Cricket Green Medical Practice

Quality Report

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

Summary of findings

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Summary of findings

Overall summary

Cricket Green Medical Practice is a large GP practice based in Mitcham, providing primary care services to around 10 000 patients. During our inspection we inspected regulated activities of diagnostic, screening treatment of diseases and injury.

Cricket Green Medical Practice is a modern, purpose built surgery, established at its new site since 2009. In addition to standard primary care services the practice offers many specialised clinical services, such as maternity care and anti-coagulant clinics. The practice offers extended opening hours including Saturday morning appointments.

We spoke with eight patients and received 20 comments cards. All the patients we spoke with and comment cards received rated the care given as being good. However patients reported being unhappy with the current appointments system which they described as inflexible and difficult to make appointments. The practice told us they were aware of the feedback from patients and they were introducing a new appointments booking system from 9 June 2014.

The practice had systems to report, record and review incidents. Patients were protected from the risk of abuse because staff had received appropriate training and they were aware of how they would raise safeguarding concerns. There were appropriate systems in place to manage medicines, and patients were protected from the risk of infection. We found that good systems were also in place to deal with emergencies and emergency equipment was available and regularly checked.

The practice promoted best practice by implementing care based on published guidance. Local CCG meetings were attended by GPs, where among other subjects; current developments in care were discussed. Good systems were place for monitoring and improving outcomes for patients by ensuring that health reviews occurred at specific times and referrals were followed up to ensure patients received timely care. We found that clinical audits were used as a quality improvement tool for the care provided to patients. Health promotion leaflets were accessible for patients to enable them to make informed choices.

The practice was caring, comments cards received and patients spoken with all demonstrated that patients were treated with dignity and shown empathy. Support was offered to bereaved families and a local carer's support group was available. The practice operated a Patient Participation Group (PPG) whom they worked closely with to improve patient care. Patients told us that they felt involved in decisions related to their care and treatment and their decisions were respected. We observed that staff maintained patient confidentiality at all times.

Patients varying needs were responded to, this is because care and services provided were tailored to the needs of the local population. Extended hours and Saturday morning clinics were offered at the practice which allowed flexibility to patients. Patients were offered online appointment bookings and repeat prescription requests which allowed flexibility to all patients. The practice welcomed feedback and participation from patients and the PPG and had responded to concerns about the appointments system.

The practice had a clear, written vision and strategy to deliver high quality care and promote good outcomes for patients. The strategic plan was clear and incorporated in the appraisal system for staff. Audit systems were used to ensure adequate monitoring of patient care with the aim of improving care and delivery. Staff were provided with learning opportunities to develop their skills and maintain good clinical practice.

Older people had access to a group of GPs and they received regular health reviews. Emergency appointments were available for mothers, babies and children.

The practice was able to register patients who lived in the area temporarily and they had a policy for following up mental health patients who failed to attend appointments.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice had systems to report, record and review incidents. Patients were protected from the risk of abuse because staff had received appropriate training and they were aware of how they would raise safeguarding concerns. Appropriate systems were in place to manage medicines, and patients were protected from the risk of infection. We found that good systems were also in place to deal with emergencies and staff recruitment. Emergency equipment was available and regularly checked.

Are services effective?

The practice promoted best practice by implementing care based on published guidance. Local CCG meetings were attended by GPs, where among other subjects; current developments in care were discussed. The practice had good systems in place for monitoring and improving outcomes for patients by ensuring that health reviews occurred at specific times and referrals were followed up to ensure patients received timely care. We found that clinical audits were used as a quality improvement tool for the care provided to patients. The practice had an appropriate induction plan, which all staff went through. The practice worked in partnership with other health and social care providers to ensure patients received collaborated care. Health promotion leaflets were accessible for patients.

Are services caring?

All eight patients we spoke with and 20 comments cards received demonstrated that patients felt well cared for. Support was offered to bereaved families and a local carer's support group was available. The practice operated a Patient Participation Group whom they worked closely with to improve patient care. Patients told us that they felt involved in decisions related to their care and treatment and were their decisions were respected.

Are services responsive to people's needs?

The practice was responsive to patients varying needs. Extended hours and Saturday morning clinics were offered at the practice which allowed flexibility to patients. Patients were offered online appointment bookings and repeat prescription requests. The practice welcomed feedback and participation from patients and the PPG and implemented identified changes.

Summary of findings

Are services well-led?

The practice had a clear, written vision and strategy to deliver high quality care and promote good outcomes for patients. Staff we spoke with felt valued and took pride in the achievements of the practice. The strategic plan for the practice was clear and incorporated in the appraisal system for staff. The practice used audit systems to ensure adequate monitoring of patient care with the aim of improving care and delivery.

Summary of findings

The six population groups and what we found

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

Older people
The provider had arrangements in place to respond to the needs of this population group.

Services were well led by an enthusiastic group of GPs. All patients we spoke with were positive with the practice. They felt well cared for and respected by staff.

People with long-term conditions
The provider had arrangements in place to respond to the needs of this population group. People with long term conditions received effective and safe care from staff that was caring. Care plans were developed with other service providers to ensure care continuity.

Mothers, babies, children and young people
The provider had arrangements in place to respond to the needs of this population group.

We found that staff were aware of best practice guidance for the safe and effective care of this population group. Emergency appointments were always offered to this population group.

The working-age population and those recently retired
The provider had arrangements in place to respond to the needs of this population group.

We found that the practice responded well to peoples changing needs through the use of information technology and offering weekend appointments.

People in vulnerable circumstances who may have poor access to primary care
The provider had arrangements in place to respond to the needs of this population group.

We found that vulnerable patients living in the area where allowed to register with the practice. Vulnerable patients were also closely monitored with appropriate health checks being offered.

People experiencing poor mental health
The provider had arrangements in place to respond to the needs of this population group.

There was a policy for non-attenders to ensure they were not lost in the system.

Summary of findings

Summary of findings

What people who use the service say

We spoke with eight patients during our inspection and received 20 completed comments cards.

Patients reported being happy with the care and treatment they received. However all patients we spoke with during our visit reported being unhappy with the current appointments system which they felt could be improved on as it was difficult to obtain appointments.

We looked at patient feedback from the NHS choices website. Feedback left by patients in the last three months preceding our visit described the staff at the practice as caring. However three patients also expressed their disatisification with the appointments booking system which they felt needed to be changed to allow flexibility when booking appointments.

The Patient Participation Group (PPG) had conducted a patient survey in March 2014. The results demonstrated that patients were happy with the care received but needed an improvement in the appointments booking system. This was being addressed by the practice.

Cricket Green Medical PracticeCricket Green Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector who was accompanied by two specialist advisers, (a GP and a practice nurse) and an Expert by Experience.

Background to Cricket Green Medical Practice

Cricket Green Medical Practice is a large GP practice based in Mitcham, providing primary care services to around 10 000 patients. The practice is located at 75-79 Miles Road, Mitcham, Surrey, CR4 3DA.

Cricket Green Medical Practice is a modern, purpose built surgery, established at its new site since 2009. In addition to standard primary care services the practice offers many specialised clinical services. The practice holds surgeries every weekday from 8.30am-12noon and from 3.30pm with the last appointment at 6.20pm.Late night surgeries are held on Mondays, Tuesdays & Thursdays until 8pm.Saturday surgeries run from 9.00am-12noon.

The practice has six GPs consisting of three partners and three salaried GPs, three practice nurses, a practice manager, three administrative staff and seven reception staff.

The practice is a teaching practice, providing training to medical students from St. George's Hospital on a regular basis.

The health of people in Merton is generally better than the England average, and deprivation is lower. While life expectancy is significantly better than the England average, there is wide variation within the borough from east, where life expectancy is lower, to west. Priorities in Merton include reducing the gap in life expectancy between the least and the most deprived parts of Merton, reducing mortality due to heart disease and cancer, addressing major risk factors such as smoking, diet, exercise and alcohol, and improving sexual health.

Why we carried out this inspection

We inspected this out-of-hours service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before. The practice was registered with CQC on 1 April 2013

How we carried out this inspection

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

- Is it safe?

Detailed findings

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

Prior to our inspection we carried out an analysis of data from our Intelligent Monitoring system. This did not highlight any significant areas of risk across the five key question areas. As part of the inspection we contacted a number of key stakeholders, including NHS England, Merton Clinical Commissioning Group and Healthwatch Merton, and reviewed the information they gave us. We carried out an announced visit on 20/05/14. During our visit we spoke with a range of staff such as GPs, practice nurses, health care assistants, reception staff and representatives from the patient participation group. We also spoke with patients who used the service, their family members and observed how patients were being cared for. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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Are services safe?

Summary of findings

The practice had systems to report, record and review incidents. Patients were protected from the risk of abuse because staff had received appropriate training and they were aware of how they would raise safeguarding concerns. Appropriate pre-employment checks had been carried out on staff prior to them starting work. There were systems in place to manage medicines, and patients were protected from the risk of infection. We found that good systems were also in place to deal with emergencies, including contingency plans. Emergency equipment was available and regularly checked.

Our findings

The practice had systems to report, record and review incidents. Patients were protected from the risk of abuse because staff had received appropriate training and they were aware of how they would raise safeguarding concerns. Appropriate pre-employment checks had been carried out on staff prior to them starting work. There were systems in place to manage medicines, and patients were protected from the risk of infection. We found that good systems were also in place to deal with emergencies, including contingency plans. Emergency equipment was available and regularly checked.

Safe patient care

The practice had systems in place to report incidents to the local Clinical Commissioning Group (CCG) and relevant bodies such as the Medicines and Healthcare Products Regulatory Agency (MHRA). Staff we spoke with told us that they were familiar with the incident reporting process. All eight patients we spoke with during our inspection did not raise any concerns about the safety of the practice.

Learning from incidents

The practice recorded and reviewed all incidents. We saw a record of minutes from monthly meetings where incidents that had occurred had been discussed and risk assessments developed to reduce the likelihood of incidents re-occurring. For example we saw that nurses were required to check each other's prescription medicines to reduce errors as this had been identified following a previous incident.

Safeguarding

Patients using the practice were protected from the risk of abuse because the practice had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. The practice had safeguarding vulnerable adults and child protection policies. These were available on the practice's intranet, which was easily accessible to staff. Staff we spoke with where aware of how to access the policies.

Training records confirmed that all staff working at the practice had completed child protection training to the most appropriate level for their job role; Level 1 for

administration staff, Level 2 for nurses and Level 3 for the GPs. The practice had a lead practitioner in safeguarding. They shared updates in safeguarding with staff and also attended local safeguarding meetings for children.

The practice had contact details for the local safeguarding teams and staff we spoke with were aware of the process for making referrals. All concerns were reported to the practice's safeguarding lead. The practice had a high number of patients who were the subject of a child protection plan or who had been identified as being "in need". Therefore, the practice had introduced an audit system to ensure their care was monitored and dealt with appropriately. For example logs of appointments were kept of key health reviews undertaken to ensure the GPs continued to monitor the health and well-being of the child.

Monitoring safety and responding to risk

There were a variety of policies and systems in place to monitor and respond to safety and patient risk. For example, there was a policy which guided staff on how to manage disease outbreaks and how to ensure there were sufficient staffing levels during busy periods, such as flu vaccination. The practice completed a risk register and outlined actions to minimise any risks identified. The practice kept a log of children at risk or subject to child protection plans so that their care and any action taken could be reviewed easily.

Medicines management

Patients were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage them. The practice had an up to date policy on the management of medicines and staff we spoke with were aware of the procedures. We found that medicines were appropriately stored in secure locked cabinets and the vaccination fridges were locked. No controlled drugs were used at the practice. All the medicines we saw were in date and there was a system in place to record and monitor their expiry dates.

Medicines for repeat prescriptions were reviewed frequently to ensure they were still suitable for the patient, thus protecting them from risks associated with medicines. Prescriptions were kept safe and monitoring was in place to ensure the risk of misuse was minimised. For example prescription pads were locked away and serial numbers were recorded and checked on a regular basis.

Fridges used for storing vaccines and medicines were fit for purpose. The minimum and maximum temperatures were recorded and monitored daily. A fridge guidance policy was available, which described the temperature requirements of storing medicines and vaccines. The fridges were wired into switch-less sockets to avoid them being switched off accidentally.

Cleanliness and infection control

Patients were protected from the risk of infection because appropriate guidance had been followed. There was an infection control policy and records confirmed that staff had undertaken infection control training and continued to receive refresher courses. The infection control lead nurse showed us records of audits and spot checks they had undertaken at the practice. It was evident that improvement actions were undertaken following these spot checks, such as clinical staff removing jewellery during patient care to minimise the risk of cross infection.

The practice was clean on the day of our visit. Patients we spoke with told us they were happy with the cleanliness of the practice. Appropriate hand washing facilities were available and a domestic company was contracted to undertake the general cleaning of the premises. A log of the duties they carried out daily was available and we noted that staff checked this to ensure all aspects of cleaning were being performed. There were appropriate facilities for the storage and removal of clinical waste.

Staffing and recruitment

Appropriate checks were undertaken before staff began work and there was a recruitment policy in place. Records viewed demonstrated that staff working at the practice had full Disclosure and Barring Service (DBS) clearance, appropriate references and qualifications that had been verified before they commenced work at the practice.

Dealing with Emergencies

There were arrangements in place to deal with foreseeable emergencies, which included a contingency and recovery plan was in place. This plan risk assessed foreseeable emergencies, the impact on patients and how the practice would continue to provide services in the event of an emergency. The plan covered local arrangements with other providers on delivering care in the event of incidents which would affect service provision.

The practice kept medicines and equipment for use in medical emergencies and these were checked on a regular

basis. All staff had completed resuscitation training and training on how to use a defibrillator. The practice carried out practice emergency scenarios to assess how well staff would deal with real life emergencies. Records we viewed confirmed this.

Equipment

Patients were protected from unsafe or unsuitable equipment. All emergency equipment at the practice were checked regularly and records of these checks were available.

Are services effective?

(for example, treatment is effective)

Summary of findings

The practice promoted best practice as care and treatment was informed by national guidance. Local Clinical Commissioning Group (CCG) meetings were attended by GPs where, among other subjects, current developments in care and local priorities were discussed. The practice had good systems in place for monitoring and improving outcomes for patients by ensuring that health reviews occurred at specific times and referrals were followed up to ensure patients received timely care. The practice used the Quality and Outcomes Framework (QOF) to measure performance and had its own programme of clinical audit. The practice had an appropriate induction plan for all staff. The practice worked in partnership with other health and social care providers to ensure patients received co-ordinated and effective care. Health promotion leaflets were accessible for patients and interventions were linked to the population needs.

Our findings

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Promoting best practice

The policies and interventions on care we viewed referenced nationally recommended guidance, including National Institute for Health and Care Excellence (NICE) guidelines. For example post- natal women were offered six week depression screening based on NICE guidance. Staff we spoke with told us that they shared information on updates and changes to relevant guidelines at staff meetings. Clinical updates were also available on the practice's intranet, which was accessible to all staff.

The practice attended meetings with the local Clinical Commissioning Group (CCG) where they discussed current developments in care. The practice taught and trained medical students. The senior partner at the practice was part of the training team for the London Denary and so shared developments and updates with colleagues.

Management, monitoring and improving outcomes for people

The practice had systems in place to monitor and improve the outcomes for patients. For example the electronic records system used at the practice alerted staff if a patient was due for a health review, which ensured reviews occurred routinely and patients with conditions, such as diabetes and hypertension were monitored on an ongoing basis. All referrals made from the practice to other providers were followed up to ensure patients received timely care.

Are services effective?

(for example, treatment is effective)

The practice used the Quality and Outcomes Framework (QOF) to measure performance. The QOF is the annual reward and incentive programme detailing GP practice achievement results. For example, the practice reviewed their previous ratings to increase the number of asthma management clinics offered at the practice.

Clinical audits were used as a quality improvement tool for the care provided to patients. For example the practice carried out audits to check that each member of staff who carried out cervical smears had a less than a 2% inadequate rate (Inadequate smear test occurs when a sample on the microscope slide is unsuitable for analysis and the patient has to have a repeat sample taken). Patients who received inadequate smear results may worry as they needed to be re-tested. This audit was part of the practice's internal audit programme. As a result of this audit, training needs had been identified for some staff and had been implemented. A repeat audit was planned for December 2014 to ensure that clinicians had improved in the smear taking.

Feedback and information from local CCG meetings was used to implement care needs identified for the local population. For example local information had identified the need to increase diabetes screening and awareness and patients were being offered screening and information on managing diabetes.

Staffing

The practice's recruitment and selection policy outlined the induction plan for all staff. This included a set of detailed learning objectives which required approval by the practice manager for non –clinical staff and by GPs for clinical staff. The induction included a period of shadowing staff in similar roles .We spoke with a new member of administrative staff who confirmed they had received an induction where they shadowed and were supervised.

The practice's training log showed that both clinical and non-clinical staff had attended basic life support training within the last year. Child protection training had also been completed at Level 2 and Level 3 by nurses and GPs respectively and Level 1 for non-clinical staff. Other training completed included vulnerable adults, mental capacity, mental health awareness, confidentiality, consent, risk assessment or infection prevention and control. The practice's computerised training log sent alerts to staff when they were due to attend a refresher course.

The practice manager was responsible for undertaking appraisals for non-clinical staff. The appraisals for all staff involved, "objective setting", as part of the personal development plan. The practice nurses were appraised by the clinical nursing lead who was, in turn, appraised by the GPs. Records confirmed that all staff had completed their appraisals in April 2014.

The GPs appraisals were completed internally. They also had a process for internal peer review where they discussed clinical cases and areas of development. Two of the GPs had completed their revalidation at the time of our inspection. Revalidation is the process which doctors demonstrate they are up to date and fit to practise.

The practice closed one afternoon a month to hold education meetings. We viewed the minutes of previous meetings and the agenda that had been set for the meeting that was planned for a day after our inspection. They showed that clinical topics were discussed and information updates were shared.

Working with other services

The practice worked in partnership with other health and social care providers to ensure patients received effective and co-ordinated care. The practice held meetings with other providers such as district nurses, local community mental health teams and health visitors on a regular basis. We saw records that confirmed information relating to patients care was discussed and action plans created. The lead GP working with children and families told us that they contacted health visitors as soon as they identified children and families that required support.

Records of patients who had attended accident and emergency or the out of hour services were received electronically and reviewed by a GP. Our discussion with the lead for safeguarding demonstrated that they had responded to information requests from social services .Meetings were also held weekly with the palliative care team to discuss and update individual care plans for patients who were receiving end of life care. The practice worked closely with the Merton CCG. GPs attended monthly meetings to discuss service delivery and contractual issues. This ensured services offered were in line with local requirements.

Health, promotion and prevention

We saw a variety of health promotion leaflets displayed in the practice waiting rooms, which were available to

Are services effective?

(for example, treatment is effective)

patients to support them in promoting and preventing ill health. All new patients were offered screening tests to detect conditions such as diabetes, high blood pressure and obesity. During these tests, staff took the opportunity to provide specific health prevention information that was applicable to the patient.

The nurses offered a number of childhood vaccination sessions to children registered at the practice to protect against childhood diseases. The practice did not have a smoking cessation service as this was provided through local pharmacies but they actively referred people when needed and posters were displayed in the waiting areas.

Are services caring?

Summary of findings

All eight patients we spoke with and the 20 comments cards received demonstrated that patients felt well cared for. We looked at patient feedback from the NHS choices website. Feedback left by patients in the last three months preceding our visit described the staff at the practice as caring. Support was offered to bereaved families and a local carer's support group was available. The practice operated a Patient Participation Group (PPG) whom they worked closely with to improve patient care. For example we saw minutes from the PPG meetings were educational seminars on health matters suggested by patients were discussed and an action plan by the practice was implemented. Patients told us that they felt involved in decisions related to their care and treatment and were their decisions were respected. We observed that staff maintained patient confidentiality at all times.

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Respect, dignity, compassion and empathy

All patients we spoke with told us that they felt well cared for, and their dignity was maintained and respected. We looked at patient feedback from the NHS choices website. Feedback left by patients in the last three months preceding our visit described the staff at the practice as caring. However we viewed the GP national survey for patients conducted in 2013. Approximately two out of five 5 patients had felt staff at the practice had treated them with dignity and respect.

Staff demonstrated that the wishes of the patients were to be listened to, respected and responded to whenever possible. We noted that staff spoke to patients in a discreet and friendly way. All consultations took place in rooms designed to ensure confidentiality and dignity.

We saw leaflets informing patients that they could ask for a chaperone during examinations if they needed one. A chaperone is a person who acts as a witness for a patient and a medical practitioner during a medical examination or procedure. The practice offered support to bereaved families through counselling or referral to the carers support group. During our visit we observed a member of a local carers support group promoting their service. They told us that this was an arrangement that the practice had put in place to ensure patients were aware of the service.

The practice had a confidentiality policy and staff had undertaken confidentiality training during induction. Staff

Are services caring?

were aware of their responsibility to maintain patient confidentiality. We observed that computer screens with patient information used in reception were not within the reach of patients and staff did not leave them unattended to protect patient confidentiality.

Involvement in decisions and consent

The practice had a Patient Participant Group (PPG). We met with two representatives from the PPG during our visit. However, the PPG was not representative of the patient population in the area. For example, there were no patients from ethnic and minority groups or patients with learning difficulties or mental health representatives. We discussed this with the practice and they told us that they were making efforts to encourage different people to join the group to ensure its views were balanced. For example, the practice was introducing the use of online meetings to allow flexibility for more patients to join the group. The practice conducted two surveys in collaboration with the PPG in 2013 and 2014, which identified concerns with the appointment booking system. As a result, the practice was in the process of improving this to make it more accessible.

Patients told us that they felt involved in decisions relating to their care and information was readily available to support and inform them of care choices. GPs were aware of the Mental Capacity Act 2005 and were able to describe the process of seeking consent for patients who may lack capacity to make decisions about their health and care. This included children, patients with learning difficulties and mental health conditions.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The practice was responsive to patients varying needs. Care and services provided were tailored to the needs of the local population. Extended hours and Saturday morning clinics were offered at the practice which allowed flexibility to patients. Patients were offered online appointment bookings and repeat prescription requests. The practice welcomed feedback and participation from patients and the PPG and had responded to concerns about the appointments system.

Our findings

The practice was responsive to patients varying needs. Care and services provided were tailored to the needs of the local population. Extended hours and Saturday morning clinics were offered at the practice which allowed flexibility to patients. Patients were offered online appointment bookings and repeat prescription requests. The practice welcomed feedback and participation from patients and the PPG and had responded to concerns about the appointments system.

Responding to and meeting people's needs

The practice responded well to patients' varying needs. Health screening was offered and took account of patients ethnicities, backgrounds and age. For example staff were aware of the high incidence of diabetes in the local community and so ensured screening and referrals were offered at contact. Staff told us that some patients requested to see the same doctor and this was accommodated as much as possible. Patients we spoke with confirmed they were able to see the same doctor during non-emergency appointments. The practice had both female and male GPs and patients had a choice who they saw. GPs conducted home visits for people who were unable to attend the practice in person. In addition, the practice registered patients on a temporary basis such as those living in hostels or in vulnerable circumstances.

The practice was easily accessible to mobility aid users. The practice was located on three floors and all floors had a working lift.

The GPs and nurses told us they discussed immunisations uptake with parents at every contact and records were followed through at registration for children moving in from abroad or elsewhere to ensure they had completed the recommended immunisation schedule.

The practice used information identified by the CCG to deliver care. For example, patients from identified risk groups were offered screening for blood pressure, diabetes and sexual health which were identified as local needs.

We were told by staff that due to the diversity of the local population, language interpretation services were used when requested or when identified. We saw leaflets displayed in the reception area that advised patients that an interpreter could be requested.

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

The practice offered extended opening hours five days of the week. Morning appointments were offered from 08:30 on weekdays and there was a Saturday morning surgery from 9am till 12 noon. The practice operated 15 minute slots for all their appointments that were not emergencies to ensure patients had sufficient time with the GPs and nurses. Routine appointments could be booked up to one month in advance and emergency appointments were booked on the day either by walking into the clinic, by telephone or via the online booking service.

All patients we spoke with felt that the current appointments systems was poor and limited them access to see a GP in an emergency. They reported waiting on the telephone for a long time and by the time they were answered all appointments were already booked for the day. Those patients who were booked as emergencies were seen at the end of the morning sessions without an allocated time and they told us they could be waiting for a long time. A patient survey conducted by the practice in late 2013 and March 2014 with the PPG reflected similar feedback. In response to this feedback, the practice was introducing a new appointments system. We saw this advertised on the practice website and information leaflets displayed in the surgery. We were advised that the new system would allow patients to book appointments at any time throughout the day. Patients would be asked to leave a telephone number where a GP would ring them back for a consultation. If the problem could be managed over the phone, or with advice then that would happen. However if the consultation needed to be continued in person, or the problem could not be dealt with on the phone, the GP would book the patient in to see the most appropriate person on the day. We saw information on the practice website advising of the new appointments system and information about this was displayed throughout the surgery.

The practice had an online booking system for repeat prescription medicines and this provided flexibility to patients who were working or could not attend the surgery to request repeat prescriptions.

Concerns and complaints

The service had a complaints policy in place and this was available to patients on the practice website and was displayed in the practice waiting areas. An allocated complaints lead was available at the practice. We viewed the practice leaflet which briefly outlined the complaints policy. The complaints log kept at the practice showed a total of four complaints had been received between January and May 2014. All complaints had been responded to according to the practice policy. The PPG was used to inform the practice of patient experiences through surveys and this information was used to improve care provided.

Are services well-led?

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

Summary of findings

The service was well-led. The practice had a clear, written vision and strategy to deliver high quality care and promote good outcomes for patients. Staff we spoke with felt valued and took pride in the achievements of the practice. The strategic plan for the practice was clear and incorporated in the appraisal system for staff. The practice used audit systems to ensure adequate monitoring of patient care with the aim of improving care and delivery.

Our findings

The service was well-led. The practice had a clear, written vision and strategy to deliver high quality care and promote good outcomes for patients. Staff we spoke with felt valued and took pride in the achievements of the practice. The strategic plan for the practice was clear and incorporated in the appraisal system for staff. The practice used audit systems to ensure adequate monitoring of patient care with the aim of improving care and delivery.

Leadership and culture

The practice had a clear, written vision and strategy to deliver high quality care and promote good outcomes for patients. Staff told us they felt delivering good care and respecting patients was their role in delivering the practice strategy. They felt the culture of the practice valued them and as such they had a sense of belonging and took pride in the achievements as well as improvements that needed to take place. The practice had an annual strategic plan which was discussed in staff appraisals and goals set of how staff would aim to work towards these.

Governance arrangements

The practice had a clinical governance policy in place. It was evident that all staff were aware of the responsibilities of different levels of management and relevant processes and structures to support this were in place. For example the governance structure at the practice specified that the senior partners were responsible for operational decisions.

Records confirmed that clinical staff undertook continuing professional development, relevant to their speciality to keep up to date with changes therefore minimising poor practice. Records of staff registrations and revalidations with the Nursing and Midwifery Council (NMC) and the General Medical Council (GMC) were updated to ensure patients were protected. A risk register was operated at the practice .All potential risks were recorded and monitored and plans were devised to reduce the risk of them reoccurring. Staff we spoke with were able to explain the purpose of clinical audits in practice. We found that staff undertook audits relevant to their area of work. For example administration staff were responsible for undertaking audits such as appointments and waiting times and clinical staff carried out disease management and prescribing.

Are services well-led?

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

Systems to monitor and improve quality and improvement

We were shown records and systems that were currently in place to ensure adequate monitoring of patient care with the aim of improving care and delivery. For example an audit had taken place in December 2013 to identify the reason why some patients found it difficult to obtain appointments. Following this audit the practice had found that a number of patients pre-booked future appointments which they failed to attend. The practice decided to send reminder text messages a day before the appointment and this helped remind patients to either attend or cancel appointments which were then available to other patients.

Guidance from NICE was used to implement care plans and interventions therefore improving the quality of care delivered to patients. The GPs told us that they relied on each to confirm patient diagnosis and some challenging cases were discussed during the staff meetings.

Patient experience and involvement

The practice operated a PPG and feedback from them was acted on. For example the changes that were being introduced to the appointment booking system from 9 June 2014, had been identified from feedback received from patient user surveys. The practice worked closely with a volunteer patient support group for carers. On the day of our inspection a representative from the volunteer carer support group was attending the practice to provide support information. They told us that they communicated feedback from their members to the practice and comments were always welcomed.

Staff engagement and involvement

Staff told us that they felt involved in decisions made at the practice. All staff confirmed that they attended a practice meeting held every third Wednesday of the month and this was protected time as the surgery closed during this period. We saw minutes from previous meetings and an agenda of a meeting that was being held the next day after our inspection. Staff told us that they were able and encouraged to raise concerns.

Learning and improvement

The practice provided learning opportunities for staff members internally and externally. Staff told us they were encouraged to identify areas of knowledge improvement and they either identified conferences or short courses. For example nurses attended updates and training on vaccine delivery and the management of long term conditions. Following an audit of staff conducting smears, learning needs had been identified and implemented to improve practice.

Identification and management of risk

The practice had identified risks that could have an impact on service delivery. For example a detailed business continuity plan was available and this clearly outlined actions to take in severe weather, staff sickness and absence, adverse weather conditions and lack of power. All identified risk were logged in the practice risk register and discussed at meetings.

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.

Summary of findings

The provider had arrangements in place to respond to the needs of this population group.

Our findings

The provider had arrangements in place to respond to the needs of this population group.

We found that staff were aware of best practice guidance for the safe and effective care of this population group. The practice offered assessments based on the "Healthy Child Programme", which ensured all care given was in line with national guidance. All mothers were offered screening such as cervical smears, as recommended nationally. Mothers could access the practice in a number of ways to suit them and their children, such as the Saturday clinic or late opening service. Sick babies and children were always offered an emergency appointment. A variety of clinics for vaccinations and post natal checks were available and working mothers were able to book weekend appointments. The practice had a GP specialising in children`s health and offered specialist advice. Midwifery service was also offered at the practice and this helped expectant mothers to plan their care locally with their GP involvement.

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).

Summary of findings

The provider had arrangements in place to respond to the needs of this population group.

Our findings

The provider had arrangements in place to respond to the needs of this population group .We saw evidence that demonstrated that the practice held meetings to discuss and update care plans for people with chronic conditions with other care providers to ensure safe management of treatment. Interventions were appropriately targeted, to improving care quality for patients with long-term care needs.

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.

Summary of findings

The provider had arrangements in place to respond to the needs of this population group.

Our findings

The provider had arrangements in place to respond to the needs of this population group.

We found that staff were aware of best practice guidance for the safe and effective care of this population group. The practice offered assessments based on the "Healthy Child Programme", which ensured all care given was in line with national guidance. All mothers were offered screening such as cervical smears, as recommended nationally. Mothers could access the practice in a number of ways to suit them and their children, such as the Saturday clinic or late opening service. Sick babies and children were always offered an emergency appointment. A variety of clinics for vaccinations and post natal checks were available and working mothers were able to book weekend appointments. The practice had a GP specialising in children`s health and offered specialist advice. Midwifery service was also offered at the practice and this helped expectant mothers to plan their care locally with their GP involvement.

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.

Summary of findings

The provider had arrangements in place to respond to the needs of this population group.

Our findings

The provider had arrangements in place to respond to the needs of this population group.

The provider had arrangements in place to respond to the needs of this population group. We found that the practice responded well to peoples changing needs. Appointments and prescriptions were requested from the online site as well as weekend appointments and this offered a flexible choice for those who were working and not able to attend the practice. This population group was offered screening as required.

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).

Summary of findings

The provider had arrangements in place to respond to the needs of this population group.

Our findings

The provider had arrangements in place to respond to the needs of this population group.

We found that vulnerable patients living in the area where allowed to register with the practice. Vulnerable patients were also closely monitored with appropriate health checks being offered such as children on protection plans or people with learning difficulties. Interpreting services were available for patients who did not use English as a first language. All patients were offered screening during registration.

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.

Summary of findings

The provider had arrangements in place to respond to the needs of this population group.

Our findings

The provider had arrangements in place to respond to the needs of this population group. Meetings were held and patients care was discussed with other providers such as the community psychiatric team, to ensure vital information was shared. There was a policy for non-attenders to ensure they were not lost in the system. This policy outlined that three attempts of contact were made by telephone, or letter. Each of these attempts were to be documented in the patient record area. If no response was received from the three attempts then the clinician was to discuss the patient with the lead GP who would follow this up with the local community mental health team.