the General Medical Services (GMS) contract for general practices. QOF is used by NHS England to provide financial incentives for practices to carry out specific activities that promote screening, prevention and early intervention on a range of clinical conditions. The practice's overall score for the clinical indicators was higher than the local and national average.

The practice participated in clinical audits and peer review, which led to improvements in clinical care. We saw a number of clinical audits had recently been carried out. The results and any necessary actions were discussed at the weekly GPs meetings. For example, a project on patients with heart failure identified that there was no recall system in place to periodically check heart failure patients. An action plan was developed to ensure this was rectified.

Complete, accurate and timely performance information was published by the practice. This included the results of the patient survey and the subsequent action plan.

Staffing

Staff were appropriately qualified and competent to carry out their roles safely and effectively.

There were effective induction programmes in place for all staff, including locums. We found there were comprehensive induction packs for each role within the practice. We looked at the locum information pack and saw that the induction lasted between two and four weeks. Two of the GP registrars working at the practice told us they had received an 'excellent' induction.

Staff had opportunities for professional development beyond mandatory training. One of the nurses told us "We have our usual annual training but I have also had the opportunity to do other courses, such as diabetes and alcohol & drugs awareness. This training also enabled staff to maintain their professional registration. One of the doctors was the designated lead on training. Monthly meetings were held with nurses and healthcare assistants to review educational needs. The doctor also arranged for coaching sessions and acted as a mentor for these staff.

Each month the practice closed for an afternoon for Protected Learning Time (PLT). Some of the time during these afternoons was dedicated to training. One of the doctors is an expert on resuscitation methods and has delivered training sessions to staff during PLTs. Some training was also delivered by external experts, for example, childhood illnesses and basic first aid.

The practice had mechanisms in place to ensure appropriate levels of appraisal of staff. The nurses and healthcare assistants had an annual appraisal with one of the doctors and the strategic manager and we found these were up to date. The practice manager told us they were behind on appraisals for some of the administrative staff, but had plans in place to address this.

The practice did not have formal training plans in place for staff. The local Clinical Commissioning Group (CCG) had requested that a training needs analysis be completed and submitted by the end of June 2014. The practice manager told us this work was ongoing. The CCG had funded access to some on-line training which would also enable the practice to develop a training matrix. This would enable the management team to see at a glance when training was due.

Working with other services

The doctors worked closely with other health and social care providers, to co-ordinate care and meet people's needs. The practice safeguarding lead had good relationships with social services, health visitors and school nurse services. One of the regular monthly meetings was wholly devoted to reviewing all children registered at the practice who were on the social services 'at risk' register. Meetings were held every four weeks with the Community Psychiatric Nurse (CPN) to review named patients.

The practice maintained a palliative care register. A monthly meeting was held which was attended by the clinical team and the Macmillan nurses. We saw there were procedures in place to inform the local out of hours service about any patients on a palliative care pathway.

Health, promotion and prevention

The practice proactively identified people who may have needed ongoing support. This included carers, those receiving end of life care and those at risk of developing a long term condition. Patients with long term conditions were reviewed each year, in the month of their birthday.

Are services effective?

(for example, treatment is effective)

We found that new patients were offered a 'registration medical' with the practice nurse to ascertain details of their past medical histories, social factors including occupation and lifestyle, medications and measurements of risk factors (e.g. smoking, alcohol intake, blood pressure, height and weight).

Information on a range of topics and health promotion literature was available to patients in the waiting area of the practice. This included information about screening services, smoking cessation and child health.

Are services caring?

Summary of findings

Overall the service was caring. Patients we spoke with were very complimentary about the practice. They all told us the staff were caring and helpful. The practice's own patient survey also produced consistently positive results.

Our findings

Respect, dignity, compassion and empathy

We spoke with 14 patients. They were all happy with the care they received. People told us they were treated with respect and were positive about the staff. Comments included "I have found all of the staff very helpful", "I am happy with the nurses and the care they give me" and "The doctor was excellent, they went into detail about my treatment."

Before the inspection took place we had asked people who used the service to complete CQC comment cards. We received four completed cards. The comments were all positive, "I was very pleased in the way I was seen by the doctor", "Excellent service" and "Kind and helpful staff."

We also looked at the results of the most recent patient survey, which was published in January 2014. Over 250 patients completed the survey during November 2013. Of those, 98% described their overall satisfaction with their visit as good or better.

We observed the waiting area and saw staff responded to patients in a caring way. For example, there was a designated member of staff to 'meet and greet' patients. We saw staff support patients to check in for their appointment.

Staff were aware of how to respect people's privacy and dignity. Consultations took place in purpose designed rooms with an appropriate couch for examinations and curtains to protect privacy and dignity. There were signs explaining that patients could ask for a chaperone during examinations. We were told only the nurses and healthcare assistants were trained to act as chaperones. We spoke with these staff and they described the process they would undertake to protect people. The results from the patient survey showed that patients felt their privacy was respected.

Involvement in decisions and consent

We saw there was a variety of patient information on display throughout the practice. This included information on health conditions, health promotion and support groups.

Are services caring?

Patients told us they felt they had been involved in decisions about their care and treatment. They said the clinical staff gave them plenty of time to ask questions and responded in a way they could understand. They were satisfied with the level of information they had been given.

We asked staff how they ensured they obtained consent from people. Staff were all able to give examples of how they obtained verbal or implied consent. Comments included “I would always explain what I was doing; if I was carrying out an invasive procedure I would say what I was going to do then ask if the patient was OK with that. I would then record in my notes that the procedure was performed with consent” and “If I am doing a blood test for example, I would ask if it’s OK first.”

One of the doctors described the procedures they would follow where people lacked capacity to make an informed decision about their treatment. They told us an assessment of the person's capacity would be carried out first. If the person was assessed as lacking capacity then a “best interest” discussion needed to be held. They knew these discussions needed to include people who knew and understood the patient, or had legal powers to act on their behalf. This should ensure any decision made on behalf of the patient was done in their best interests.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

Overall the service was responsive to people's needs. The practice offered telephone consultations or face to face appointments depending on each patient's preference or need. Patients had the option to book appointments over the telephone or on-line. The premises were accessible to those with a physical disability. There was a clear complaints policy; staff and patients were aware of how to make and respond to any complaints.

Our findings

Responding to and meeting people's needs

The practice was accessible to patients with mobility difficulties. The consulting rooms were large with easy access for all patients. There were passenger lifts available for people to use if their appointment was on the lower ground floor. Free parking was available in a large car park directly outside the building. We saw there were marked bays for patients with mobility difficulties.

We asked staff how they made sure that people who spoke a different language were kept informed about their treatment. Staff told us they had access to an interpretation service. This meant patients whose first language was not English were supported to be access the service and communicate their needs.

Staff told us that where patients were known to have additional needs, such as being hard of hearing, were frail, or had a learning disability this was noted on the medical system. This meant the general practitioner or nurses would already be aware of this and any additional support could be provided, for example, a longer appointment time. The clinicians would also always go to the waiting area to escort the patient to the consultation room. The practice manager told us that a decision had been made not to install a loop system (to aid hard of hearing patients) due to concerns over confidentiality, but that they were considering purchasing a portable system.

Each patient registered at the practice had a designated 'named GP.' Within the practice there were small teams of 3 or 4 doctors who were responsible for covering each other's patients during periods of absence. This ensured continuity of accountability, even if patients saw other doctors. Patients had the option to change their named GP, for example, if they preferred a male or female member of staff.

Access to the service

Castlegate Surgery is open from 8.00am to 6.30pm Monday to Friday. We found that patients were able to book appointments either by telephone or using the on-line system. Face to face and telephone consultations were available, to suit individual needs and preferences. Each

Are services responsive to people's needs?

(for example, to feedback?)

day one of the doctors is the named 'duty doctor'. They told us the duty doctor carried out the home visits and any urgent appointments. This meant anyone with an urgent problem was seen on the same day.

We looked at the results from the most recent patient survey. We saw that 86% of respondents described their satisfaction with the opening hours as good or better. 70% of patients felt they could see a practitioner within 48 hours. We also spoke with some patients on the day of our inspection. The majority of people told us they could make an appointment within a reasonable timescale.

We found the practice had an up to date leaflet which provided information about the services provided, contact details and repeat prescriptions. The practice also had a clear, easy to navigate website which contained detailed information to support patients. This included several 'How do I' guides, for example, 'register at the practice', 'get test results' and 'get help out of surgery hours.' This demonstrated patients were provided with information on how to access the service.

Concerns and complaints

We saw there was a detailed complaints policy in place. This was contained in the practice leaflet and was available on the practice's website.

All of the patients we spoke with said that they knew they could speak to a member of staff if they had a complaint. One patient said "I haven't had any reason to complain but I have confidence that if I had to it would be resolved quickly."

Staff we spoke with were aware of the complaints policy. They told us they would deal with minor matters straight away, but would inform the practice manager of any complaints made to them. This meant patients could be supported to make a complaint or comment if they wanted to.

Are services well-led?

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

Summary of findings

Overall the service was very well led. There was a strong and visible leadership team, with a clear vision and purpose. There were clear lines of accountability and responsibility within the practice. Staff were committed to improving standards and encouraged good working relationships amongst the staff and other stakeholders.

Our findings

Leadership and culture

There was a well established management structure with clear allocations of responsibilities. Each of the doctors had leadership roles, for example, one doctor was responsible for human resources, GP training and was the clinical lead for diabetes. Another of the doctors regularly engaged with the local CCG to discuss the needs of the local population.

We spoke with eight of the nine GPs and with both of the GP registrars. They all demonstrated a clear understanding of their area of responsibility. Each person took an active role in ensuring that a high quality service was provided to the patients. From our observations it was evident there was a strong leadership team.

We found there was an open culture. Staff were encouraged to raise any concerns and told us they were supported by managers.

Governance arrangements

Castlegate Surgery had a clear corporate structure designed to support transparency and openness. There were systems in place to monitor all aspects of the service. Documented weekly GP 'Quality Improvement' and 'Shared Learning' meetings were held. These sessions were used to discuss any serious incidents, complaints and clinical governance issues in detail. Any lessons learnt or actions identified were then cascaded to the other members of the team.

We found staff were aware of what they could and couldn't make decisions on. For example, when we spoke with medicines management staff, they were clear about when repeat prescriptions could be issued and when they had to be authorised by one of the doctors.

Systems to monitor and improve quality and improvement

The practice proactively evaluated the services provided. We saw records of the checks and audits carried out to make sure the practice delivered high quality patient care. These included clinical audits, checks of patient referrals, staffing, the environment and medication. We saw if any issues were identified a plan was developed with a timescale for action. The practice manager told us about the results of a recent review of the telephone booking

Are services well-led?

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

system. The findings of the review led to an improved triage system, whereby the patient, guided by trained reception staff decided whether a telephone or face to face appointment was the best option for them.

Patient experience and involvement

The practice had an active Patient Forum. We saw there were 10 patient members of the Forum and representatives from the practice, including the Strategic Manager. The Forum generally met every other month; all minutes were available on the practice website or at reception upon request.

We spoke with a member of the Forum. We saw the group were involved in how the practice operated. They told us they were fully involved in setting objectives with the practice for the year ahead, and contributed to any changes required following the annual patient survey. They said they were listened to and felt that patient opinion and feedback was always welcomed by the practice and suggestions were acted upon. This showed patients were involved in the monitoring of the practice.

Staff engagement and involvement

Practice staff met regularly. There were various weekly meetings, including a practice meeting attended by the doctors and practice management team, a clinical team meeting; a GP shared learning session and a nursing team meeting. In addition, there were monthly meetings prior to the PLT (practice learning time) afternoons for all staff. The clinical staff told us they felt listened to and able to raise any concerns they had. One person said “Everyone is approachable; I feel I can discuss anything.” Another said “The support is absolutely fantastic.”

Some of the administrative staff told us they did not feel as supported. There had been a period of change and a recent job evaluation which had unsettled some staff. We raised this with the practice manager and one of the GPs, they informed us they were aware of the issue and were taking steps to address staff’s concerns. One of the concerns was a perceived lack of communication between the different teams in the practice. A ‘Delivery Team’ was set up to improve the communication. Representatives from each team had been appointed, with the aim of cascading information and allowing for two-way communication. For example, any decisions made at the doctors meetings would be filtered through the Delivery Team to all staff.

The practice had robust whistleblowing procedures and a detailed policy in place. Staff we spoke with were all able to explain how they would report any such concerns. They were all confident that concerns would be acted upon.

Learning and improvement

The practice had management systems in place which enabled learning and improved performance. For example, a critical event was noted in relation to a missed follow-up of a patient who had accessed the local out of hours service. The provider demonstrated it had learned from this and improved the arrangements by altering the process for handling the incoming information from the out of hours provider.

A monthly meeting was held with the other practice located in the community hospital. This enabled peer review and was an opportunity for shared learning. We found there was a willingness at all levels to respond to change to improve and enhance the service.

Identification and management of risk

The practice ensured that any risks to the delivery of high quality care were identified and mitigated before they became issues which adversely impacted on the quality of care. Risks were discussed at the monthly practice meeting; any action taken or necessary was documented and cascaded to all staff.