Dr PV Gudi and Partner

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.

Contents

Summary of this inspection

Page

Overall summary 2
The five questions we ask and what we found 3
The six population groups and what we found 4
What people who use the service say 5
Areas for improvement 5

Detailed findings from this inspection

Our inspection team 6
Background to Dr PV Gudi and Partner 6
Why we carried out this inspection 6
How we carried out this inspection 6
Detailed findings 8

Summary of findings

Overall summary

Dr Gudi and Partner offer a range of primary medical services from the Hill Top Surgery at 68 Hill Top, West Bromwich.

We found that the practice provided a safe, effective, caring, responsive and well led service. We found that there was a heavy reliance on the experience and expertise of the practice manager but that there were no contingency plans in place should the manager be away unexpectedly for any length of time.

Patients we spoke with were generally happy with the service they received at the practice, although some patients told us that it was difficult to get a routine appointment at short notice.

In advance of our inspection we talked to the local clinical commissioning group (CCG) and the NHS local area team about the practice. Neither of these organisations had any significant concerns about it.

We also examined patient care across the following population groups: Older people; those with long term medical conditions; mothers, babies, children and young people; working age people and those recently retired; people in vulnerable circumstances who may have poor access to primary care; and people experiencing poor mental health. We found that care was tailored appropriately to the individual circumstances and needs of patients in these groups.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The services at Hill Top Surgery were safe. The practice had a good track record on safety. There was effective recording and analysis of significant events to ensure that lessons learnt were always shared among relevant staff. There were robust safeguarding measures in place to help protect children and vulnerable adults. There were reliable systems in place to manage medicines in the practice effectively.

Are services effective?

The services at Hill Top Surgery were effective. There were systems in place to ensure that treatment was delivered in line with best practice standards and guidelines. The practice had carried out a number of audits of its activities but had not yet fully completed any clinical audit cycles. There was evidence of multi-disciplinary working and the practice was taking part in an initiative to reduce unplanned hospital admissions among its patients. There was a reliance on using locum doctors to provide sufficient appointments to meet patient demand.

Are services caring?

The service at Hill Top Surgery was caring. All the patients we spoke with during our inspection were very complimentary about the service. All the patients who completed a comment card in the weeks before our inspection were entirely positive about the care they received. We saw staff interacting with patients in a caring and respectful way.

Are services responsive to people's needs?

The service was responsive to people's needs although we did not see evidence of pro-active efforts to reach out to all population groups. Patients told us that the appointment system at the practice did not always work well and that they could not see the doctor for a routine appointment without some delay. There was an open culture within the organisation and a clear complaints policy.

Are services well-led?

The service was well led. There was a strong leadership with a clear vision and purpose, although not all staff were aware of the practice's stated mission. Governance structures were robust and there were systems in place to manage risks.

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
Care was tailored to individual needs and circumstances. There were regular 'patient care reviews' involving patients, and their carers where appropriate. Unplanned hospital admissions and readmissions for this group were regularly reviewed and improvements made. Older patients had a named GP responsible for their care.

People with long-term conditions
The practice supported patients and carers to receive coordinated, multi-disciplinary care whilst retaining oversight of their care. The practice specifically reviewed unplanned hospital admissions for this group so that lessons could be learnt. The practice ran regular clinics for patients with a range of long term conditions. It had particularly targeted the high proportion of diabetic patients in its population group.

Mothers, babies, children and young people
The practice worked with local health visitors to offer a full health surveillance programme for children under five. Checks were also made to ensure the maximum uptake of childhood immunisations. There was a nurse led baby clinic every week.

The working-age population and those recently retired
The practice offered extended opening times two days a week to provide easier access for patients who were at work during the day. Patients were offered a choice when referred to other services.

People in vulnerable circumstances who may have poor access to primary care
The practice had identified patients with learning disabilities and treated them appropriately. There were no barriers to patients accessing services at the practice. Patients were encouraged to participate in health promotion activities, such as breast screening, cancer testing, and smoking cessation.

People experiencing poor mental health
Care was tailored to patients' individual needs and circumstances, including their physical health needs. Annual health checks were offered to people with serious mental illnesses. Doctors had the necessary skills and information to treat or refer patients with poor mental health.

Summary of findings

What people who use the service say

We spoke with five patients during our inspection. They varied in age and they had been registered with the practice for between four and 23 years. They described the staff as respectful, nice, and helpful. Patients also told us that they were involved in decisions about their care and treatment, and that they were treated with dignity and respect.

We collected six Care Quality Commission comment cards from a box left in the surgery in the week before our visit. Most of the comments on the cards were very positive. Two patients commented that it could sometimes be difficult to get an appointment. In the most recent national GP patient survey, 60% of the practice's patients who responded said they would recommend the practice to a friend. This is below the regional average of 69%.

The practice used an independent company to conduct an annual survey of its patients. The most recent survey showed that the practice was close to or above the national benchmark in 18 out of 25 key indicators. The most common concern expressed by patients was difficulty in obtaining appointments.

Areas for improvement

Action the service SHOULD take to improve

There should be contingency plans to deal with the possibility of the practice manager being unexpectedly absent for a prolonged period.

The process for sharing information about patients with the out of hours service should be improved.

There should be better security for medicines stored in the nurse's room.

There should be more formalised checks on the contents of the medicine bags used during home visits.

Dr PV Gudi and Partner

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector and a GP. The team included a second CQC inspector and a practice manager.

Background to Dr PV Gudi and Partner

Dr PV Gudi and Partner provide a range of primary medical services to just over 4,000 patients from purpose built premises known as Hill Top Surgery. The surgery is situated at 68 Hill Top, West Bromwich.

There are two GP partners at the practice. The practice uses locum doctors to fill a long term vacancy for a third GP. There is a practice nurse and a health care assistant based at the surgery. There are a total of 17 GP sessions each week and nine sessions held by the practice nurse.

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

The inspection team carried out an inspection of Dr PV Gudi and Partner at Hill Top Surgery. This was an announced inspection on 13 August 2014. We spoke with five patients and six staff. After our visit, we spoke with a member of the patient participation group (PPG) over the telephone. The purpose of a PPG is to act as an advocate on behalf of patients when they wished to raise issues and to comment on the overall quality of the service at the practice.

We observed how staff dealt with patients in person and over the telephone. We discussed anonymised patient care plans. We spoke with and interviewed a range of staff including the GP, the practice manager, the practice nurse, reception and administrative staff. We also reviewed comment cards where patients shared their views and experiences of the service. These had been provided by the Care Quality Commission (CQC) before our inspection took place. In advance of our inspection we talked to the local clinical commissioning group (CCG) and the NHS England local area team about the practice.

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

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

We also 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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care

Detailed findings

- People experiencing poor mental health

Are services safe?

Our findings

Safe Track Record

The practice was able to demonstrate that it had a good track record on safety. We saw records to show that performance had been consistent over time and where concerns had arisen they had been addressed in a timely way. The manager showed us that there were effective arrangements in line with national and statutory guidance for reporting safety incidents. We saw that the practice kept separate records of clinical and non-clinical incidents and the manager took all incidents into account when assessing the overall safety record.

There were clear accountabilities for incident reporting, and staff were able to describe their role in the reporting process and were encouraged to report incidents. We saw how the practice manager recorded incidents and ensured that they were investigated. The partners held an annual meeting to review the practice's safety record over the previous year.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. Staff initially recorded incidents as soon as they occurred using a significant event form. The practice manager then formally recorded the incident in the incident log book and entered the details of the incident onto the practice computer system.

We saw evidence that learning from incidents was shared with staff in a timely and appropriate manner in order to reduce the risk of the incident occurring again. The practice also notified the local Clinical Commissioning Group (CCG) of individual events. The CCG is the NHS body responsible for commissioning local NHS services.

There was a named clinician at the practice with responsibility for receiving official alerts about medical devices and medicines. We saw that there was a robust procedure in place to ensure that this information was shared appropriately within the practice.

Reliable safety systems and processes including safeguarding

The provider had policies and systems in place to ensure that patients were safeguarded against the risk of abuse. There was a named GP lead for safeguarding and we saw that all staff had received training appropriate to their role. Effective safeguarding policies and procedures were in place and were fully understood and consistently implemented by staff. We saw that information about the local authority's safeguarding process was readily available to staff. There was close cooperation with the local health visitors which helped to identify children at risk and keep them safe.

There was a written chaperone policy available for all staff. There was a poster on the waiting room wall that explained to patients when a chaperone could be appropriate. The practice nurse showed us the procedure for recording when one was used. The checklist provided audit information and confirmed that patients had been offered the service. Only the nurse and HCA were used as chaperones. The practice nurse was fully aware of the role of the chaperone. We were told that receptionists and admin staff were not trained and were not used in the role. Two patients told us that they had a chaperone in the room when they received personal treatment.

Monitoring Safety & Responding to Risk

The practice had a single practice nurse and a single health care assistant. We were told that it was practice policy that the healthcare assistant and nurse did not have annual leave at the same time. If for any reason both members of staff were unexpectedly off at the same time, one of the doctors undertook some of the work such as immunisations. Other work, such as dressings, would be undertaken by the district nurses. As a last resort, patients would have their appointments cancelled if a doctor felt that this did not pose an unacceptable risk.

The practice had chosen not to have a defibrillator. The practice manager told us that all staff had received training around basic life support and anaphylactic shock and we saw records to confirm this. This training was refreshed for all staff annually.

An oxygen cylinder was available in the nurse's treatment room. The nurse told us that this was easily transportable. Labels and dates on the cylinder showed that it had been serviced and checked by an external company.

Medicines Management

We saw that some medicines were stored in an unlocked cupboard. We were told that the room in which the medicines were kept was always locked whenever it was not occupied. However, during the inspection we saw that

Are services safe?

this was not always the case, although only for a short period. In our discussions with the nurse and practice manager it was determined that it was best practice for medicines to be kept in a locked cupboard.

Medicines stored included adrenaline, water for injections, and antibiotics. The medicines were kept to replenish emergency medicines only. We saw records that confirmed that these were checked by the nurse or health care assistant. The expiry dates were recorded so that staff knew when they were due to expire and needed to be replaced. Controlled drugs were not stored at this practice.

Emergency boxes had been made up and were kept in each of the clinical rooms. Emergency items in the boxes included medicines and airways (adult and paediatric sizes). We saw information that showed that the boxes were regularly checked by the nurse or health care assistant.

The doctors and nurse carried a 'Visit' bag containing medicines and equipment when making visits to patients' homes. The nurse told us that anything used was usually replaced on return to the practice. There was no formal process for checking the bags and evidence to confirm that the bags were checked was not available. Following discussions with the nurse we were confident that she would introduce a formal system for this. We saw a list that showed what should be in the bags.

Cleanliness & Infection Control

We saw that the practice was clean. Patients we spoke with said they were satisfied with standards of hygiene at the practice. There were systems in place to reduce the risk and spread of infection. We observed and staff told us that personal protective equipment was readily available and was in date. Patients confirmed that staff wore personal protective equipment when needed. Hand sanitation gel was available for staff and patients throughout the practice. We saw staff used this. There were hand washing posters above each wash hand basin throughout the practice including in the patients' toilet.

We spoke with the practice cleaner. The cleaner had a very clear understanding of when and how every part of the building needed cleaning. We saw that cleaning materials were safely stored. There were infection control policies in place and all staff understood the importance of ensuring that the policies were always followed.

The practice only used disposable instruments during minor surgical procedures. We saw how the used instruments and other clinical waste were safely disposed of.

Staffing & Recruitment

The practice based its staffing requirements on its experience of how the practice had operated over the years. Consideration had been given to the treatments and care that patients required. A practice nurse was employed for 36 hours per week. A health care assistant (HCA) was employed to support the nurse. Over the past five years the HCA had received further training to ensure their competence to undertake identified tests and treatments within the scope of their role.

Staffing was monitored and reviewed as required although the practice manager told us that they did not use a formal system for this. We were told by the practice manager, and staff confirmed that administrative and receptionist staff were aware of each other's roles and so were able to stand in for each other in times of absence or busy periods

The practice was reliant on locum GPs to fill a long standing vacancy. The locums were supplied by an agency and it was clear that a large number of different locum doctors had worked at the practice, sometimes for only a very short period.

Dealing with Emergencies

The practice had a written business continuity plan in place. The document detailed the responsibilities of the two partners and the practice manager in the event of the plan needing to be implemented. All three had a copy of the plan in their homes. We saw that the plan was reviewed and updated every six months and when suppliers, contact numbers, doctors or staff changed.

The plan covered eventualities such as the loss of computer system/essential data, incapacity of doctors or staff and loss of essential utilities. The plan was clear and told staff what to do in an emergency. Staff were aware of the plan and had access to a paper and online copy. Staff we spoke with were clear about what action they should take in the event of an emergency.

We found that two of the five patients we spoke with knew where the assembly point was, should the fire alarm go off.

Are services safe?

Three patients were unable to fully understand the question due to language barriers. Emergency instructions were displayed for staff and patients, although these were only available in English.

Equipment

There were policies in place for the safe use and maintenance of equipment. We saw that portable appliance testing had been regularly carried out on electrical equipment throughout the surgery.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

The practice actively participated in recognised clinical quality and effectiveness schemes such as the national Quality and Outcomes Framework (QOF) and local CCG led enhanced service schemes. These schemes have a financial incentive to help improve the quality of clinical care in general practice.

A doctor showed us how they used the National Institute for Health and Care Excellence (NICE) templates to help diagnosis and treat illnesses. The practice used NICE guidance to ensure the care they provided was based on latest evidence and was of the best possible quality. Patients received up to date tests and treatments for their disorders. We saw that any revised NICE guidelines were identified and shared with all clinicians appropriately.

The clinicians we spoke with confidently described the processes to ensure that written informed consent was obtained from patients whenever necessary. We saw evidence that patients who had minor surgery at the practice had been properly informed of the risks and benefits of the procedure. We were told that verbal consent was recorded in patient notes where appropriate. Clinicians were aware of the requirements of the Mental Capacity Act (2005) used for adults who lacked capacity to make specific decisions. They also knew how to assess the competency of children and young people to make decisions about their own treatment.

We saw that the practice was suitably equipped with the necessary equipment to help clinicians investigate and diagnose the typical range of conditions patients might present with. The equipment was in good order and there was evidence that it had been regularly recalibrated if necessary.

The doctors had access to an online prescribing decision support system. The system ensured that the doctors were prescribing in line with national and local guidelines and that their prescribing decisions offered patients effective treatments. A clinical pharmacist from the local Clinical Commissioning Group (CCG) visited the practice every three months to review prescribing habits at the practice and to offer advice.

Management, monitoring and improving outcomes for people

The Practice had a system in place for carrying out clinical audits. Examples included audits of post-operative infection, vitamin D deficiency, and a review of kidney screening results in diabetic patients. A second audit of kidney screening results was to be carried out shortly to see if the results had improved. This would complete the audit cycle.

Doctors in the surgery carry out minor surgical procedures in line with their CQC registration under the Health and Social Care Act 2008 and NICE guidance. The staff were appropriately trained and kept up to date. They also regularly audited their results and used that in their learning.

The practice was participating in a national initiative to reduce unplanned admissions to hospitals among its patients. Care plans had been put in place for elderly patients most at risk of unplanned admissions and regular review meetings were held to assess performance.

Effective Staffing

The practice was reliant on locum doctors to meet the needs of its patients. The locums were provided by an external agency. We saw evidence that the practice checked locums' CVs and their enhanced disclosure and barring service (DBS) or old style criminal records bureau (CRB) records before accepting them from the agency. The agency was not able to supply the same locum on a regular basis. We saw that quite a large number of different locums had been used over the past year. A new locum was working at the practice for the first time on the day of our inspection. Although the locums helped the practice with its capacity problems, there was inevitably some loss of continuity in the care of patients.

The practice had a recruitment policy in place and we saw evidence that an appropriate process was followed when recruiting new staff. Enhanced disclosure and barring service (DBS) checks were carried out on all nursing staff and health care assistants to help ensure their suitability to work with vulnerable patients. We also saw evidence that written references were sought and obtained for new administrative staff.

The practice checked that its doctors were correctly registered on the GP performers list. Doctors must have had a DBS (or old style criminal records bureau - CRB)

Are services effective?

(for example, treatment is effective)

check to be added to the GP performers list so the practice did not carry out its own additional checks. The practice had also obtained DBS checks on reception and administrative staff. The practice also checked regularly to ensure that clinical staff remained registered with their appropriate professional body.

Staff told us that they had regular appraisals and that the process was supportive and positive. They also told us that training was readily available and relevant to their role.

One of the doctors at the practice organised regular educational sessions for local clinicians who were members of the 'Hill Top Medical Forum'. The forum was addressed by consultants and specialists in a range of conditions that were relevant or of interest to the group.

Working with other services

There was evidence of appropriate multi-disciplinary team working at the practice. A multi-disciplinary palliative care meeting was held every two months to discuss patients receiving end of life care. The meeting was attended by doctors and nurses from the practice along with community nurses and Macmillan nurses where appropriate.

We were told that doctors from the practice regularly carried out joint visits with district or Macmillan nurses to patients receiving end of life care.

There was some confusion between staff in the practice as to how they sent up to date information about patients receiving end of life care to the out of hours doctor service. There was no formal procedure to ensure that information was reliably sent. We saw that information about patients seen by the out of hours service was faxed to the practice each morning. A doctor signed the forms to indicate that they had been reviewed and acted upon as necessary. The same system also worked for reviewing hospital discharge letters. However, the practice was about to upgrade its computer system which would make information sharing with other healthcare providers much easier.

We were told that patients who had blood tests carried out at the practice were invited to telephone the reception staff to obtain their results. However, if a test result was abnormal, patients would be contacted by a doctor, either by telephone or letter. Administrative staff were able to confirm normal test results if patients telephoned the practice, but always referred patients to a clinician if results were abnormal.

Health Promotion & Prevention

Health promotion literature was readily available to patients and was up to date. This included information about services to support them in smoking cessation schemes for instance. People were encouraged to take an interest in their health and to take action to improve and maintain it.

We saw that new patients were invited into the surgery when they first registered to find out details of their past medical and family health histories. They were also asked about social factors including occupation and lifestyle and medications. This enabled the clinicians to assess new patients' risk factors.

The practice proactively identified patients who were also carers and offered them additional support. Staff and clinicians were automatically alerted to patients who were also registered as carers. This ensured that doctors were aware of the wider context of the person's health needs. Carers could also be referred to external carer support organisations that could provide additional practical and emotional support.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We observed patients being treated with respect and dignity throughout our time at the practice. We saw that the nurse displayed a positive attitude towards her patients. She explained to us the support she gave to patients to make sure that referrals were followed through. She also told us that she saw part of her role as providing education and ensuring that patients followed any advice they had been given after they left the practice.

Patients were given the time they needed to ensure they understood the care and treatment they required. Three patients we spoke with confirmed that they never felt rushed.

A privacy and dignity policy was in place and all staff had access to this. Privacy screens and window blinds were present in all clinical rooms. The nurse told us that these were always used and that the door was closed when personal procedures were carried out. The approach explained to us reflected the guidance in the practice policy.

Following the death of a patient the practice contacted the family by phone and invited them to visit the practice to talk. Bereaved family members were offered the opportunity to speak with the GP or nurse whenever they wanted. A counselling service was also available with a counsellor who visited the practice regularly.

Involvement in decisions and consent

The nurse told us that she explained treatments and tests to patients before carrying out any procedures. Patients were given an explanation of what was going to happen at each step so that they knew what to expect.

Patients told us they felt that they had been involved in decisions about their own treatment and that the doctor gave them plenty of time to ask questions. They were satisfied with the level of information they had been given and said that any next steps in their treatment plan had been explained to them.

We saw the practice's consent policy and its guide to the Mental Capacity Act 2005 (MCA). These provided staff with information about making decisions in the best interest of patients who lacked the capacity to make their own decisions. Clinicians were aware of patients who needed support from nominated carers and ensured that carers' views were listened to as appropriate.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to people's needs

The practice understood the different needs of the local population and took appropriate steps to tailor its service to meet these needs. The practice had a significant proportion of Asian patients on its list. The Asian population can be at a higher risk of developing diabetes. We were shown measures the provider had taken to target patients with diabetes, particularly those who seemed to have difficulty in managing their own condition effectively.

We looked at the measures in place at the practice to accommodate patients' equality, diversity and information needs. We were told that the two GP partners spoke a number of languages common in the local community. In addition, there were interpretation facilities available to assist patients if required. The availability of the interpretation service was publicised in the practice handbook. Patients who needed to use the service were automatically booked a double length appointment to allow time for the conversation between the doctor and patient to be translated.

The practice was situated in a purpose built surgery. There was a ramp to the front door and automatic doors to assist patients with mobility problems or with children in push chairs. However, there was a step into the building which it would not be easy to negotiate in a wheelchair. There was level access to the building from the car park at the rear of the practice. Staff told us that patients using wheelchairs usually arrived by car and used the rear entrance anyway.

Access to the service

Patients could make appointments by phone or in person. The practice was about to introduce a new computer system which would allow patients to book appointments online. The practice leaflet made clear that patients could book follow up appointments up to three months in advance.

The practice was closed between 12.30pm and 4.15pm each day. Patients who called during the day when the surgery was closed heard a recorded message advising them that they could call one of the doctors using a mobile number. The doctors told us that they gave patients a mobile number to use but they did so very rarely.

Several patients told us that it could sometimes be difficult to obtain a routine appointment without having to wait nearly a week. However, all the patients we spoke with told us that it was possible to get an urgent appointment on the same day if necessary. Patients could telephone the practice to talk to a doctor at the end of each surgery session, but there were no bookable telephone appointments. The practice's own most recent survey found that appointments and being able to talk to a doctor on the phone were the two issues that patients were least satisfied about. In response the practice provided extra GP sessions to try and meet demand. It had also briefly introduced a system that required a doctor to talk with every patient wishing to make an appointment but this had proved unpopular and was discontinued.

Some patients we spoke with also complained that they had to wait too long once they arrived for the appointment. The practice had recognised that some patients were taking up more time with the doctor and had introduced more double length appointments to manage waiting times better.

Patients could order repeat prescriptions by post or in person at the surgery. The practice aimed to have the prescription ready for collection within 48 hours. A new computer system shortly to be introduced at the practice would allow patients to order prescriptions online.

Meeting people's needs

The practice had a written cultural and religious policy that covered the different possible cultural and religious needs of patients and staff. Topics covered included diet, blood transfusion, intravenous drugs, birth (family planning, terminations), fasting, modesty, and dying and death. Specific instructions related to an individual patient's care and their cultural or religious beliefs were tagged on their files to alert staff to their care and treatment preferences. Staff were aware of religious festivals such as Ramadan and the relevance of these to their patient population.

Patients requiring further specialist investigation or treatment were referred using the 'choose and book' system. This was organised by a delegated secretary or the practice manager in their absence. The doctors told us that they ensured that patients understood the choices they had and that they were happy they had made the right choice

Are services responsive to people's needs?

(for example, to feedback?)

Concerns & 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 complaints process publicised in the waiting room, on the practice web site and in the practice leaflet. Patients we spoke with had not had any cause to complain but they believed any complaint they made would be taken seriously.

We saw the practice's log and annual review of complaints it received. The review recorded the outcome of each complaint and identified where learning from the event had been shared at a practice meeting.

Are services well-led?

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

Our findings

Leadership & Culture

The practice had its mission statement displayed on a poster in the waiting room. The practice's mission statement was 'to provide the best possible care to our patients within available resources'. Administrative staff we spoke with did not seem familiar with the existence of the poster but were able to describe a culture that closely resembled the statement on it.

There was no written strategy or long term plan for the practice in place. One of the partners told us that they often discussed longer term plans informally but they did not feel it necessary to record these discussions. There were no practice wide objectives in place to drive the quality of care up. The partners told us that they preferred an informal approach to leadership. The partners had discussed the possibility of a strategic merger with two other local practices but one had decided against the plan. Since then the partners had been discussing a looser collaboration of local practices to create a bank of locums and support or administrative and management functions.

The partners had been trying to recruit an additional partner for some time without success. They were aware of the potential problems for continuity of care for patients due to the over reliance on locum doctors. However they had judged that this risk was balanced by the need to provide enough appointments for their patients.

We saw that the staff performance monitoring system was used as much to recognise and reward good performance as to identify any potential underperformance. All the staff we spoke with said they felt valued and respected by the practice manager. There were regular practice meetings although administrative staff told us they felt more comfortable raising any issues with the practice manager in private rather than speaking up during meetings.

We found that the practice relied heavily on the experience and expertise of the practice manager. It was clear that the administrative staff in the practice would not be able to carry out all of the practice manager's duties in her absence. The practice manager told us that she brought forward tasks or delayed them prior to going on holiday. She also told us that she regularly accessed and responded to work emails while on holiday.

Governance Arrangements

The practice had a clear governance structure designed to provide assurance to patients and the local clinical commissioning group (CCG) that the service was operating safely and effectively. There were clearly identified lead roles for areas such as medicines management, complaints and incident management, and safeguarding. The responsibilities were shared between the doctors, the nurse and the practice manager.

Systems to monitor and improve quality & improvement (leadership)

The practice had a system to assess and monitor the quality of service that patients received. We saw the provider carried out a number of audits designed to assess the quality of its services. Some of this monitoring was carried out as part of the Quality and Outcomes Framework (QOF). This is an annual incentive programme designed to reward good practice. The practice was able to demonstrate that it was meeting the required QOF targets.

In addition to monitoring and reporting its performance against the national quality requirements, the provider had developed and agreed quality indicators with the local CCG. The indicators were monitored and performance was reported to the CCG on a monthly basis. This enabled the practice and the CCG to see at a glance if any aspect of performance was below expectation and to put plans in place to improve the situation.

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

The practice had a patient participation group (PPG). A PPG is made up of practice staff and patients that are representative of the practice population. The main aim of the PPG is to ensure that patients are involved in decisions about the range and quality of services provided by the practice. The practice manager was aware that the PPG for Hill Top Surgery was not representative of the practice population. There were only six members of the group and all attempts to attract more members representing a wider cross section of the local community had proved unsuccessful. However, the group was consulted on a variety of issues affecting the running of the practice. We saw the most recent annual review of the group's activities. This included an action plan to tackle issues identified by the group. The group had identified problems with appointments, telephone access, and privacy at the reception desk.

Are services well-led?

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

The practice used an independent company to carry out an annual survey of its patients. One of the benefits of this was that it enabled the practice to compare its performance with other practices. Just over 100 patients responded to the most recent survey in March 2014. The results showed that the practice was close to or above the national benchmark in 18 out of 25 key indicators. The most common concern expressed by patients was difficulty in obtaining appointments.

The staff we spoke with told us that they felt able to express their views to the practice manager and that any suggestions they had for improving the service would be taken seriously.

Management leadership through learning & improvement

We saw evidence that learning from significant events took place and appropriate changes were implemented. We saw that there were systems in place for the practice to audit and review significant events and that action plans were put in place to help to prevent them occurring again.

One of the doctors at the practice organised regular educational sessions for local clinicians who were members of the 'Hill Top Medical Forum'. The forum was addressed by consultants and specialists in a range of conditions that were relevant or of interest to the group.

Identification & Management of Risk

There was no formal register of corporate risks at the practice but we saw evidence that some risks had been identified and action taken to minimise their potential impact. For instance there was a contingency plan to deal with loss of utility services in the building.

Older people

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

Our findings

The practice offered a specific clinic every Monday afternoon for older people. The appointments were with the practice nurse.

The practice actively targeted older people to attend surgery for 'flu vaccinations. Patients who attended for 'flu vaccinations or a health check were always offered additional relevant health information. Housebound patients were visited by the doctor or a nurse for routine 'flu vaccinations

The practice also targeted patients over 75 to offer them a vaccination against shingles.

All patients over the age of 75 were being provided with a named GP to help achieve continuity of care and reduce risk to patients. Patients in this group had been informed by letter who their named doctor was.

The practice undertook work to review older patients who had frequent unplanned hospital admissions and readmissions. This was to identify any unmet health needs or a need to educate patients about managing their conditions to prevent subsequent admissions.

The practice held a register of patients with dementia and ensured that they were offered regular health checks.

People with long term conditions

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

Our findings

The practice ran regular clinics for patients with long-term conditions such as diabetes, chronic obstructive pulmonary disease, cardiovascular disease and asthma. We saw the practice followed a call and recall protocol to ensure that as many patients as possible with long term conditions regularly attended for a review.

The practice had identified patients with poorly controlled diabetes and invited them to additional educational meetings to support the self-management of their condition.

The practice held regular multi-disciplinary team meetings to manage the care of patients nearing the end of their lives.

Mothers, babies, children and young people

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

Our findings

The practice offered lifestyle advice to pregnant patients.

The practice held a nurse led baby clinic every week and offered every new mother a postnatal check six weeks after the birth of their baby. The practice delivered the full range of childhood immunisations.

New mothers were given an education pack put together by practice. The pack included advice on breast feeding, immunisation schedules, first aid, and the safe storage of children's medicines.

There was a separate area in the waiting room for patients with young children. There was health promotion information in this area of the waiting room specifically aimed at the parents of young children.

Working age people (and those recently retired)

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

Our findings

The practice was open for extended hours two nights a week to enable people working people to make appointments outside of their normal working day. Patients could also consult the doctors by telephone rather than visiting the surgery.

The surgery offered an in-house service to take patients' blood for testing. However, patients could be referred to a local hospital to have their blood taken if they wanted an appointment earlier than the practice opened.

Patients could choose to be referred for further treatment or investigation at a hospital closer to their place of work if required.

The practice ran regular well woman and well man clinics.

The practice ran a regular cervical smear clinic with recall periods dependent on identified risks.

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

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

Our findings

There were no barriers to accessing the services at the practice for any vulnerable group. The staff believed that patients could access the practice's services without fear of stigma and prejudice.

Homeless people and travellers were able to receive a service without having to provide an address. Staff were expected to assist patients with filling in any forms if necessary.

The practice had identified patients with learning disabilities. These patients had individual care plans and were offered an annual health check.

People experiencing poor mental health

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

Our findings

The practice held a register of its patients known to have poor mental health. The practice was in the process of developing individual care plans for each patient on the register. Counselling services were available at the practice from a visiting counsellor. Doctors recognised and managed referrals of more complex mental health problems to the appropriate specialist services.

The practice held a register of patients with dementia. These patients were offered a full annual health review. Carers were involved in the reviews as necessary.