Arran Medical Centre

Quality Report

Mull Croft
Smiths Wood
Birmingham
B36 0PU
Tel: 0121 7704043
Website: www.arranmedicalcentre.co.uk

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We completed a comprehensive inspection at Arran Medical Centre on 10 November 2014. We found the practice to be good in the five key areas that we looked at and gave the practice an overall rating of good.

Our key findings were as follows:

- Patients were protected from the risk of abuse and avoidable harm. The staff we spoke with understood their roles and responsibilities and there were policies and procedures in place for safeguarding vulnerable adults and children.
- Infection control audits were completed to monitor compliance with infection prevention and control standards. The premises were clean and tidy and records were kept to ensure standards were maintained.
- Patients received care and treatment which achieved good outcomes, promoted a good quality of life and was based on the best available evidence. Systems were in place to review the care needs of those patients with complex needs or those in vulnerable circumstances.
- Patients told us that the GP listened to what they had to say and discussed their health needs with them. Staff were seen to be caring and treated patients with dignity and respect.
- The practice worked collaboratively with other agencies and regularly shared information to ensure good, timely communication of changes in patients care and treatment.
- Staff were aware of their roles and responsibilities and worked well as a team. There was evidence of good management support systems in place.

However, there were also areas of practice where the provider should make improvements:

- The practice should ensure that documentary evidence is available to demonstrate the action taken to address any significant events, incidents or accidents.

Summary of findings

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, reviewed and addressed. The majority of risks to patients had been assessed and well managed. Sufficient amounts of equipment were available which had been regularly maintained and was in good working order. Staff recruitment systems were robust and sufficient staff were on duty to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. Staff had received training appropriate to their roles. The practice had undertaken staff appraisals and personal development plans for all staff were completed. Multidisciplinary working was evidenced and improvements had recently been made regarding this. New patient checks were undertaken and patients were referred to other lifestyle services as needed.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Accessible information was provided to help patients understand the care available to them. We saw that staff treated patients with kindness and respect ensuring confidentiality was maintained. Compassion was shown to the family of bereaved patients with condolence cards and letters being sent with offers of an appointment to see the GP if required.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. There was an effective triage system in place. Children requiring an urgent appointment were always offered same-day appointments. Home visits and telephone consultations also took place. The practice had all of the necessary equipment to treat patients and meet their needs.

Summary of findings

There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision and strategy, although this had not been formalised, staff were aware of the vision and their responsibilities in relation to this. There was a strong leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and these were regularly reviewed and updated as necessary. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. The practice offered proactive, personalised care to meet the needs of older patients in its practice population. There were a range of enhanced services, for example the unplanned admissions enhanced service. This was a scheme to avoid unplanned admissions to hospital by focusing and coordinating care for the most vulnerable patients. The aim was to effectively support them in their home. An enhanced service is a service that is provided above the standard general medical service contract.

The practice was responsive to the needs of older patients, including offering home visits, telephone consultations and rapid access appointments for those with complex needs.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. The practice had a range of protocols in place which set out the processes for the management of patients with various long term conditions in line with best practice. Patients with long term conditions received regular reviews to check their health and medication needs from trained clinical staff that maintained their skills and knowledge in these areas. When needed, longer appointments and home visits were available.

The practice had identified patients and developed care plans for those with the most complex needs as part of the unplanned admissions enhanced service. The practice worked with relevant health care professionals to deliver a multidisciplinary package of care within the patient's home. An enhanced service is a service that is provided above the standard general medical service contract.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk of harm. For example, children and young people who had a high number of A&E attendances. Well baby clinics and child health checks were carried out at the practice. Appointments were available outside of school hours and the premises were suitable for children and babies. We were provided with examples of joint working with midwives, health visitors and school nurses.

Summary of findings

All staff had received training in safeguarding children so that they had the knowledge and understanding to act if they were concerned about a child.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offer continuity of care. The practice was proactive in offering online services, telephone consultations and had extended opening hours until 7.30pm on Tuesdays.

The practice offered health checks for patients between the ages of 40 to 74 and screening services such a cervical screening to help detect early signs of disease. There was a range of health information and promotion of health screening checks which reflected the needs for this age group. Patients that needed support to live healthier lifestyles were referred to appropriate services available outside the practice.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with learning disabilities. The register for patients with learning disabilities showed the majority had received an annual health check in the last 12 months. The practice offered longer appointments for people with learning disabilities.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). People experiencing poor mental health had received an annual physical health check. The practice regularly worked with

Summary of findings

multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. There were systems in place to ensure safe prescribing of antidepressants.

The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations.

Summary of findings

What people who use the service say

As part of the inspection we sent the practice a box with comment cards so that patients had the opportunity to give us feedback. We received five completed comment cards and on the day of our inspection we spoke with three patients. Positive comments were received about the practice and the care and support provided.

We reviewed comments made on the NHS Choices website to see what feedback patients had given. One person had rated the Arran Medical Practice and left positive feedback.

We looked at results of the national GP patient survey carried out in 2012/13. Findings of the survey were based on a comparison of the regional average for other practices in the local Clinical Commissioning Group (CCG). A CCG is an NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services. Areas that were assessed as worse than expected included access to appointments and patients' overall experience. Improvements should be undertaken to improve satisfaction scores in these areas. Areas in which the practice does best related to convenience of appointments, the helpfulness of reception staff and the nurse was good at giving patients enough time during their appointment. The people who we spoke with on the day of our inspection told us that it was not difficult to get an appointment with the GP; we were told that people could see the GP of their choice and did not have to wait long.

Areas for improvement

Action the service SHOULD take to improve

- Documentary evidence should be available to demonstrate the action taken to address any significant events, incidents or accidents as required.
- Improvements should be made to the storage of clinical waste and the labelling of waste bags.

Arran Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector; the team included a GP, a practice manager and a second CQC inspector.

Background to Arran Medical Centre

Arran Medical Centre is based in the Solihull Clinical Commissioning Group (CCG) area. The practice provides primary medical services to approximately 5,200 patients in the local community. This practice list is divided between the Arran Medical Centre and the branch surgery at the Sheldon Medical Centre. The population covered is predominantly white British. This inspection report covers the findings of our inspection of the Arran Medical Centre only.

The lead GP at the Arran Medical Centre is male. Arran Medical Centre is a teaching practice and currently both male and female GP registrars are training at the practice (a GP Registrar is a qualified doctor who is training to become a GP through a period of working and training in a practice). Additional staff included a practice manager, one practice nurse (female). There were seven administrative staff that supported the practice, including a finance manager. One pharmacist also supported the practice once a week.

The practice offers a range of clinics and services including, asthma, child health and development, long acting reversible contraception and minor surgery.

The practice has opted out of providing out-of-hours services to their own patients. This service is provided by Badger, who are an external out of hours service provider contracted by the CCG.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This provider had not been inspected before and that was why we included them.

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

How we carried out this inspection

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

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

Detailed findings

- Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- The working-age population and those recently retired (including students)
- 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 hold about the practice and asked other organisations to share what they knew. We reviewed comment cards where patients and members of the public shared their views and experiences of the service. We carried out an announced visit on 10 November 2014. During our visit we spoke with a range of staff including a GP, nurse, practice manager and administration staff and we spoke with patients who used the service. We also spent some time observing how staff interacted with patients but did not observe any aspects of patients care or treatment. We spoke with a member of the Patient Participation Group (PPG) who told us their experience not only as a member of the PPG but also as a patient of the service. The PPG is a way in which patients and the practice can work together to improve the service.

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. Staff discussed recent incidents that had occurred and confirmed that they had received feedback regarding these.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the twelve months prior to our inspection. All staff we spoke with said that incidents and complaints were discussed at practice meetings. This showed the practice managed these consistently and could evidence a safe track record over time.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed the records of significant events that had occurred during the last twelve months. We saw that there had been a low incidence of significant events at this practice. A slot for significant events was on the monthly practice meeting agenda. Staff we spoke with confirmed that significant events were discussed at practice meetings and all staff were able to recall the significant events that had occurred during the past twelve months. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. However, the minutes of practice meetings did not always record the action taken regarding significant events. The significant events form used to record information did not always detail the action taken or the date by which the action should be achieved .The practice manager was able to demonstrate actions but documentation seen did not always clearly demonstrate this.

We saw documentary evidence to demonstrate that audits of patient safety incidents were conducted to identify and monitor any trends.

National patient safety alerts were disseminated by the GP to practice staff. Staff told us that alerts were printed out by the GP and given to relevant staff who then signed a document to acknowledge that they had read the information. Copies of national patient safety alerts were available for all staff to review as required. These alerts were also discussed at practice meetings to ensure all staff were aware of any relevant to the practice.

Reliable safety systems and processes including safeguarding

The practice GP was the appointed lead in safeguarding vulnerable adults and children. We saw records which confirmed that they had undertaken additional training to enable them to fulfil this role. The practice manager confirmed that all other staff had undertaken basic level 1 safeguarding vulnerable adults and children training. Training records seen confirmed this. There was no documentary evidence to demonstrate that all clinical staff had undertaken training at a level appropriate to their role.

Staff we spoke with knew how to recognise signs of abuse in vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible. All staff were aware who the safeguarding lead was at the practice and confirmed that they could always speak with them if they had a safeguarding concern.

The practice had systems to manage and review risks to children, young people and vulnerable adults. We were shown copies of multi-disciplinary meetings regarding protection of vulnerable adults and children. Examples of recent adult safeguarding were discussed with us. The computer system enabled an alert to be placed on the practice's electronic records to highlight vulnerable patients. This included information so staff were aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. Relevant children's services data could be accessed direct on the practice computer system. Audits were completed to confirm that records were up to date.

A chaperone could be present during intimate examinations. This is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. We saw that the

practice had a chaperone policy in place. Notices advising patients of the availability of chaperones were visible on the waiting room noticeboard and in consulting rooms. Formal chaperone training had not been undertaken by staff. We were told that chaperone duties were discussed at practice meetings regularly but we did not see evidence of this in the notes that we saw. There was inconsistency amongst staff in the understanding of the role and responsibility of a chaperone. However, patients that we spoke with confirmed that they had been offered chaperones and were happy with the service offered. The practice manager had developed a presentation which would be discussed with staff at their next practice meeting. The presentation was detailed and included, for example the roles and responsibilities of a chaperone and information regarding how staff should raise concerns if they were unhappy with any aspects of an examination.

We asked staff about the practice's policy for whistle blowing. Whistleblowing is when staff report suspected wrong doing or poor practice at work, this is officially referred to as 'making a disclosure in the public interest'. The staff we spoke with were aware of this process and were aware of their responsibility to raise any concerns they had. We were told that the whistle blowing policy was available to staff on the practice's computer system. Patients we spoke with on the day of our inspection did not raise any safety concerns.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system which collated all communications about patients including scanned copies of communications from hospitals. Blood test results were reviewed by the GP and text reminders sent to patients for appointments. We were told that the telephone numbers were routinely checked as part of the consultation to ensure that the patient's correct details were recorded.

Medicines Management

We discussed medicines management with the practice nurse, practice manager and GP. We looked at the storage of medicines in medicine refrigerators and found they were stored securely and were only accessible to authorised staff. Refrigerator temperatures were recorded on a daily basis and computerised records were also kept. There was a clear policy for ensuring medicines were kept at the required temperatures. This was being followed by the practice staff.

We looked at the medication available for use in the event of a medical emergency. We saw that these medications were stored appropriately and were easily accessible to staff when required. Processes were in place to check medicines were within their expiry date and suitable for use. All of the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff that generated prescriptions were trained and how changes to patients' repeat prescriptions were managed. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance and kept securely at all times.

We were told that systems were in place to ensure that prescribing was checked against effectiveness and costs. This ensures that prescribing costs remain low whilst effectiveness is not compromised.

Cleanliness & Infection Control

We observed the premises to be visibly clean and tidy. Patients we spoke with told us that they had no issues regarding cleanliness or infection control at the practice. We saw there were cleaning schedules in place which recorded the tasks to be completed. Cleaning records were also kept which had been completed to demonstrate cleaning undertaken. The practice manager monitored the cleanliness of the premises by means of a 'spot check'.

We looked at how infection prevention and control procedures were managed at the practice. The practice nurse confirmed that she was the lead for infection control and had recently undertaken training regarding infection control and hand hygiene. Infection prevention and control measures in place included the use of personal protective equipment (PPE), infection control audits, clearly labelled sharps bins and spillage kits.

Blood or bodily fluids such as vomit, urine and other body substances could generate spills. They need to be treated promptly to reduce the potential for spread of infection

with other patients, staff or visitors. We saw that spill kits were available in clinical areas and in the reception. Staff were aware where spill kits were stored and when they should be used.

We were told that all clinical staff were up to date with relevant immunisations and we saw records to confirm this.

We saw that personal protective equipment (PPE), including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how and when they would use these.

Infection control audits seen showed that improvement had been identified and acted upon. Support was being provided by the infection control and prevention nurse from the clinical commissioning group (CCG) regarding the newly implemented infection control audit system.

We discussed the arrangements for managing clinical waste. We were shown consignment notices which demonstrated that clinical waste was being removed from the premises by an appropriate contractor. We saw that clinical waste was stored in a locked room in a container. However, waste was hand tied and not labelled. The practice manager made enquiries to relevant companies about waste labels and gave us assurances that these would be available and in use as soon as possible.

We were told that the practice was not carrying out regular checks for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). These checks are important in order to reduce the risk of infection to staff and patients. The need to complete a legionella risk assessment was highlighted as an area for action in a recent health and safety audit undertaken.

Equipment

We saw evidence to demonstrate that equipment available at the practice was suitably maintained to keep people safe. Records were available to show that portable electrical appliances had been checked on an annual basis to ensure they remained safe to use. Stickers were displayed on equipment indicating the last testing date. Records were also available to demonstrate that annual calibration and maintenance had been undertaken on equipment as required. Where items failed this test we saw that new equipment had been purchased.

Staff told us that new equipment requests were made through the practice manager and we were told that staff had all of the equipment necessary to enable them to carry out diagnostic examinations, assessments and treatments.

We saw that equipment such as a defibrillator; oximeter and nebulisers were available for use in medical emergency situations. Records were available showing that equipment was regularly checked to ensure it was available for use and in good working order.

Staffing & Recruitment

At the time of our inspection there were no staff vacancies at the practice. Recruitment policies were available to assist with future recruitment of staff and the practice manager was aware of the appropriate recruitment checks that should be undertaken.

Records we looked at contained evidence that recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications and criminal records checks via the Disclosure and Barring Service (DBS). We saw that there was a low turnover of staff with the majority having worked at the practice for many years.

We discussed the systems in place for managing expected and unexpected staff absences. There was an arrangement in place for members of staff, including nursing and administrative staff to cover each other at times of sickness or annual leave. We were told that staffing levels were also increased during busy periods at the practice. Staff told us there were usually enough staff to maintain the smooth running of the practice and to ensure patients were kept safe.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. We saw a sample of risk assessments completed, such as health and safety, control of substances hazardous to health (COSHH) and fire risk assessments.

We saw that the practice had a detailed health and safety policy. Health and safety information was displayed for staff to see and there as an identified health and safety representative.

Good

Are services safe?

We saw that systems had been put in place to alert staff to high risk patients who repeatedly do not attend (DNA) their appointments. We were told about the reminder and recall systems in place. The computer system also enabled alerts to be put in place regarding vulnerable and housebound patients. Reception staff were aware when to fast track patients and offer immediate telephone consultations or appointments.

Alerts were also in place to identify patients with the same or similar names. This helped to ensure that correct information was available to the GP or for when prescribing medicines.

The systems in place to ensure that patients with complex medical problems were safeguarded were discussed. For example, those patients receiving anti-depressant medication or those at risk of overdose were not offered repeat prescriptions until their condition was stable. The local pharmacist was informed about these patients.

Arrangements to deal with emergencies and major incidents

A business continuity plan was in place to deal with a range of emergencies such as power failure, loss of telephone and computer systems and access to the building. Various issues that may impact on the daily operation of the practice were recorded along with details of the actions to be taken to reduce and manage the risk. This included using the Sheldon Medical Centre as a base if the Arran Medical Centre was not accessible and various contact details were included to enable staff to report issues.

Systems were in place to manage emergencies. This included staff training and emergency medication and equipment. Emergency medication and equipment was appropriately stored and signage was in place showing the location of the emergency equipment. We saw records to show that emergency medication was checked to ensure that it was available and within its expiry date. All medicines seen were in date and fit for use. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly.

We saw records showing all staff had received training in basic life support.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We discussed how relevant and current evidence-based guidance, standards, best practice and legislation were used to develop how care and treatment was delivered. The GP was aware of the need to stay updated regarding changes to guidelines. We were told how clinicians accessed and kept up to date with national guidelines.

Systems were in place to review the care needs of those patients with complex needs or those in vulnerable circumstances. Palliative care meetings took place on a monthly basis with a multidisciplinary team and the practice carried out annual health checks for people with mental health illness. We were told that if the patient was seen at a secondary care service regarding their mental health, the GP would only complete a physical examination and not enquire about the patient's mental health. We saw that care plans were in place for those patients with mental health needs.

Patients had their needs assessed and care planned in accordance with best practice. Action plans were put in place for all patients at a high risk of admission. These patients had direct telephone access to the practice manager in case of emergency.

We were told about the systems in place to avoid unplanned hospital admissions. Patients were either visited at their home or if they were able they visited the practice. Care plans were written and kept in a folder in the reception. The practice manager was in the process of recording this information on the practice's computer system.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in the decision-making process.

We spoke with the manager of a local nursing home which had patients registered with the practice. We were told that regular meetings were held and medication reviews were undertaken.

Management, monitoring and improving outcomes for people

The practice carried out reviews as part of the Quality and Outcomes Framework (QOF). The QOF is a national performance measurement tool which awards practices achievement points for managing some of the most common chronic diseases, for example asthma and diabetes. Overall the practice were meeting their performance targets for QOF. We were told about the systems in place for recalling patients for annual reviews of their long term health conditions.

The practice had a system in place for completing clinical audits. We saw five clinical audits that had been undertaken, for example we saw audits regarding the use of a specific medicine for diabetic patients, a minor surgery audit regarding infection and histology and a flu audit. We saw that were issues had been identified, action plans had been put in place and reflected learning was documented.

Multi-disciplinary meetings were held on a monthly basis to manage and monitor the care delivery, treatment and support of patients receiving palliative care. Community services involved in the care delivery of these patients attended these meetings.

We were told about various monitoring and screening systems in place to improve patient outcomes. Cognitive impairment screening was undertaken to identify those patients who may be suffering from dementia. A cognitive impairment test was used as part of this process. Falls risk assessments were also undertaken. This assessment tool covers the identification and management of the risk of falling for people aged 65 years of age and above.

Effective staffing

Systems in place for the recruitment and training of staff were robust. We saw the staff recruitment policy which had recently been implemented. Staff personnel files that we reviewed contained sufficient pre-employment information to demonstrate that robust processes had been followed.

Records showed that staff had attended training considered mandatory by the practice such as annual basic life support as well as other training courses. Staff told us that the lead GP was very proactive and good at suggesting training courses. We discussed the practice nurse's defined duties that they were expected to perform and saw training certificates which demonstrated that they were trained to fulfil these duties. We saw information which confirmed that the GP was up to date with their continuing professional development requirements. The lead GP had

Good

Are services effective?

(for example, treatment is effective)

been revalidated or had a date for revalidation. Revalidation is the process by which GPS are appraised annually and every five years undertake a fuller assessment. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practice and remain on the performers list with NHS England).

Administrative staff we spoke with also confirmed that they received regular training. We were told that the Clinical Commissioning Group (CCG) sent training information through to the practice and the practice manager arranged training on behalf of staff. Staff said that they could ask to attend other training courses if they had a particular need or interest.

Arran Medical Centre was a training practice and currently there were three GP registrars at the practice. A GP registrar is a qualified doctor who is training to become a GP through a period of working and training in a practice. They will usually have spent at least two years working in a hospital before they move to a general practice. Registrars are closely supervised by a senior GP or trainer. The GP registrars we spoke with said they had undertaken induction training at the practice and records seen confirmed this. They also told us that they felt supported and held regular weekly tutorials/meetings with the GP as part of their training and they were able to add information for discussion to the weekly agenda. Feedback from the registrars we spoke with was positive.

We were told that 'Map of Medicines' had been included on the computer system and this was very helpful. Map of medicines is a computer tool which encouraged joint decision-making between the patient and the GP through a care map which gives a clear visual representation of the options available for managing the patient's condition.

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Staff we spoke with said that they were able to speak out during appraisals and request training as needed.

Working with colleagues and other services

Systems were in place to help ensure that there was a multi-disciplinary collaborative approach to providing care and treatment. We saw minutes of multi-disciplinary meetings which took place on a monthly basis regarding those patients with end of life care needs. We were told that district nurses regularly visited the practice and spoke with the practice manager or GP as required.

Practice meetings were also held on a monthly basis and we were told and saw minutes of meetings which confirmed that district nurses and virtual ward staff had recently started to attend these meetings. A virtual ward is a method of providing support in the community to people with the most complex medical and social needs. Virtual wards use the systems and staffing of a hospital ward, but without the physical building: they provide preventative care for people in their own homes.

We saw that the practice effectively shared information with other services, for example the out of hours service. Systems were in place to ensure that special patient notes were sent to out of hours providers so that important information was shared. (Special patient notes is information recorded about patients with complex health and social care needs used to alert or highlight any specific care requirements, long term care plans or any other item of useful information for the patient).

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received both electronically and by post. The practice policy outlined the timescales and responsibilities for all staff in passing on, reading and taking action on any issues arising from communications with other care providers. The GP seeing these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

Information Sharing

We discussed the systems in place to share and record information. The practice had systems in place to provide staff with the information needed to offer effective care. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were trained on the system. Alerts were available within the system to ensure staff were aware of key information relevant to each patient. There was a shared system with the local out of hours provider to enable patient data to be shared in a secure and timely manner.

Good

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

We were shown evidence to demonstrate that the GP had recently undertaken deprivation of liberty, mental capacity and safeguarding training. Staff we spoke with were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. There was a named lead and staff were aware of who this was.

The practice had a policy regarding consent which had been reviewed annually. The staff we spoke with were aware of the importance of patients' consent to care and treatment. The practice nurse discussed systems in place to record consent including implied consent. We were told that the computer system generated the standard consent form available which must always be signed by the patient.

All minor surgical procedures and a patient's verbal consent were documented in the electronic patient notes. Systems were in place to ensure consent for any treatment was received.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. These care plans were reviewed annually or as needed. The GP demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

Health Promotion & Prevention

We were told how people were supported to live healthier lives, this included referring people to health trainers, giving advice during consultations and signposting people to other services available. Health trainers help people to develop healthier behaviour and lifestyles. They offer practical support to change people's behaviour to achieve their own choices and goals. A smoking cessation clinic was held at the practice and posters were displayed informing patients of this service. We saw that health promotion literature was available in the waiting area and the practice website also provided 'lifestyle advice'. This would help to encourage patients to take an interest in their health and to take action to improve and maintain it.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities and these patients were being offered an annual physical health check. We saw that information was recorded which alerted staff to the fact that the patient was due a health check. We were told that health checks were undertaken, care plans agreed and recorded and patients were signposted to other services as necessary. We saw information to demonstrate that a learning disabilities nurse had visited the practice and reviewed patient records to ensure that information was up to date. We saw that no issues were identified and annual health checks for patients with a learning disability were up to date.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance There was a clear policy for following up non-attenders and the practice nurse discussed the difficulty they encountered encouraging parents to attend childhood immunisation clinics with their children. We were told about the systems in place to remind people of the need to attend for vaccinations which included text messages and reminder letters. Details of the 'vaccination schedule' which guided patients to the frequency of vaccinations were available on the practice website.

The practice nurse was responsible for undertaking any relevant assessments of patients with long term conditions but there were no specific clinics held, such as diabetes, or asthma at the practice. The practice nurse told us that patients preferred not to be constrained by clinic times and were able to book a time which suited them.

The practice's performance for cervical smear uptake was 79.1% which is below the national average of 81.89%. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice completed an annual audit of patients who did not attend. There was a named nurse responsible for following-up patients who did not attend screening.

It was practice policy to offer all new patients registering with the practice a health check with the practice nurse. The GP was informed of all health concerns detected and these were followed-up in a timely manner.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We spent some time in the reception and waiting area observing the interactions between staff and patients. We spoke with staff and patients to find out about confidentiality, respect, and compassion. We saw that staff were careful to ensure confidentiality when discussing patients' treatments in order that confidential information was kept private. Patients told us that staff always maintained confidentiality. We were told that conversations of a more private nature would be held in a treatment room or at the side of the reception desk. We saw a notice on the reception desk requesting people waiting to book in to stand away from the desk so as to respect other people's privacy. We saw this system in operation during our inspection. We saw that staff were respectful when dealing with patients and those patients we spoke with confirmed this. We were told that staff treated patients with respect and courtesy. Patients said that they had a lot of trust in the staff and the service provided at the practice.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed so that conversations taking place in these rooms could not be overheard.

Patients completed Care Quality Commission (CQC) comment cards to provide us with feedback on the practice. We received five completed cards and they were all positive about the service. Patients we spoke with on the day of our inspection said that the GPs knew their medical history and confirmed that there was good communications between the GP and the patient. We were told that reception staff were kind and caring and the GPs always listened to what patients had to say. Patients said they were satisfied with the care provided by the practice.

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection told us the GPs always listened to what they had to say and discussed any health issues with them fully. We were told that the GP always explained what was wrong and why it had happened. Patient feedback on the comment cards we received was also positive and aligned with these views. The GP registrar and the secretary we spoke with told us about the 'Map of Medicines'. This computer based tool gave GPs access to locally customised referral forms and clinical information during a consultation. Information could be saved directly into the patient record. The Map of Medicines also gave GPs details of the information resources available for patients and their carers. Staff said that this system was extremely useful and easy to use.

Staff told us that translation services were available for patients who did not speak English as their first language. We saw that the practice website could be translated into 65 different languages.

We saw that the waiting area contained information posters and leaflets signposting people to the various local services available regarding some health related conditions. We saw staff on the day of our inspection giving information to a patient regarding an external service.

Patient/carer support to cope emotionally with care and treatment

Staff were aware of where to signpost people for additional support regarding bereavement. We saw that leaflets were available in the waiting area signposting patients to 'Cruse'. Cruse are a bereavement charity which provide free care and bereavement counselling. Staff told us that families who had suffered bereavement were sent a card signed by staff offering their condolences. A letter was also sent offering an appointment to see the GP if they required.

Staff also told us that any patients on their palliative care list were telephoned upon discharge from hospital. This enabled staff to offer support and to give contact details for any external organisations that would be able to provide support.

The practice website recorded the importance of registering as a carer for a patient. This information was then added to the notes of the person that they were caring for so that emergency contact links were easily accessible. We were told that support services could also be offered to carers who may need help with their caring duties. This could include referring to health trainers if required. A health trainer helps people to develop healthier behaviour

Good

Are services caring?

and lifestyles. They offer practical support to change behaviours to achieve patients' own choices and goals. We saw that the practice computer system alerted the GP if a patient was also a carer.

Patients we spoke with on the day of our inspection said that staff were compassionate and provided help and support when required. The comment cards received also confirmed this. Staff we spoke with had a caring attitude and showed empathy towards people suffering ill health.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had an active patient participation group (PPG). The practice manager told us that they were continually recruiting for new members. Information about the PPG was available on the practice website and posters had been put on display in the waiting area of the practice. PPGs are a group of patients who meet on a regular basis and are involved in decisions that may lead to changes to the services the practice provides.

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs. We discussed the practice development plan and were told that this was reviewed by the Clinical Commissioning Group (CCG) on an annual basis. A CCG is an NHS organisation set up to organise the delivery of NHS services in England. We saw that an action plan had been developed and lead roles identified to implement the action required.

The practice had a palliative care register and had monthly multidisciplinary meetings to discuss patient and their families care and support needs. Staff were aware of the number of people on the palliative care register. The practice's computer system had been updated with current information. Alert systems were in place so that staff would be made aware if a patient on the palliative care register telephoned in order that staff could prioritise their call. Staff said that they telephoned people on their palliative care register upon discharge from any hospital stay. We were told that staff enquired whether there were any additional services required and signposted patients to external support services if required.

The practice worked collaboratively with other agencies and regularly shared information (special patient notes) to ensure good, timely communication of changes in care and treatment.

A weekly 'surgery' was held for patients who resided at a local care home and visits were made on an as needed basis. We were told by the care home manager that the GP was usually quick to respond to requests and when issues were identified, the practice was responsive to feedback.

Home visits were available for those patients who were housebound or immobile and the practice website confirmed this. Longer appointments were available for people who needed them and those with long term conditions. This also included appointments with a named GP or nurse. This supported patients with the management and monitoring of long term conditions.

The practice website recorded the various services available at the practice; this included antenatal care provided by midwives, phlebotomy, minor surgery and family planning clinics. Appointments were available outside of school hours for children and young people and extended opening hours on a Tuesday helped to ensure that working age patients had access to the service.

Tackle inequity and promote equality

The practice was located in a single storey building with all services therefore being provided at ground floor level. This made movement around the practice easier and helped to maintain patients' independence. A disabled parking space was available in the car park. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms.

As part of the inspection process we reviewed the practice's website to see what information was available to patients. A translation service was available which enabled patients to translate the information into 65 different languages. An audible version of the information on the website was also available (in English). This helped those patients whose first language was not English and those with poor vision gain access to information.

The practice website stated that the practice could only accept new patients that lived in the practice area. However, following discussions with the GP we were told that travellers or homeless people would be able to register with the practice.

Access to the service

Comprehensive information was available to patients about appointments on the practice website. The practice website could be translated into 65 different languages and also provided a 'listen' service. This enabled those with poor vision to hear audio information from the practice website. The website reminded people that appointments could be booked online. Other information such as how to

Good

Are services responsive to people's needs?

(for example, to feedback?)

arrange urgent appointments, telephone consultations and home visits was also available. Staff we spoke with confirmed that patients were able to book appointments in person at the practice, over the telephone or online. We were told that text message reminders were sent to people for test results, and to those people who did not attend their appointment. Telephone consultations where completed if required. The practice website provided information about fitness to work notes to support people to return to work.

We were told about the arrangements in place to ensure patients received urgent medical assistance when the practice was closed; this information was also detailed on the practice website. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Reception staff told us about the system for booking appointments. We were told that patients could book an appointment up to two weeks in advance. Appointment slots were available each day to be filled by people who may need to see a GP in an emergency. If these appointments slots were all used up, we were told that the patient could speak with the GP over the telephone who would then either conduct a telephone consultation or arrange an appointment as necessary. We were told that children requiring an urgent appointment were always offered same-day appointments. Patients who we spoke with confirmed that they were able to see a GP on the day that they telephoned if it was an emergency.

This practice was open between the hours of 8am and 6.30pm, Monday to Friday. Appointment times differ slightly. Various systems were in place to aid working patients to access the service. This included extended opening hours on a Tuesday evening between 6.30pm – 7.30pm and patients being provided with telephone advice by the GP. Text messages were sent to remind people of their appointments and to give test results which fell within the "normal" range.

Listening and learning from concerns and complaints

We saw that information was available to help patients understand the complaints system. Staff told us that patients were able to complain verbally or could complete a complaints form. The practice website gave contact details and a link to the Parliamentary and Health Service Ombudsman's (PHSO) website. The PHSO has a role to investigate complaints where individuals feel that they have been treated unfairly or have received poor service from government departments and other public organisations including the NHS in England.

The practice complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person for handling complaints. Staff were aware of whom to forward complaints to within the practice. Staff were able to describe the complaints procedure and confirmed that this included a meeting with the practice manager and GP if required.

We looked at the complaints received during 2014. The practice manager had completed an analysis of the complaints received to try and identify any themes or trends. We were told that complaints were discussed at practice meetings. Minutes of these meetings showed that complaints were discussed. This helped to ensure that all staff were able to learn from complaints. Staff we spoke with confirmed this and said that they were encouraged to contribute ideas and suggestions for any improvement action that might be required.

Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

Are services well-led?

Good

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

Our findings

Vision and Strategy

We discussed the vision of the service with the practice manager. We were told that there was no formally documented vision statement or strategy for future working. However, the practice manager was able to discuss future changes with us but confirmed that this was not recorded although it had been discussed during practice meetings. Staff confirmed that they were kept up to date with potential changes. We were told that they discussed new ideas and new ways of working at these meetings and all staff were invited to contribute. We met with a member of the PPG during the inspection, they were also aware of planned changes to the practice. A PPG is a way for patients and GP practices to work together to improve services and to promote health and improved quality of care.

Staff we spoke with had a caring attitude and all discussed the need to provide high quality care. The practice website recorded a synopsis of the 'Patient Charter'; a full copy of this document could be requested from reception. The patient charter listed the rights and responsibilities of patients, such as the right to be treated courteously at all times.

Governance Arrangements

Information governance, (IG), is the set of multi-disciplinary structures, policies, procedures, processes and controls to manage information. Information governance supports the organisation's immediate and future regulatory, legal, risk, environmental and operational requirements.

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. Policies and procedures we looked at had been reviewed annually and were up to date. The practice manager confirmed that they were currently reviewing and updating all policies and procedures. Staff were informed when changes were made and were required to read the amended policy.

We saw evidence to demonstrate that there was a programme of internal audit, which was used to monitor quality. Systems were in place to identify where action should be taken. We were provided with audit information regarding complaints, infection prevention and control, significant events and prescribing.

The practice had achieved a 100% compliance rate for the information governance (IG) toolkit for 2012/13. The IG Toolkit is an online system which allows NHS organisations and partners to assess themselves against Department of Health Information Governance policies and standards. The toolkit had not as yet been completed for 2013/14.

Leadership, openness and transparency

We spoke with six members of staff and they were all clear about their own roles and responsibilities Staff were aware that there were lead roles and knew who to speak with if they needed any guidance or had concerns , for example, in areas such as infection control, safeguarding or complaints. Policies we saw recorded the name of the person with the lead role. Staff who undertook the lead role told us that they had received training and support in order to undertake this task.

The practice manager worked at both the Arran Medical Centre and at the Sheldon Medical Centre. Staff said that they had access to a duty rota so that they always knew how to contact the practice manager. Staff told us that they felt valued, well supported and knew who to go to in the practice with any concerns. We were told that the GPs and the practice manager were approachable and supportive and open to feedback from staff. Staff also said that they were able to raise issues at the monthly practice meetings. We saw the minutes of practice meetings which demonstrated that meetings were held on a monthly basis and that staff had the opportunity to comment or raise issues if they wished.

Staff told us that they felt supported and also supported each other as necessary. We were told that staff worked well as a team and also that they felt appreciated for the work that they did.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment, induction and disciplinary policy which were in place to support staff.

Practice seeks and acts on feedback from users, public and staff

Are services well-led?

Good

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

We discussed the methods used to obtain patients views and experiences regarding the service they received. We saw that there was a comments box in the patient waiting area. We were told that patients had made suggestions, for example a drinks machine in the waiting area. However, cost and time constraints meant that this request had not been met.

The practice had an active patient participation group (PPG) which currently had six members. We met with a member of the PPG on the day of inspection. We were told that the PPG met every three months at the practice and a member of staff acted as chair person, made notes and gave feedback to the practice manager and GPs. We were told that the practice provided good support to the PPG members.

The PPG member that we spoke with stated that they were not able to attend each meeting due to other commitments but felt that improvements could be made in how the practice responded to suggestions made by the PPG. Some examples of suggestions made were discussed. We also discussed these with the practice manager who was able to demonstrate that some of the changes had been made as a result of PPG comments. For example on-line appointment booking had been introduced to try and reduce pressure on phone lines when people telephoned the practice.

We saw the minutes of the last two PPG meetings. Members were able to attend the meeting or be a 'virtual member' giving their comments and feedback either over the telephone or via email. This helped to ensure that feedback was obtained and meetings were able to continue when PPG members were not physically able to attend the meeting.

The practice website gave information about the PPG and invited patients to become a member of the group if they wished to shape the nature of health services provided in their local community. A brief summary of the PPG meeting minutes were available on the practice website. Posters on display in the waiting area also encouraged people to become members of the PPG. The practice manager also discussed other methods which had been used to increase membership numbers which unfortunately had been unsuccessful.

Satisfaction surveys were undertaken on an annual basis, the analysis and action plan following the last satisfaction survey was reviewed. Previous satisfaction survey results were available on the practice website. The action plan recorded that further satisfaction surveys would be conducted to identify if changes made had been successful.

We were told that the practice manager and GP had an 'open door' policy meaning that staff could speak with them at any time. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff said that they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning & improvement

Arran Medical Centre was a GP training practice and there were three GP registrars working there at the time of our inspection (a GP Registrar is a qualified doctor who is training to become a GP through a period of working and training in a practice). The practice website confirmed that they had trainee doctors and took medical students from Warwick University.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training. Staff we spoke with told us that they all worked well as a team to address and resolve problems in the delivery of high quality care.

The practice had completed reviews of significant events and other incidents and shared these with staff via meetings to ensure the practice improved outcomes for patients.