The Laurie Pike Health 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.

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 Laurie Pike Health Centre on 5 March 2015. The overall rating for the practice is good. We found the practice to be good in the safe, effective, caring, responsive and well-led domains.

Our key findings were as follows:

- Systems were in place to ensure that all staff had access to relevant national patient safety alerts. Staff worked together as a team to ensure they provided safe, co-ordinated patient care.
- Infection prevention and control systems were well managed and staff had received appropriate training.
- Staff were friendly, caring and respected patient confidentiality. Patients we spoke with said that all staff were compassionate, listened to what they had to say and treated them with respect. We observed that staff at the reception desk maintained patient's confidentiality.
- There was a register of all vulnerable patients who were reviewed regularly. Patients we spoke with told us they were satisfied with the care they received and their medicines were regularly reviewed. GPs carried out clinical audits to check that patients received the correct medicines for their health needs.
- The practice had a clear vision to deliver high quality care and promote good outcomes for patients. This was evident when speaking with staff and patients during our inspection. There was a clear leadership structure with named staff in lead roles.
- Teams of specialist staff were shared with other practices within the Vitality Partnership. Each team consisted of GPs and nurse who had specialist knowledge in dermatology and rheumatoid arthritis. The teams held regular clinical sessions at the practice to assess and treat patients who had skin and long term joint conditions. These patients would otherwise have been referred to a hospital.

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. The practice had a good track record for safety. There was effective recording and analysis of significant events and lessons learnt were cascaded to all relevant staff for prevention of recurrences. There were robust safeguarding measures in place to help protect children and vulnerable adults. Reliable systems had been arranged for safe storage and use of medicines and vaccines within the practice. There were designated leads to oversee the hygiene standards within the practice to prevent infections.

Are services effective?

Good

The practice is rated as good for providing effective services. The practice took account of clinical guidelines such as National Institute for Health and Clinical Excellence (NICE) when providing care. Arrangements were in place to identify, review and monitor patients with long term conditions and those in high risk groups. Patients had access to a range of support to maintain a healthy lifestyle and improve their health. All staff had received core and mandatory training appropriate to their roles and further training needs had been identified and planned. Staff appraisals to support their roles and personal development plans were in place for staff. Multidisciplinary working was evidenced to ensure patients received integrated care.

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 care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that clinical staff treated patients with kindness and respect. Reception staff approached patients appropriately, in a helpful way and ensured confidentiality was maintained. There were arrangements in place to provide patients with end of life care that respected patients' needs and wishes.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice made use of information to understand and respond to the needs of their local population. They had consequently achieved Quality Outcomes Framework (QOF) points similar to or above the national average. QOF is a voluntary national performance target for managing some of the most common chronic diseases, for example asthma and diabetes. Senior practice staff engaged with the NHS

Summary of findings

Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified. There was an accessible complaints system with evidence demonstrating that the practice responded appropriately and in a timely way.

Are services well-led?

Good

The practice is rated as good for being well led. All staff worked closely together to innovate and promote continuous improvements. There was strong leadership with a clear vision and purpose. All staff were encouraged and involved with suggesting and implementing on-going improvements that benefitted patients. Governance structures were robust and there were systems in place to effectively manage risks. Staff had identified the need for change and made improvements that benefitted patient care and treatment. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. The practice offered proactive, personalised care to meet the needs of the older people in this population group. All patients over 75 years of age had an allocated named GP. This is an accountable GP to ensure these patients received co-ordinated care. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs. The wishes of patients requiring end of life care were met, this included care being provided in the patient's home by the GP and multi-disciplinary team. Telephone consultations were available so patients could call and speak with a GP if they did not wish to or were unable to attend the practice.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. The practice held registers for patients with long term conditions and offered structured reviews for these patients to check their health and medication needs were being met. Patients with long term conditions were reviewed by GPs and nurses to assess and monitor their health condition so that any changes could be made. For those with the most complex care needs, we saw the GPs worked with a range of health and care professionals to deliver a multidisciplinary package of care. Care plans were in place to help manage and provide integrated care. Patients were able to see a GP in an emergency if their health was deteriorating.

Families, children and young people

Good

The childhood vaccination programme was undertaken by the practice nurse. Regular searches of patient data were carried out and those who had not attended for immunisation were contacted and asked to make an appointment. Appointments were available outside of school hours and the premises were suitable for children and babies. We were provided with good examples of joint working with health visitors. Women were given advice and information about cervical screening programs. Midwives held ante natal clinics at another practice. Post natal clinics were held at the practice and staff had good links with health visitors.

Working age people (including those recently retired and students)

Good

The practice was rated as good for the care of working age people (including those recently retired and students). A number of clinics

and services to promote good health and wellbeing were available for all patients. Emergency appointments, telephone consultations and extended hours with a GP, nurse or health care assistant were available until 8pm each Wednesday. Extended clinical sessions were also offered at the other practices within the Vitality Partnership for other weekday evenings and Saturday mornings to enable patients who worked to attend. Telephone consultations could also be arranged and patients could order their repeat prescriptions on line. The practice was proactive in offering health advice on their website as well as a full range of health promotion and screening which reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients and had sign posted vulnerable patients to various support groups and third sector organisations. 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 had access to an interpreting service if English was not their first language so that they could have a consultation with the GP in a language they understood. Staff who worked at the practice spoke a range of languages and could assist some patients whose first language was not English.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Patients experiencing poor mental health had received an annual physical health check. GPs had the necessary skills and information to treat or refer patients with poor mental health. Practice staff worked in conjunction with the local mental health team and community psychiatric nurses to ensure patients had the support they needed. There were multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. There was advanced care planning for patients with dementia. An advanced nurse practitioner carried out home visits to patients with dementia who were not able to access the practice.

Summary of findings

What people who use the service say

We spoke with 14 patients during our inspection who varied in age. Some had been registered with the practice for many years. They informed us that staff were polite, helpful and knowledgeable about their needs. Patients told us they were given enough explanations so they understood about their health status and felt they were encouraged to make decisions about their care and treatment. They all gave us positive feedback about the standards of care they received.

Patients told us it was easy to obtain repeat prescriptions. We received mixed comments about the new appointments system, which had been in place for four months. This new process involved the GP phoning the patient back to discuss their health needs. If the GP felt that an appointment was necessary a same day appointment was offered. We received four negative comments about access for appointments. One patient told us they had waited seven minutes before the phone was answered, another patient's phone did not accept withheld numbers so the call back did not happen. Two patients told us they did not like the call back system.

We collected 31patient comment cards on the day of the inspection. Positive comments were made by 30 patients regarding the care they received, the helpfulness of staff and their ability to book an appointment. One patient commented that the care was good but they did not feel listened to or able to speak with a GP easily.

We looked at results of the national GP patient survey dated 2013. These are based upon national averages and the latest ones posted were:

- 67.3% of respondents would recommend the practice which was below average,
- 77.2% were satisfied with the opening times which was average,
- 71.58% felt it was easy to get through by telephone which was average,
- 67.9% had good or very good experience for making an appointment which was below average,
- 76.99% reported their overall experience was good or very good was above average.

The practice had a Patient Reference Group (PRG). They are a way for patients and practice staff to work together to improve services and promote quality care. We spoke with three members of the PRG including the chair person. They told us they were influential in encouraging the practice to review and improve patients' ability to make appointments. The appointments system had been changed in October 2014. However, all three PRG members told us they would like to have more involvement with the operations of the practice and its on-going improvements.

The Laurie Pike Health 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, and a practice manager who were specialist advisors. An expert by experience was part of the inspection team and had personal experience of using primary medical services.

Background to The Laurie Pike Health Centre

Laurie Pike Health Centre is based in the Sandwell and West Birmingham local Clinical Commissioning Group (CCG). The practice provides primary medical services to approximately 12000 patients in the local community of Aston. Practice staff told us there are a large number of African Caribbean and Southern Asian patients registered at the practice. There are high rates of unemployment and deprivation in the area.

There is one female and four male GP partners in this practice. This helped to ensure that patients could book an appointment with a female or male GP if they preferred. All partners have lead roles such as safeguarding and clinical governance. The practice is a training practice for doctors. There are also salaried GPs and registrars working at the practice. Registrars are doctors who are training to become a GP. Advanced nurse practitioners, practice nurses and health care assistants are employed and have lead roles. For example, infection control and dementia care. The practice manager is supported by a reception team leader, receptionists and administration staff who work varying hours.

The practice is a Primary Medical Service contract (PMS) with NHS England. A PMS contract ensures practices provide a set of services that are specified in the contract. Patients are registered with an individual GP.

Laurie Pike Health Centre is part of Vitality Partnership which has resulted in joined up services provided by 11 practices. This offers patients the ability to be seen at any of the practices within the group. Between them, extended services are provided each weekday evening and on Saturday mornings. Patient's medical records can be accessed at any practice within the group to ensure continuity.

Two teams of specialist staff are shared with other practices within Vitality Partnership. The teams consist of GPs and nurses who have specialist knowledge in dermatology and rheumatoid arthritis. The teams hold regular clinical sessions at the practice for patients who would normally be referred to a hospital consultant.

The practice offers a range of clinics and services including, asthma, child health and development, contraception, chronic obstructive pulmonary diseases (COPD) and minor surgery.

The practice opening times are from 8am until 6.30pm daily and until 8pm each Wednesday.

The practice has opted out of providing out-of-hours services to their own patients. This service was provided by an external out of hour's service contracted by the CCG.

Why we carried out this inspection

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

Detailed findings

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.

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?
- 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 our inspection, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 5 March 2015. During our inspection we spoke with a range of staff including five GPs, two advanced nurse practitioners, one practice nurse, health care assistant, practice manager, the reception team leader and three receptionists. We also spoke with 14 patients who used the service and observed, how patients were being cared for and staff interactions with them. We looked at personal care and treatment records of patients. Relevant documentation was also checked. Patients had completed 31 comment cards giving their opinion about the service they received. We spoke with three members of the Patient Reference Group (PRG) who told us their experience not only as a member of the PRG but also as a patient of the service. The PRG 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 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 how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. A member of clinical staff we spoke with gave an example of a recent significant event which had resulted in capturing some requests for repeat prescriptions These were patients who needed medicine reviews before further prescriptions could be issued.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents and ensuring that staff learnt from these incidents. Records were kept of significant events that had occurred during the last 12 months and these were made available to us. Administration staff we spoke with discussed the systems for logging incidents/significant events which involved recording information on an online report template. Two GPs discussed two significant events with us and the actions that had been taken to prevent further occurrences. One concerned a delay in re-commencing a medicine after a patient had been discharged from hospital. This indicated a breakdown in communications and changes were made to prevent this happening again.

Clinical staff spoken with confirmed that significant events, incidents and complaints were discussed at their regular monthly business/ clinical staff meeting and they were able to give some examples. The reception team leader confirmed that reception staff regularly attended the meetings on a rotational basis.

National patient safety alerts were disseminated by the practice manager to relevant staff to read and sign off. Safety alerts were discussed at business/clinical staff meetings to ensure all were aware of any relevant to the practice and where action needed to be taken. All staff spoken with knew where patient safety alerts were kept.

Reliable safety systems and processes including safeguarding

The practice had a lead GP and a deputy lead appointed for safeguarding vulnerable adults and children. This was to ensure that a GP was available at all times. All clinical staff had had been trained to the appropriate level in safeguarding to enable them to fulfil their roles. Practice training records made available to us showed that all nonclinical staff had received relevant role specific training on safeguarding. All staff we spoke with were aware who the leads were and who to speak with if they had concerns about patient safety. We saw that there were policies regarding the protection of vulnerable children and work had commenced on developing a policy regarding vulnerable adults.

Staff were aware of their responsibilities regarding information sharing and documentation of safeguarding concerns and were aware that they should contact the relevant agencies in or out of hours. Contact details of agencies were easily accessible to staff in clinical rooms and the reception area.

Community staff including health visitors were invited to attend the monthly business/clinical meetings so that patients who were considered to be at risk could be discussed. There was close co-operation with health visitors which helped to identify children at risk and keep them safe. An alert was included on the file of those who were at risk so that they could be easily identified.

We saw that a chaperone policy was in place. Chaperone duties were usually undertaken by nursing staff or health care assistants. A chaperone is a person who serves as a witness for both a patient and a medical practitioner as a safeguard for both parties during a medical examination or procedure. Non-clinical staff had received chaperone training so that they were aware of the role and responsibilities of a chaperone. The practice manager was in the process of caarying out risk assessments of those non-clinical staff who carried out chaperone duties. We saw chaperone notices were displayed in all clinical rooms and the waiting area of the practice. Some patients we spoke with were aware that they could have a chaperone if needed.

Medicines management

Patients were able to order repeat prescriptions on line, by fax, by email, in person or via their local pharmacy. Patients

we spoke with said they were happy with the system. There was a protocol for repeat prescribing which was in line with national guidance and was followed by practice staff. Patients who had repeat prescriptions received regular reviews to check they were still appropriate and necessary.

We found that vaccines were stored within the recommended safe temperature range in a lockable fridge. Temperature checks were taken and recorded each day. Medicines were kept within locked cupboards.

The practice had two 'grab bags' that GPs used when they made home visits to patients. The medicines in these bags were checked and recordings made every week. This ensured there were adequate stocks in place and that they were in date and safe for administration.

Cleanliness and infection control

We were told that an external cleaning company completed daily cleaning at the practice. We saw that cleaning records were kept. Details of the required frequency for cleaning areas of the practice and the responsibilities of cleaning staff was also recorded in cleaning schedules. We observed the premises to be visibly clean and tidy. Patients we spoke with and comment cards received confirmed that patients found the practice clean and had no concerns about cleanliness or infection control.

The responsibility for monitoring hygiene standards and infection control was shared between an advanced nurse practitioner (ANP) and a practice nurse. We discussed infection prevention and control with the ANP. They told us that all clinical rooms were audited every month and the recordings included where actions needed to be taken. We were told that the staff member who used the rooms were responsible for carrying out any required actions. For example, an action for the February 2015 audit included the need to remove overfull sharps boxes and to replenish the liquid hand washing soap. The ANP told us that if actions were repeated on three occasions the issues were discussed openly during the monthly business/clinical meetings.

We asked how the hygiene levels of non-clinical areas were checked. They told us they carried out spot checks and there was a cleaning staff communication book where requests could be recorded. The ANP told us that all staff were encouraged to make use of this facility if they saw areas where improvements could be made.

We saw that there were good supplies of protective personal equipment (PPE) available. Staff we spoke with confirmed that there were always adequate stocks of PPE.

All staff had attended training on infection control and the leads had attended specialist training to equip them with the skills needed for this role.

There was a register maintained for recording employee's Hepatitis B immune status. We found these were up to date.

A legionella risk assessment had been carried out. Legionella is a germ found in the environment which can contaminate water systems in buildings.

Equipment

The clinical staff we spoke with told us they had sufficient equipment to enable them to carry out their duties including, assessments and treatments. The practice manager told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and we saw documentary evidence of this. We saw evidence of calibration of relevant equipment; for example a blood pressure monitor.

Staffing and recruitment

There were systems in place to monitor and review staffing levels to ensure any shortages were addressed and did not impact on the delivery of the service. Staff, including nursing and administrative staff were able cover each other's annual leave and resources from the branch surgery could be utilised when necessary. GPs also provided cover for each other. We were told that locum GPs were not used.

We looked at three staff files, including the file of the most recent member of staff employed at the practice. There was evidence that appropriate pre-employment checks were completed prior to staff commencing their post. This included photographic identity, references and a Disclosure and Barring Service (DBS) check at an appropriate level for the role and responsibilities. The DBS check is a criminal records check that helps identify people who are unsuitable to work with children and vulnerable adults. Non-clinical staff had been risk assessed to ensure patient safety when this staff group spoke with patients.

Good

Are services safe?

We saw that relevant checks were completed to ensure clinical staff were up to date with their professional registration, for example nurses were registered with the Nursing and Midwifery Council (NMC). The NMC was set up to protect the public by ensuring that nurses and midwives provide high standards of care to their patients and clients. The practice also kept a record to demonstrate that GPs were registered on the performers list. Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by the General Medical Council (GMC) can the GP continue to practice and remain on the performers list with NHS England.

Monitoring safety and responding to risk

Staff had received regular fire safety training and participated in regular fire drills to maintain their knowledge of how to respond in an emergency.

We saw that fire escape routes were kept clear to ensure safe exit for patients in the event of an emergency.

There was a health and safety policy in place and staff knew where to access it. A fire safety risk assessment was in place and had been reviewed annually to ensure it was still relevant.

Arrangements to deal with emergencies and major incidents

Staff at the practice had received training in medical emergencies such as basic life support. The practice had a defibrillator and oxygen on standby for dealing with medical emergencies. These were checked regularly to ensure they were fit for purpose.

Emergency medicines and equipment were kept in clinical rooms and staff knew where they were stored. We saw information that confirmed they were regularly checked and that the medicines remained in date and fit for administration.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks were identified and actions recorded to reduce and manage the risk. Risks identified included power failure, computer failure, and access to the building. Areas of responsibility for staff were identified along with risks and actions recorded to reduce the risk. The document also contained relevant contact details for staff to refer to.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinical staff told us they were accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

Patients with long term conditions were reviewed by the GPs and the practice nurses to assess and monitor their health condition so that any changes could be made. Each GP took a lead role for some conditions. For example, dermatology and gynaecology. Advanced nurse practitioners (ANP) and practice nurses led in asthma, smoking cessation, chronic obstructive pulmonary disorders (COPD) and childhood immunisations. One ANP carried out home visits to patients who had dementia and were not able to access the practice.

We were told that the computer system included 'flags' to alert staff if a patient was also a carer of a patient and for those patients on the practice's palliative care register. This information was be useful to ensure that staff were able to provide the level of support required and signpost patients to appropriate services if required.

We were told about the systems in place to avoid unplanned hospital admissions. We were shown recordings that had been made whereby all patients who had been admitted to hospital had been reviewed and where possible processes put in place to avoid further admissions.

The practice referred patients appropriately to secondary and other community care services such as community nurses. The practice used the Choose and Book system for making the majority of patient referrals. The Choose and Book system enabled patients to choose which hospital they would prefer to be seen at.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs and nursing staff 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 this decision-making.

Management, monitoring and improving outcomes for people

Clinical staff actively participated in recognised clinical quality and effectiveness schemes such as the national Quality Outcomes Framework (QOF) and the local Clinical Commissioning Group (CCG) enhanced service schemes. QOF is a national performance measurement tool. We were shown the latest QOF achievements that told us practice staff were meeting or above average for all of the national standards. For example, 96% for palliative care and a 95% achievement for contraception.

There was a system in place for carrying out clinical audits. One audit concerned antibiotics prescribed for patients who had urinary tract infections. The outcome of the audit carried out from February to April 2014 highlighted that some patients had not received therapeutic antibiotics. Actions were taken and the audit was repeated January to February 2015. The outcome was that improvements had been made in that more patients had received appropriate treatment. We saw that other audits carried out included a full cycle to ensure that improved practices were put in place.

GPs were supported by a pharmacist who attended the monthly business/clinical meetings. The pharmacist provided advice about medicines that GPs prescribed for patients.

Weekly clinical meetings were held by GPs. Standards of care were discussed and whether any changes could be made to improve outcomes for patients.

There were arrangements in place to ensure women received cervical screening by one of the GP partners and the practice nurse. Samples were sent to a local NHS hospital to be analysed and reported on in line with national guidance and recall systems

GPs in the practice undertook minor surgical procedures in line with their registration and NICE guidance. The staff were appropriately trained and kept their skills up to date.

Effective staffing

Practice staff included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff had attended training courses that were relevant to their roles. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses.

GPs had completed their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller

assessment called revalidation. 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).

All staff had annual appraisals that identified any learning needs from which action plans were documented. We saw that the advanced nurse practitioners, practice nurses' and health care assistant's appraisals were carried out by clinical staff. This was so that that their practices could be discussed and appropriately checked.

Working with colleagues and other services

Discussions with staff and records showed that the practice worked in partnership with other health and social care providers such as social services, end of life care teams and district nursing services to meet patients' needs.

There were systems in place to ensure that the results of tests and investigations from out of hours services and hospitals were reviewed and actioned that patients had attended.

The practice had opted out of providing OOH hours services. This had been contracted by the CCG to an external service provider. The practice forwarded appropriate information of patients that were on end of life (EOL) care so that the OOH service would be aware of any management needs while the practice was closed. The practice received an electronic summary for patients who had accessed the OOH service. These patients were reviewed and followed up where necessary by the GPs at the practice.

Patients were invited to contact the practice to receive their test results. However, if a test result was abnormal, patients would be contacted and informed by the GP either face to face or by telephone consultation.

Information sharing

We saw evidence that the practice held multi-disciplinary meetings to discuss the needs of complex patients for example those with end of life care needs to ensure important information was shared. We saw joint working arrangements were also in place with the palliative care team.

The GP's we spoke with told us they had good working relationships with community services, such as district nurses. There was good evidence of joint working relationships and their ability to make contact with each other at short notice when a patient's condition changed to enable provision of appropriate care.

There was a system in place to ensure the out of hours service had access to up to date treatment plans of patients who were receiving specialist support or palliative care.

Consent to care and treatment

The patients we spoke with told us they had been involved with decisions about their care and treatments. They told us they had been provided with sufficient information to make choices and were able to ask questions when they were unsure.

Patients who had minor surgery had the procedure explained to them and the potential complications before they were asked to sign a consent form to confirm this.

Clinicians were aware of the requirements within the Mental Capacity Act 2005. This was used for adults who lacked ability to make informed decisions. Staff gave examples of how a patient's best interests were taken into account when a patient did not have capacity to make decisions about their treatment.

GPs knew how to assess the competency of children and young people about their capability to make decisions about their own treatments. They understood the key parts of legislation of the Childrens and Families Act 2014 and were able to describe how they implemented it in their practice. GPs demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 years of age who have the legal capacity to consent to medical examination and treatment).

Health promotion and prevention

The practice manager told us all new patients were offered a health check. New patients were asked to attend the practice to undergo a health check and a review any illnesses they had and medicines they received.

Patients who were due for health reviews were sent a reminder letter and if they failed to attend a further reminder letters would be sent to them. Patients were asked about their social factors, such as occupation and lifestyles. These ensured GPs were aware of the wider context of their health needs.

Good

Are services effective?

(for example, treatment is effective)

Patients were encouraged to take an interest in their health and to take action to improve and maintain it. We saw some health and welfare information displayed in the waiting area.

Annual health checks were offered to all patients who were aged 65 years or more.

Patients were encouraged to take an interest in their health and to take action to improve and maintain it. We saw some health and welfare information displayed in the waiting area. For example, breast screening, shingles vaccinations for patients aged 70 years and safe alcohol consumption.

A range of tests were offered by practice staff including spirometry (breathing test) blood pressure monitoring and cervical smears to regularly monitor patient's health status.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We saw that staff treated patients with kindness and respect ensuring their confidentiality was maintained. Reception staff told us that a consultation room was always available if a patient requested private discussions. Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room and that patients' privacy and dignity was maintained during examinations, investigations and treatments.

There was a privacy and dignity policy in place and all staff had access to this. We saw that all clinical rooms had window blinds and privacy screening. Clinical staff told us the consulting room door was kept closed when patients were being seen. We observed staff knocking on doors and waiting to be called into the room before entering. We saw that clinical room doors were closed during consultations and that conversations taking place in those rooms could not be easily overheard.

We spoke with 14 patients on the day of our inspection. We received 31completed cards where patients shared their views and experiences of the service. Our discussions with patients on the day and feedback from comment cards told us patients felt that staff were caring and their privacy and dignity was respected.

Care planning and involvement in decisions about care and treatment

We found that patient care was an absolute priority and was embraced by the whole practice team. Providing the GP was holding clinical sessions on the day, patients were able to choose and request to be seen by a particular GP. There was a list on display of which GPs were working on the day in the waiting area and on the practice website. This provided continuity of care and patients told us they liked the service. If it was an urgent appointment the patient may be seen by a different GP.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Patient/carer support to cope emotionally with care and treatment

The respective GP contacted bereaved families and offered a range of services they felt to be appropriate for the family to access. There were also bereavement counselling services available and GPs could make referrals to them.

We saw information was on display in the waiting area for patients to pick up and take away with them. They informed patients of various support groups and how to contact them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice delivered core services to meet the needs of the main patient population they treated. For example, screening services were in place to detect and monitor the symptoms of long term conditions such as asthma and hypertension. There were nurse led services such as diabetes which aimed to review patients with long term conditions. There were immunisation clinics for babies and children and women were offered cervical screening. Patients over the age of 75 years had been informed of an accountable GP who ensured their care was co-ordinated.

The practice had a mental health register and records of patients who had had annual health checks. There was a palliative care register and monthly multidisciplinary meetings were held to discuss patient and their families care and support needs. We were informed by an advanced nurse practitioner about a patient they had recently seen who they were concerned about. The duty GP was informed who responded immediately by carrying out a risk assessment of the patient to check their levels of safety.

Some patients who had learning disabilities had annual health checks but there was no formal systematic approach to ensuring all of these patients received annual health checks. The senior GP acknowledged that arrangements needed to be put in place.

Staff carried out regular diary checks of patients who had long term conditions and sent them a letter to remind them their review was due. Those who did not attend (DNA) were sent another reminder letter. Patients were sent text messages to remind them to attend for the appointment they had made.

There was a mixture of male and female GPs available at the practice which gave patients the option of receiving gender specific care and treatment.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' and buying health and care services. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. For example, clinical staff maintained regular liaison with a pharmacist to ensure patients received appropriately prescribed medicines.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Reference Group (PRG). Such as installation of a new telephone system to improve patient access.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services and had made arrangements for meeting their needs.

Staff told us that translation services were available for patients who did not have English as a first language. This service could be arranged to take place either by telephone or in person. Between them practice staff were able to speak a range of languages to assist patients. The languages were Arabic, Moru, Punjabi, Hindi, Urdu and Bengali.

Various systems were in place to aid working patients to access the service. This included extended opening hours and telephone triage.

The practice had an equality and diversity policy and staff were aware of it. Patients we spoke with did not express any concerns about their rights about how they were treated by staff.

Access to the service

From October 2014 the appointments system had changed in that patients were no longer able to book appointments with GPs in advance. When a patient requested an appointment they received a call back from a GP who asked questions to ascertain if the appointment was needed. Those who needed to be seen were offered a same day appointment. We received some mixed patient comments about this service. Some patients said they preferred not to have to wait for a call back. The new system had resulted in a much reduced number of patients who did not attend (DNA) for their appointments.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice had extended opening hours on Wednesday evenings until 8pm. Patients were able to access other practices within the Vitality Partnership on weekday evenings and on Saturday mornings.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. The out of hours service was provided by an external service contracted by the CCG. Details of the out of hours provider was available on the practice phone and in the patient leaflet.

Patients were able to book and order repeat prescriptions online from their own homes. This was useful for working age patients as well as those who had difficulty with their mobility.

The premises were accessible by patients who had restricted mobility. There was a toilet suitable for people who were disabled. The corridors and doorways to consulting rooms were wide enough to accommodate wheelchairs. All consulting rooms were located on the ground floor.

Listening and learning from 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.

There was a dedicated practice leaflet that informed patients of how to make a complaint and what they could expect. It included the contact details of NHS England and the local ombudsman if the complainant was not satisfied with the outcome of the investigation.

We saw that the practice had received 10 complaints during the previous 12 months. They had dealt with them appropriately and written responses had been sent to complainants. Lessons learned had been documented to prevent recurrences. For example reception staff had been reminded of the 'importance of customer care'.

There was a system in place for regular reviews of complaints received by the practice. We saw that individual complaints were discussed at clinical staff meetings and later analysed by the practice manager to check if there were any trends so that systems could be put in place to prevent them. The records indicated that no trends had been identified.

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

The practice had a clear vision to deliver high quality care and promote good outcomes for patients and this information was available on the practice website. We saw that the practice charter included five statements regarding patient care, treating patients with respect and staff training.

We spoke with 14 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. They told us they felt an integral part of the team and were actively encouraged to make suggestions for making further improvements. The practice manager told us they would continue striving to improve the service.

Governance arrangements

There was a clear governance structure at the practice that provided assurance to patients and the Clinical Commissioning Group (CCG) that the service was operating safely and effectively. CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' and buying health and care services. There were clearly defined lead roles for areas such as safeguarding and regularly checking that the clinical sessions met patient's needs. Responsibilities were equally shared between all respective staff to ensure a fair workload was in place.

The practice held strategy meetings for staff to attend to discuss the practice operations and where improvements could be made.

We saw that regular practice meetings were held that enabled decisions to be made about issues affecting the general business of the practice. All staff were encouraged to attend these meetings. Records were made of the meetings and any actions that arose from these meetings were clearly set out and reviewed to ensure required changes were made. Staff told us they could make suggestions for improvements and that they were treated as equals by senior staff.

Leadership, openness and transparency

We saw evidence of staff appraisals that were regularly undertaken. Staff members we spoke with told us that they aimed to provide a caring service but were not aware of any visions and values of the practice.

Staff members we spoke with felt supported in their roles and were able to speak with the practice manager if they had any concerns. They told us that opportunities for progression were discussed and actioned where appropriate. Staff members we spoke with described the culture of the organisation as supportive and open.

Practice seeks and acts on feedback from its patients, the public and staff

We found there were strong, positive relationships between practice staff and the Patient Reference Group (PRG). We looked at the minutes from the latest PRG meeting; we were told by the senior GP these were these were held every three months. The minutes dated October 2014 informed us there was a good informing process from senior practice staff to keep everyone updated. They also included progress against any areas where improvements had been made such as, the appointments system.

During our inspection we spoke with three members of the PRG. They told us that the meetings were led by senior practice staff and were not being held quarterly; as they should have. They told us they would like to be invited to suggest agenda items prior to the meetings. They told us they were influential in encouraging the practice to review and improve patient's ability to make appointments. However, all three PRG members told us they would like to have more involvement with the operations of the practice and its on-going improvements. They felt they could make a bigger contribution.

Staff we spoke with told us they felt well supported and were able to express their views about the practice. They said they were encouraged to make suggestions for improvements and these were taken seriously by senior staff.

Management lead through learning and improvement

Staff told us that senior staff supported them to maintain their clinical professional development through training and mentoring. We looked at some staff files and saw that

Are services well-led?

Good

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

regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.

GP's held regular meetings to discuss each patient who had been admitted to hospital to monitor their progress and to determine if there were any lessons to be learnt.

The practice had completed reviews of significant events and other incidents and shared them with staff through meetings to ensure the practice improved outcomes for patients. There had been 13 recorded during the previous 12 months. For example, an incorrect vaccine had been administered to a patient. This was raised with the team leader and systems put in place to double check vaccines prior to administration.