The Smethwick Medical Centre

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.

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Overall summary

The Smethwick Medical Centre provides a range of primary medical services for approximately 10,000 patients. Services are provided from their main two storey building in Smethwick and their branch surgery at the Hollybush Medical Centre in Quinton three miles away. This inspection was carried out at the Smethwick Medical Centre main surgery. The practice is part of the 'Vitality Partnership' which is an extended partnership of practices in central Birmingham and the border of Sandwell.

Prior to our inspection we spoke with patients during a listening event held locally and a representative of the Patient Participation Group (PPG). This is a group of patients from the practice who seek the views of patients regarding the service and work with the practice to develop plans to address areas where improvements could be made. We also spoke with the local area team from NHS England, the local Clinical Commission Group (CCG) and the local medical committee. During our inspection we spoke with staff and patients attending the practice that day.

We found that the practice was safe, effective, caring, responsive and well-led. There were robust systems and processes in place to ensure the safety of patients and staff. The practice was committed to learning from when things went wrong and engaged in significant event and clinical audit. Clinical audit is a way of finding out if healthcare has been provided in line with recommended standards.

Patients we spoke with at the practice reported that the practice was caring and that they were treated with respect. The majority of patients reported satisfaction with the care they received from the practice but there were concerns expressed regarding difficulty in getting appointments. This has been an area where the practice have been working over a period of time with the PPG and have implemented actions to improve access.

The practice were proactive in identifying the needs of the practice population and had analysed data and implemented changes to how services were delivered as a result. The practice offered services to include provision of health care to all population groups.

There was a specific GP with an interest in care of older people and mental health. We found that patients with long term conditions were managed effectively.

The practice offered facilities for young children and mothers for support and advice and opportunity to take up national screening programmes for immunisation and cervical screening. There were extended opening hours and online appointments to provide improved access to services for those patients who work. The practice had systems in place to identify vulnerable people and those with mental health problems who may need additional support and referral to more specialised services.

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.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice was safe. There were systems in place to ensure monitoring of safe practice and arrangements for addressing any issues which may present risks to patients or staff. Staff were trained in safeguarding procedures and demonstrated an understanding of the safeguarding policy and their responsibilities within the practice. There were sufficient staff with the appropriate skills to carry out their roles and who were trained to deal with unforeseeable emergencies.

Are services effective?

Services were effective. The practice demonstrated commitment to best practice standards and had systems in place to ensure that these were adopted by all staff. Regular clinical audit was carried out to review care and improve standards of care for patients as a result. The significant event analysis (SEA) process was embedded within the practice demonstrating commitment to learning from when things went wrong. There was sufficient, well maintained equipment and facilities within the practice to enable all staff to carry out their roles effectively. There was evidence of joint working with other agencies and communication internally and externally to enhance patient care.

Are services caring?

The practice was caring. We spoke with patients who reported that they were treated with kindness, respect and dignity. They reported positive experiences during consultations with clinicians and felt listened to. Consent was always sought prior to procedures and patients felt involved and informed regarding their care and treatment.

Are services responsive to people's needs?

The practice was responsive. There was evidence of genuine commitment to the comments and views via the Patient Participation Group and comment cards. There was constant analysis and review of the appointments system which the practice had accepted from patient feedback was the issue that mattered most to patients. The practice had a robust system for dealing with complaints and implemented it accordingly.

Are services well-led?

The practice was well led. The practice had recently become part of a larger organisation and had taken steps to ensure that staff were well informed of changes. They had implemented new policies and

Summary of findings

procedures to ensure that staff were aware of their role and responsibilities in all areas of the practice. There was commitment to staff training and development through appraisal and one to one discussions and an open and honest culture was evident throughout the practice. Staff reported that they knew who to contact if they needed help with concerns or issues occurring in the practice.	

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people
The practice had a proactive approach to meeting the needs of older people. There were GPs with special interest in the elderly and had developed services within the practice to promote care and improve care for elderly patients with dementia and other mental health problems. The practice had a systematic method of identifying patients with specific conditions and adopted care according to patient's personal need and physical and mental capacity. The practice employed their own staff with specific roles in care of the elderly.

People with long-term conditions
The practice had a systematic approach for identifying patients and managing patients with long term conditions. Specific clinics were held to ensure patients had access to annual review and opportunity to discuss their condition when education and change of management was necessary. The practice and community nurses offered ongoing management and support to patients with long term conditions and communication between all disciplines was evident.

Mothers, babies, children and young people
The practice had a midwife who attended the practice weekly to deal with women during pregnancy. Smoking advice and education regarding pregnancy and childbirth were provided during this time. The practice offered child health clinics at both surgeries to provide medical checks, immunisation and development reviews for babies with both the GP and health visitor as well as advice and support for new mothers.

Postnatal screening and cervical screening was also offered in line with the national programme together with signposting to other services where necessary.

The working-age population and those recently retired
The practice offered extended appointments between 6pm and 8pm two evenings per week to allow patients who work to access health care. There were also facilities to allow patients who work to request a call back to discuss their problem with a GP or advanced nurse practitioner and determine if an appointment is necessary.

Summary of findings

Online booking and repeat prescription requests were also available to provide more opportunity to attend the practice for those people who worked.	
People in vulnerable circumstances who may have poor access to primary care The practice had a system for identifying patients with learning disabilities and offered annual physical health checks. They also had a register of carers to support and signpost to alternative support agencies where necessary. The practice offered temporary resident care for those patients with no fixed address and provided immediate necessary treatment where appropriate. Advice and signposting was offered where necessary.	
People experiencing poor mental health There were GPs in the practice with a special interest in mental health who worked with other services to provide an holistic approach to care involving specialists. They also offered the service of an onsite counsellor and had access to a drug and alcohol counsellor to support patients with addictions. This allowed patients direct access to additional support without being referred to outside agencies.	

Summary of findings

What people who use the service say

We spoke with eight patients during our inspection and viewed 33 comment cards completed by patients in the four weeks prior to our inspection. We also spoke with patients who attended a listening event organised by the West Bromwich African Caribbean Resource Centre, Cares Sandwell, Sandwell African Mental Health Foundation (Kumba Centre) and Sandwell Visual Impairments Group.

Almost all patients we spoke with expressed satisfaction with the care they received at the practice. They reported that they were treated with respect and kindness most of the time. However, they did tell us that it was difficult getting an appointment on the same day. Patients did confirm that if they needed to speak to a doctor urgently they were given a 'ring back' by either the GP or the advanced nurse practitioner.

Of the 33 comment cards we received, 19 reported a good service from the practice, commenting on professional, caring staff and an overall good service. Eleven of the cards also commented on a good service and expressed satisfaction of the care they received but also commented that they experienced difficulty when trying to book an appointment. Three cards expressed dissatisfaction from patients regarding long waiting times to see the doctor and another reporting feeling undervalued as a patient together with difficulty in booking appointments.

We received only one comment regarding the practice during the local listening event. One patient reported difficulty in booking appointments.

Overall the majority of comments were positive expressing satisfaction with the service with the exception of the ability to book appointments.

Areas for improvement

Action the service SHOULD take to improve

We found that full sharps containers were stored with clean equipment whilst awaiting collection. The provider should make arrangements for secure storage of full sharps containers away from clean areas.

We saw that patients stood close to each other whilst waiting to speak to the receptionist and patients could easily be overheard. The provider should investigate ways of improving privacy in the reception area to promote privacy and dignity for patients when talking to reception staff.

Outstanding practice

Our inspection team highlighted the following areas of good practice:

The practice offered a joint clinic once a month by a GP with a special interest in the elderly which was attended by a geriatrician and psycho geriatrician from the local hospital. This allowed patients to be seen by the GP and specialists in this area at the same appointment and removed the risk of long waiting times, difficulty in communicating care which had taken place and inconvenience to patients. It provided an integrated approach and seamless journey and promoted good care through joint working and improved communication.

The Smethwick Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP and included another CQC inspector and a practice manager

Background to The Smethwick Medical Centre

The Smethwick Medical Centre is located in Smethwick, West Midlands with a branch surgery Hollybush Medical Centre 3 miles away in Quinton, Birmingham. The branch surgery was not part of this inspection. The practice provides primary medical services for approximately 10,000 patients.

The practice has five GP partners and two salaried GPs. They employ a wide range of staff including four advanced nurse practitioners, three practice nurses, two specialist nurses in diabetes and an older adults case manager, four community nurses, a health care assistant in the practice and a community health care assistant. The clinical team is complimented by a practice manager and team of reception and administration staff.

The practice service for out of hours care is via the NHS 111 service.

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward.

How we carried out this inspection

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

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

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

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health.

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

Detailed findings

We carried out an announced visit on 11 August 2014 between 8.30am and 6pm.

During our visit we spoke with a range of staff, including GPs, advanced nurse practitioner, practice nurse, community nurses and reception staff and spoke with patients who used the service. We observed how patients were dealt with and talked with carers and family members. We also reviewed policies and procedures in use throughout the practice.

Are services safe?

Our findings

Safe patient care

The practice had recently become part of a larger health care organisation and a governance manager was working with the practice to individualise specific policies and procedures and yet be in accordance with the overall organisational policies. This was to ensure that the process was managed robustly and that all staff were clear regarding who would be responsible for patient safety issues and what to do if patient care was compromised.

The practice had a designated lead GP for specific roles, for example, safeguarding and elderly care. Staff we spoke with were aware of who to go to if they had concerns regarding safety issues.

We found that there were systems in place for reporting issues and concerns which may pose a risk to patients and staff. There was a robust system for reporting significant events and regular audits took place by clinicians to explore the effectiveness of care and whether changes in process were necessary.

We saw minutes from meetings discussing complaints, significant incidents and audits. We found that lessons learned resulted in changes which were shared throughout the practice with all staff involved. The outcomes of these changes were audited three monthly to determine the effectiveness of the actions. We saw examples of where outcomes of significant event analysis had resulted in a change of practice. For example, changes in advice given to patients regarding action to take if they did not receive a timely appointment following a two week cancer referral. Significant event analysis is where the practice report and analyse things which went wrong and make changes in practice to prevent a recurrence.

Staff we spoke with reported that they were aware of the outcomes of investigation of safety issues and that these were shared through practice meetings.

Learning from incidents

The practice had a system in place for reporting, recording and monitoring significant events. We saw a significant event policy and clear documentation which facilitated the process of significant event reporting and investigation and promoted review at one and four month intervals.

We spoke with staff who reported that an open and transparent approach existed within the practice; this was reinforced from discussions with GPs in the practice. The GPs demonstrated a genuine commitment to learning. They had adopted a no blame culture, investigated incidents and shared improvements and changes as a result with an understanding of the importance of review. Monthly meetings took place, which were attended by all GPs and clinical staff, where significant events were discussed and changes made and shared with all staff.

Safeguarding

We spoke with staff regarding safeguarding of vulnerable adults and children. All staff we spoke with had an understanding of their role and responsibility regarding this. Safeguarding information was available on the practice intranet and all staff we spoke with reported this and that they accessed it as necessary.

The practice had a nominated lead GP for safeguarding and all staff had received appropriate training in safeguarding. Staff told us that when patients were at risk or if a child is known to social services an alert was placed on the system to indicate to the staff member that the patient may need additional support or that communication with other agencies may be necessary.

Monitoring safety and responding to risk

We spoke with staff who told us that they could contact a GP if they had concerns regarding patient care. Clinical meetings involved the multidisciplinary team who had opportunities to share information regarding patients treatments and highlight any potential risks.

Staff we spoke with were aware of specific lead roles of GPs within the practice whom they could approach if necessary. The practice undertook various types of audit to identify any risks, for example, we saw evidence of a cancer audit to determine the outcome of potential cancer referrals.

Medicines management

We found that there were robust systems in place for storing and administering medicines. Vaccines were stored in the fridge and were checked regularly for expiry. We checked the vaccines and found that all were in date and stored within a locked fridge. We also looked at records for the fridge temperatures and found that they had been recorded and maintained correctly.

Are services safe?

Staff we spoke with explained the process for repeat prescriptions which was appropriate. Patients could order a repeat prescription from the practice, by post or online.

Cleanliness and infection control

During our inspection we noted that all areas appeared clean and tidy. The practice had an appropriate infection control policy which had been recently reviewed. Staff we spoke with were aware of the policy and knowledgeable regarding infection control procedures. We saw a staff training matrix showing infection control training.

We saw that an infection control audit had been undertaken in June 2014 and three areas identified for action. For example, staff training, insertion of review dates on policies and clinical waste storage. The documentation had not been completed regarding the actions, however, following discussions with several staff it was evident that the actions were in progress.

Facilities for hand washing were appropriate and staff had access to personal protective equipment in all clinical rooms. Sharps containers were stored in a locked cupboard whilst waiting for collection. However, they were stored beside clean clinical equipment. The practice identified that this was unsuitable due to potential cross contamination risk and told us they had identified a different storage area to be used.

Clinical waste was stored safety and appropriately and collected regularly by contractors. We saw written evidence to support this.

Staffing and recruitment

We spoke with the practice manager who told us that staff levels were reviewed weekly and rotas created in advance based on the clinics which were running the following week. During times of staff sickness the practice called other members of the team before requesting locum cover. They told us that patients were always given a choice whether they wished to be seen by another GP.

The practice had organised a rolling programme to deal with the high level of influenza vaccines required at certain times of year. They told us that this involved staff at all levels and included opening Saturdays to promote the service, ensure optimal attendance and prevent excessive workload during normal hours.

Dealing with Emergencies

There was a robust business continuity plan which could be implemented in the event of a major incident at the practice. We found emergency medical equipment in place to deal with emergencies which was checked regularly and recorded and staff were trained in cardio pulmonary resuscitation and anaphylaxis. We saw the training matrix which confirmed this. We found that medication was kept in the clinical rooms where immunisation or vaccination was given to allow immediate response to any reaction.

Equipment

The practice had a comprehensive and complete equipment log. All equipment was maintained and serviced by an external contractor and we saw records which confirmed that this took place at appropriate intervals. The practice manager told us that as well as routine maintenance the contractor could be contacted at any time to address any urgent issues with equipment.

Staff we spoke with told us they had sufficient appropriate equipment to carry out their role and we saw that equipment was available for staff.

Are services effective?

(for example, treatment is effective)

Our findings

Promoting best practice

The practice demonstrated commitment to monitoring and improving services for patients. They reviewed the needs of the practice population and addressed these. For example, by employing a diabetes nurse specialist and carrying out joint visits with the GP and community nurses when necessary.

There was a lead GP responsible for ensuring new clinical guidance was adopted and shared with staff. Staff told us that the practice discussed all changes to the National Institute for Health and Care Excellence (NICE) guidance, clinical pathways and patients with complex conditions at the monthly practice meeting and we saw minutes of the meetings to confirm this.

We spoke with staff regarding safeguarding children and vulnerable adults who demonstrated awareness and understanding of the Children Act 1989 and their role. Staff we spoke with also had an awareness of the Mental Capacity Act 2005 and Gillick competence. The GP we spoke with told us that many people whose first language was not English chose to communicate using a family member; however patients were offered the use of a translator which was arranged when necessary and co-ordinated with an appointment. Gillick competency looks specifically at whether doctors should be able to give contraceptive advice or treatment to under 16-year-olds without parental consent and assesses whether a child has the maturity to make their own decisions.

Management, monitoring and improving outcomes for people

Discussions with clinical staff confirmed that the practice had systems in place to ensure that current national and the local Clinical Commissioning Group (CCG) recommendations and guidance was followed. For example, the practice monitored their antibiotic prescribing and ensured that they prescribed in line with current guidance.

We saw that they had a system in place for completing clinical audit cycles. Clinical audit is a way of finding out if healthcare had been provided in line with recommended standards, if it was effective and where improvements could be made. The GPs we spoke with were able to describe several audits undertaken at the practice by different GPs relevant to the care offered to patients. The results were discussed and changes made where necessary. Examples of clinical audits included an audit of 'Two week' referral for suspected cancer following which inappropriate referrals were discussed and a re-audit planned. Another audit was of the GPs compliance with the NICE guidelines on hypertension with a follow up audit planned for one year later. We saw a examples of completed audit, for example, patients with confirmed Vitamin D deficiency which resulted in an improved uptake of the medication

Staffing

Staff were appropriately trained and competent to carry out their role. All staff had received a Disclosure and Barring Service (DBS) check and references had been sought prior to commencement of employment. Staff we spoke with verified that they had DBS checks and had undertaken a comprehensive induction at the start of their employment.

We spoke with staff and the practice manager and looked at records. We saw that new staff had received an effective induction programme, for example, we saw that nurses were mentored for one month by a senior nursing colleague before being authorised to carry out clinics. Records showed that staff received a range of training during their induction which equipped them to carry out their role, such as training in cytology, immunisations and diabetes.

We also saw that non clinical staff were trained to enable them to be effective. This included training in safeguarding and basic life support. There were arrangements in place to provide training three to four times a year in key aspects of the practice such as infection control. This coincided with training days for the medical staff which ensured that the learning opportunities for staff were protected.

There was evidence of staff appraisals and staff reported that they felt this was a relevant and supportive process. Staff told us that their personal development needs and performance were discussed during their annual appraisal meeting with their line manager. Practice nurses reported that they were also supported through practice nurse meetings which were held monthly and any issues that needed escalating were fed into the main clinical meeting. We saw minutes of the clinical meetings which confirmed this.

Are services effective?

(for example, treatment is effective)

We saw that there was a system in place for managing poor or variable performance which focused on providing support and development.

We spoke with four GPs who confirmed that they had undertaken the appraisal process in preparation for revalidation.

Working with other services

We found the practice had identified patients who had complex needs and were frequent attenders at hospital. They provided additional support to them to reduce their admission and readmission rates by working with community matrons to educate them on better management of their condition.

We saw evidence of discussions regarding this process in the clinical practice meeting. The practice employed their own community nurses, diabetes specialist nurse, older adults case manager and counsellor in addition to advanced nurse practitioners and practice nurses. An older adults case manager works specifically with older people to help them to manage their conditions and prevent unnecessary admission to hospital.

The practice worked closely with other clinical specialists from secondary care for example a geriatrician, and psycho geriatrician to deal with elderly patients with dementia and prevent unnecessary visits to the hospital.

Multi-disciplinary team meetings took place monthly where all members of the team were invited. We saw minutes of meetings which confirmed this, for example the health visitor.

The practice also communicated daily with the out of hours service to determine if patients have been seen or are likely to require help or treatment out of hours. The GPs told us that results were conveyed by 'SMS' messaging where patients had given prior consent. They told us that they received all urgent results either by letter or phone call. This was also advertised on the practice website as a method of communication. One patient we spoke with told us that they could access their test results via 'SMS'.

The community nurses told us that joint visits took place with the GP when necessary. They reported the benefit of reporting directly into patients GP records allowing all professional immediate access to their care plan.

Health, promotion and prevention

We found a limited range of information leaflets and posters in the reception area regarding health promotion and prevention of ill health including smoking cessation and depression and diabetes. There were also large visual displays about healthy lifestyles. Staff we spoke with reported that they obtained health promotion literature from the intranet when necessary.

Patients in need of extra support were identified and their needs addressed. For example, patients who required end of life care were registered on the clinical system, had care plans and were discussed at weekly clinical meetings to ensure their changing needs were met. Information was provided by the community nurses and palliative care service to ensure improved outcomes for patients through good communication.

Carers were also identified on the clinical system and an alert created on their patient record to allow staff to signpost people to local support services, where appropriate.

We found that all new patients were offered routine health checks and a full medical history was taken. Patients were offered referral to a health trainer if advice and support regarding lifestyle changes, exercise programmes, or weight control was required.

The practice engaged in the national cervical screening programme and had a delegated administrator to contact patients who had not attended to help increase uptake of the service.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

During our inspection we observed that staff treated patients with kindness and respect and maintained their dignity. We observed staff members being helpful, caring and sympathetic to patients experiencing discomfort on arrival and expedited an appointment in response to the situation.

We saw that there was a low level section of the reception to allow patients who used wheelchairs to be seen. There was also a hearing induction loop to assist patients with hearing impairment.

Patients who required an intimate examination were offered a chaperone by an appropriately trained member of staff. There was a sign to indicate this in the reception area. We also saw a notice for patients stating that a room was available for confidential discussion with the reception staff if necessary. Staff we spoke with confirmed that they offer this facility to patients. However, we observed occasions when patients who arrived at the reception were able to hear the conversation between other patients and staff.

Patients who were bereaved were supported by staff. Staff told us that families who had experienced bereavement received a follow up visit from the community nursing service to establish the need for support and signpost them to appropriate services. In addition, bereavement counselling was available from the counsellor employed at the practice and patients were referred as necessary.

Involvement in decisions and consent

We spoke with eight patients the majority of whom told us that they felt involved in making decisions about their care and treatment. This was supported by a large number of comments we received from patients who had completed comment cards prior to our inspection.

Patients told us that they were provided with information regarding their treatment and had opportunity to ask questions. We saw that the practice had a policy regarding consent. Staff we spoke with told us that they always sought patients' consent and ensured their understanding before carrying out procedures. They confirmed that this was documented in patient notes where written consent was necessary.

There was some limited information in the reception in different languages but we saw that all staff had access to information stored electronically which they could print off in a range different languages if required. Staff confirmed that they used this facility whenever necessary.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

During our inspection we saw that the practice had taken steps to understand the different needs of the population. For example they had identified patients living with dementia and had a designated GP to lead in dementia care. The practice told us that patients with dementia had access to a monthly mental health clinic at the surgery which was held to coincide with a monthly elderly care clinic. These clinics were attended by a geriatrician and psycho geriatrician from the local mental health service. This allowed both elderly patients and those suffering with dementia to receive specialist treatment and co-ordinated holistic care without the need to travel to the hospital.

From discussions with staff and the Patient Participation Group (PPG) representative there was clear evidence of a commitment to addressing the concerns of patients and drive changes to improve the patient experience. For example, the practice had worked with the PPG to address the problems around accessing appointments. The PPG, as a result, were helping the practice to raise awareness of the online booking facility to patients and had ensured the release of more online appointments. The practice worked with the PPG to carry out a survey to determine the patient's experience of their consultation with a GP. They were also working with them to develop a new practice leaflet and address some issues around the reception staff as a result of patient feedback.

The practice operated the 'choose and book' system which facilitated patients' choice of secondary health care services. During our conversations with patients we learned of two examples that showed the practice supported the needs of people with protected equality characteristics and provided care without prejudice.

We saw that people who wished to see a GP of their choice could do so within two days, but could always consult with another GP or advanced nurse practitioner on the same day using the patient 'ring back' facility. This was a facility to allow patients who were unable to access an appointment the opportunity to speak with a practitioner who could advise and decide whether a consultation was necessary that day.

The practice told us that they had recently become part of a larger health provider organisation. Part of the initial work of this organisation had been to use data about the practice patient population to identify unmet health needs. This concluded that there was a need for specific support for people with diabetes. As a result the practice had employed a diabetes specialist nurse.

Access to the service

We spoke to reception and clinical staff who told us that work had been on-going around the appointment system. Discussions with the PPG representative and minutes of meetings confirmed this.

We saw evidence that the practice had addressed issues around access to appointments and continued to make steps to improve and monitor access to appointments in response to patient feedback. We found that four week as well as same day appointments were available as well as the 'ring back' facility. Booking of appointments was available at the practice, by telephone or online.

The practice had been working with the PPG and had introduced online appointments and extra telephone lines and designated a specific member of staff to deal with telephone appointments in a separate room away from the main reception

The practice offered extended hours appointments to allow access for people who work or were unable to attend the surgery during the daytime. Repeat prescriptions were also available online or by attending the surgery. These services were advertised in the practice leaflet and online but the practice were working with the PPG who intended to promote this service further.

Patients who were housebound were offered home visits from the GP. The GPs also visited patients in care homes who were unable to get to the surgery. Housebound patients were also visited at home by the community nurses to provide services such as influenza vaccines.

Concerns and complaints

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

The practice complaints policy included actions to ensure complaints were dealt with appropriately. We looked at the complaints folder and saw it contained full details of all complaints received and a log of actions as a result. These

Are services responsive to people's needs?

(for example, to feedback?)

demonstrated that the practice had responded appropriately to patients complaints. We saw minutes of practice meetings which showed that complaints had been discussed and shared with staff.

We saw that there was a suggestions box in the reception area for patients to leave their comments regarding the practice and the practice also worked closely with the PPG to get patient feedback.

We spoke with a representative of the PPG who told us that the practice had engaged well with the group and provided representation from the practice staff to relay the views of the group to the practice. A GP also attended the meeting when required. A PPG representative was invited to attend practice meetings when specific issues required discussion.

The practice leaflet which was available to patients in the reception contained comprehensive information for patients of the complaints procedure.

Are services well-led?

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

Our findings

Leadership and culture

During our inspection we talked to staff regarding their view on leadership and the culture of the practice. Staff were aware of the current changes in the practice regarding becoming part of the Vitality Partnership and a strategy document had been developed and was seen during the inspection. Those staff members we spoke with reported being well informed and aware of the developments within the practice. They told us they had seen positive changes and that these had been shared with members of the team. One example of these changes was the recruitment of a diabetes specialist nurse.

We saw an open culture was evident and staff talked freely regarding shared learning and discussions of when things went wrong. The lead GP also demonstrated a commitment to ensure that the practice learnt from errors and improved quality of services as a result and encouraged openness and honesty. Evidence was seen from clinical audits, significant event analysis (SEA), practice meetings and clinical meetings where an inclusive approach had been adopted inviting all concerned to share learning The practice had a 'being open' policy to support this ethos and provide guidance for staff. We saw minutes of meetings at the practice and the Vitality Partnership meeting where development plans had been made, this included workforce and business planning.

The practice also had a statement of purpose setting out their aims and objectives for delivering services. It contained a detailed and comprehensive description of a range of services emphasising collaborative partnership working with other professionals to deliver holistic care and improved outcomes for patients.

Governance arrangements

A governance manager employed within the Vitality partnership was working with the practice to develop and facilitate governance arrangements surrounding the integration into the Vitality partnership. We found a range of policies and procedures in place to support quality and performance. The practice had identified lead GPs for specific areas of the practice, for example safeguarding, care of the elderly and changes in NICE guidance. Staff were aware of their responsibilities within their role and were able to explain who they would go to should they have concerns regarding anything in the practice.

Systems to monitor and improve quality and improvement

There was detailed robust documentation to support the learning and development process through staff appraisal. We saw evidence of staff appraisal and staff we spoke with confirmed that they had an opportunity to express their own learning and development needs through the process. The nursing staff reported that their appraiser listened to them and felt this was a valuable process.

We found that the practice had a continuous quality improvement system statement, which clearly set out the practice approach to analysing performance and ensure changes were made to improve patient care. This contained a range of activities which were evident throughout the practice, for example staff appraisal, Patient Participation Group (PPG), adverse events policy, incident reporting.

We saw that patients' complaints were reviewed and that annual returns were sent to the local area team indicating a breakdown and analysis of complaints which were received. This showed that the complaints had been handled appropriately and that the system was robust. We saw evidence of a log of outcomes of complaints which had been resolved within the timescale reflected in the complaints policy.

Data and information was available which was used to improve and monitor access for the practice on a monthly basis. We also saw evidence of performance data which was used to determine additional capacity required for clinical staff on a weekly basis.

Patient experience and involvement

The practice manager told us that PPG comments and plans were agreed and patient complaints and suggestions were noted and actioned where necessary. Comments were fed into practice meetings and any outcomes were communicated to staff and actions undertaken or referred to practice team meetings to discuss future actions. We spoke with a member of the PPG who confirmed that they had identified three areas to focus on for this year which were the reception staff training, a new practice leaflet and telephone access. This reflected the views and comments received from patients via the practice survey and discussions we had with patients during our inspection and

Are services well-led?

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

a recent local listening event. The PPG also carried out their own survey to determine patient views of their consultation with their doctor which demonstrated an overall positive response.

Staff engagement and involvement

The PPG reported that the practice engaged well with the group. There was an allocated GP who attended PPG meetings as well as the practice manager. Both representatives reported back to the rest of the practice via practice meetings. The practice had also invited representatives from the PPG to attend the practice meetings to report on specific issues. We saw minutes from meetings and PPG minutes which demonstrated that the practice actively supported and welcomed the work of the PPG. Action plans from the PPG were also shared and approved by the practice. For example, it was identified from feedback from patients that there were insufficient online bookings being made available. The practice increased the availability in response to this feedback and work was on-going.

The staff were aware of the Whistleblowing policy which had been reviewed and contained relevant information to support them, with allocated personnel identified to address concerns to.

Learning and improvement

The staff team members reported that they were aware of the objectives of the practice specifically around access issues and the appointment system. All staff were aware of the feedback from the PPG and demonstrated a commitment to working towards these objectives. Staff we spoke with confirmed that they are constantly reviewing the appointment system and were aware of this as a priority.

Identification and management of risk

We saw that the practice worked together to identify and manage potential risk by regular communication with all staff through staff meetings and review processes such as clinical audit. Both clinical and reception staff were aware of the reporting mechanism of significant event reporting and their roles in this process. Reception staff gave examples of when they used the SEA reporting process and demonstrated an appropriate response. For example, when a patient became aggressive at reception, staff dealt with the situation and were able to raise it as a significant event where it was investigated and procedures reviewed to reduce risk to staff and patients.

Community nurses we spoke with reported the benefit of reviewing team performance and service provision through team meetings. This allowed any areas of concern to be discussed and improvements implemented in a timely manner.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Our findings

The practice had a high number patients who are aged 75 or over. We saw that the practice had identified the needs of this group of people and developed services to address these. Each patient over 75 had a named GP and the practice provided elderly care clinics which were held monthly.

The practice had a named GP with a special interest in the elderly and had recently employed a new staff member to work with them to enhance the service for older people. They had utilised an assessment tool to identify patients at risk of repeat admissions to hospital and developed specific care plans to reduce their risks of admission.

There is also a lead GP for dementia. A mental health clinic was held monthly at the surgery run by the lead GP and a geriatrician and a psycho geriatrician from the local mental health services attended to provide an holistic approach to care and prevent unnecessary visits to hospital.

Home visits were provided for elderly housebound patients for influenza vaccination and general health promotion was also given at that time. The practice visited local care homes weekly and attended when requested in response to any medical concerns.

The practice employed their own community nurses, which further enhanced the care of elderly patients by providing continuity of care, quicker response to patients and improved communication with GPs regarding a patient's condition.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Our findings

The practice had a systematic approach for identifying and managing patients with long term conditions. They employed community nurses and practice nurses skilled in these conditions. The community nurses liaise with GPs, the Icares team and specialist nurses to provide holistic care for patients with long term conditions. Patients who were house bound were visited at home and support, advice and education on how to manage their condition offered as necessary.

Patients were allocated appointments for telephone call back to provide access whenever required. This was provided by the GP or advanced nurse practitioner.

Patients who arrived at the surgery with long term conditions and had a physical disability without an appointment were made comfortable and accommodated until an appointment became available.

The practice offered clinics for patients with long term conditions regularly throughout the year, where their condition was reviewed including medication and appropriate changes in treatment made. Influenza and shingles vaccinations were offered to all patients with long term conditions, where appropriate.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

The practice had systems in place to alert staff to children who were at risk of harm and may need additional support. Clinics were held at the surgery by the midwife for patients who were pregnant, providing support, education and advice regarding pregnancy and childbirth. There were leaflets available signposting patients to antenatal classes displayed in the surgery. The practice nurse also demonstrated awareness of a variety of services which they signposted patients to. For example, domestic abuse, children's centres and genito-urinary medicine clinics.

The practice offered specific clinics for mothers with babies where the GP carried out child medical examinations at eight weeks old. The health visitor was also available to offer support and advice around issues facing new mothers and babies. Childhood immunisations were also offered by the practice nurse who provided advice and information regarding the immunisation programme.

Screening for postnatal depression took place and cervical screening was offered in accordance with the national programme.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Our findings

The practice offered extended opening hours two evenings a week until 8pm at the main surgery. Appointments could be accessed either, online, at reception or by telephone. The late opening was advertised in the practice leaflet and on the practice website.

Repeat prescriptions were available online for those unable to access the surgery during normal working hours. There was also a facility for patients who were unable to access the surgery to have a telephone consultation with either the advanced nurse practitioner or GP if no appointments were available for the patients to access.

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

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Our findings

The practice had a system in place to identify and register patients with learning disabilities. All patients with learning disabilities were offered an annual physical health check. The practice also kept a register of carers in order to provide help, support and signposting to relevant other support services where necessary.

People with no fixed address were seen as temporary residents and given necessary treatment when they attend the practice. Patients from all groups were treated with respect and signposted to other services if necessary without any discrimination.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Our findings

The practice have a GP with special interest in elderly mental health and work with a geriatrician and psycho geriatrician for those patients experiencing dementia and other mental illness. The practice offered services from their on-site counsellor for all patients needing support for mental health problems. They also had access to the services of a drug and alcohol counsellor to support patients with addictions.