Dr Smith and Partners

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Dr Smith and Partners on 18 November 2014. We found that the practice were rated as good overall.

Our key findings were as follows:

- The practice was safe, staff reported incidents and learning took place. The practice had enough staff to deliver the service.
- The practice was effective. Services were delivered using evidence based practice.
- The premises were clean and fit for purpose and equipment was available for staff to undertake their duties.
- Staff were caring and compassionate, treated patients with kindness and respect and we saw good examples of care.
- The practice was responsive to the needs of patients and took into account any comments, concerns or complaints to improve the practice.
- The practice was well led, with an accessible and visible management team, governance systems and processes are in place and there was performance and quality management information available.

We saw some outstanding practice including :

A sexual health clinic which was offered on a Wednesday evening and a Saturday morning for the whole community and not just patients of the practice. The clinic was run and attended by one of the male GPs and two of the nursing staff.

However, there were also areas of practice where the provider needs to make improvements. For example

- Not all staff were clear who held the lead roles for safeguarding and infection control.
- Clinical audit was undertaken only when necessary and was not pro-active.

Summary of findings

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice was rated as good for safe. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe. Managers of the practice maintained safeguarding procedures and took steps to make sure staff followed them. Staff received training to the appropriate levels in safeguarding children and vulnerable adults. Patients that we talked with told us that they felt safe. There were effective medicines management processes in place, arrangements in place to deal with foreseeable emergences and equipment was checked and maintained. The practice was clean and well-maintained.

Are services effective?

Good

The practice was rated as good for effective. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence (NICE) guidance was referred to and used routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff had received training appropriate to their roles and further training needs had been identified and planned through regular appraisals. There was evidence of good multidisciplinary working in difficult circumstances, for example where district nurses and health visitors had moved into the community and were no longer attached to the practice.

Are services caring?

Good

The practice was rated as good for caring. Any negative comments we received related only to the appointment system which some patients found frustrating. However, all patients stated that once they had accessed an appointment they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also observed that staff treated patients with kindness and respect ensuring their confidentiality was maintained. Staff we spoke with were aware of the importance of providing patients with privacy. Carers or a representative were involved in helping patients who required support with making decisions

Summary of findings

Are services responsive to people's needs?

Good

The practice was rated as good for caring. Any negative comments we received related only to the appointment system which some patients found frustrating. However, all patients stated that once they had accessed an appointment they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also observed that staff treated patients with kindness and respect ensuring their confidentiality was maintained. Staff we spoke with were aware of the importance of providing patients with privacy. Carers or a representative were involved in helping patients who required support with making decisions

Are services well-led?

Good

The practice was rated as good for well-led. They had a vision and strategy which staff were involved in and eager to deliver. Staff were clear about their roles and responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management, in particular by the practice manager. There were a number of policies and procedures to govern activity and staff knew how to access these when required. Systems in place helped to monitor and improve quality and identify risk. The practice sought feedback from staff and patients and this had been acted upon where ever possible. Staff had received inductions, regular appraisals and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice was rated as good for the care of older people. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example in dementia and end of life care. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs and home visits. We saw examples where communication issues to do with the management of older people had been identified and saw where the staff had made changes to their service so that outcomes for patients could be improved. These changes included telephone conferences with community staff who had moved out of the area and telephone consultations for patients in care homes.

People with long term conditions

Good

The practice was rated as good for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. Longer appointments were offered when required and home visits were available. All these patients had a named GP and structured annual reviews to check their health and medication needs were being met. For those people with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. Nurses held regular in-house peer reviews and we saw examples where working practice was changed to accommodate patients in this category. For example nursing appointments had been altered so that patients could attend for an annual review for several long term conditions at once.

Families, children and young people

Good

The practice was rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. For example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises was suitable for children and babies. We were provided

Summary of findings

with good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

The practice provided a sexual health clinic on a Wednesday evening and Saturday morning for all patients in the community and services included emergency contraception, full sexual health screening and contraception implants. Patients were able to make gender specific requests as two female nurses and a male GP were available for consultation.

Working age people (including those recently retired and students)

Good

The practice was rated as good for the population group of the working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students, had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offer continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflects the needs for this age group. Late evening and Saturday morning appointments were available as well as telephone consultations and repeat prescription ordering on line and over the telephone.

People whose circumstances may make them vulnerable

Good

The practice was rated as good for the population group of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with learning disabilities. The practice had carried out annual health checks for people with learning disabilities and offered longer appointments when necessary. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people and had arranged telephone conferencing where it was not possible to hold meetings in person.

Reception staff knew of various support groups and third sector organisations where vulnerable patients could be signposted to when required. They were also vigilant on looking for anything untoward whilst on reception or during telephone triage and escalated any concerns to the GPs and nurses.

People experiencing poor mental health (including people with dementia)

Good

The practice was rated as good for the population group of people experiencing poor mental health (including people with dementia).

Summary of findings

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had in place advance care planning for patients with dementia. The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations including mental health charities such as MIND and SANE. The practice had a system in place to follow up on patients who had attended accident and emergency where there may have been mental health needs. Staff had received training on how to care for people with mental health needs and dementia. The practice were undertaking a local initiative to increase health checks for patients with serious mental illness. One of the GPs was trained in the management of drug and alcohol addiction.

Summary of findings

What people who use the service say

We spoke to eight patients, including three members of the patient participation group (PPG). The comments received were mostly positive about the care and treatment received. Comments about the doctors, nurses and administration staff were all positive with some patients saying that they felt everyone did their best in difficult circumstances. Some patients said that staff went above and beyond their duties and patients always felt listened to. They said the nurses in particular were very compassionate and considerate.

Most patients commented that it was difficult to get an appointment but all said that once at the practice they were treated with dignity, respect, politeness and assistance.

We received a mixture of negative and positive comments about the triage system the practice have in place but most patients we spoke to said that the staff who answered the telephones were very helpful, knowledgeable and able to deal with their issues, some of which did not require the input of a GP.

We received 34 comments cards only two of which were negative. However, nine of them mentioned difficulty accessing appointments. Some patients reported no issues at all. All the comments apart from those about appointments were very complimentary of the reception staff, the nurses, the doctors and the treatment received.

We looked at the results of the 2014 GP patient survey. This is an independent survey run by Ipsos MORI on behalf of NHS England.

These are the three results for the practice that are the highest compared to the CCG average :

- 89% of respondents say the last GP they saw or spoke to was good at treating them with care and concern - CCG (regional) average: **84%**
- 93% of respondents say the last GP they saw or spoke to was good at listening to them - CCG (regional) average: **88%**
- 88% of respondents say the last GP they saw or spoke to was good at explaining tests and treatments - CCG (regional) average: **84%**

This is where the practice did not fair so well :

- 49% of respondents find it easy to get through to this surgery by phone - CCG (regional) average: 79%
- 66% of respondents describe their experience of making an appointment as good - CCG (regional) average: 79%
- 57% of respondents usually wait 15 minutes or less after their appointment time to be seen - CCG (regional) average: 68%

The practice and patient participation group were very aware of the access issues and were continually making changes to their telephone systems to try to improve the service provided.

Areas for improvement

Action the service SHOULD take to improve

Not all staff were clear who held the lead roles for safeguarding and infection control. Reception staff who occasionally acted as chaperones had no formal training to ensure they understood the responsibilities of this role including where to stand to be able to observe the examination and how to record their attendance on patient records.

Clinical audit was undertaken only when necessary and was not pro-active.

Summary of findings

Outstanding practice

A sexual health clinic was offered on a Wednesday evening and a Saturday morning. The clinic was run by one of the male GPs and two of the nursing staff and had been set up as a practice initiative by the practice nurses. It offered patients the facility to see gender specific clinicians and was now available to the whole community and not just patients of the practice.

Dr Smith and Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**,** a GP adviser, a specialist practice manager and an expert by experience. An expert by experience is someone that has used health and social care services.

Background to Dr Smith and Partners

The surgery was purpose built in 1999. The building complies with the Disability Discrimination Act 1995 (DDA). All consulting rooms are on the ground floor with corridors and doors wide enough for wheelchairs. Car parking is available on site.

The practice delivers primary care under a General Medical Services Contract between themselves and NHS England and are responsible for a population of 7,700 patients within a large boundary of Wigan. The practice offer an open list and welcome new patients living or moving to the area.

There are a wide range of services offered which include specific clinics for child health surveillance, antenatal, cervical smears, blood pressure checks, asthma, diabetes, coronary heart disease, weight reduction and other health related conditions. The practice also offered a sexual health service which is available on a Wednesday evening from 17.00hrs until 19.30hrs and also on a Saturday morning from 10.00hrs until 12.30hrs. This service is open to everyone in the area and not just the practice patients. The service is run by two female nurses and a male GP, providing gender specific choice for patients attending.

The practice is open Monday to Friday (except Wednesday) from 08.30hrs until 18.30hrs closing every day between 12.30hrs and 14.00hrs. On a Wednesday the practice closes from 13:00hrs Consultations are by appointment 08.30hrs until 11.30hrs and 14.00hrs until 18.00hrs every day (except Wednesday when they do not re-open in the afternoon). The practice also opens on a Saturday morning from 09.30hrs until 12.30hrs for patients who work or have difficulty attending during the week.

There are five GPs (three male and two female) offering medical consultations and three female practice nurses. An administration team of eight and a full time practice manager are employed in the running of the practice.

There were no previous performance issues or concerns about this practice prior to our inspection

Why we carried out this inspection

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

This practice had not been inspected before and that was why they were included as part of the Wigan Clinical Commissioning Group.

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.

Detailed findings

How we carried out this inspection

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

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

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

- 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
- People experiencing poor mental health

Before our inspection we reviewed a range of information we held about the practice and asked other organisations to share what they knew. We asked Salford Clinical Commissioning Group (CCG) and the Local Healthwatch to tell us what they knew about the practice and the service provided. We reviewed some policies and procedures and other information received from the practice prior to the inspection. The information reviewed did not highlight any significant areas of risk across the five key question areas.

We carried out an announced inspection on 18 November 2014. During our inspection we spoke with staff available on the day. This included three GP partners, three nurses, the practice manager and four administration staff. We also spoke to eight patients, three who were part of the patient participation group. We reviewed comments from 34 CQC comments cards which had been completed.

We observed interaction between staff and patients in the waiting room and reviewed the premises.

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety such as recorded incidents, national patient safety alerts and comments and complaints received from patients. Staff we spoke to were aware of their responsibilities to raise concerns, and how to report incidents and near misses. We saw examples of five significant events which had been recorded. Each event recorded the incident, an analysis, what could be done differently, what would be done differently and an action and review. We saw that events were reviewed over time and particularly when changes had been made to working practice. This was to establish whether the change was effective.

We saw that recording and reporting was consistent over a number of years which evidenced a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We saw records of significant events that had occurred during the last 12 months. We did not see a specific slot for significant events on the practice meeting agenda and there was no dedicated meeting to review actions from past significant events and complaints. However discussions with clinical and administration staff led us to believe that significant events were debated and we saw evidence that appropriate learning did take place. We also saw that changes were made to working practice when required. Staff including receptionists, administrators and nursing were aware of the system for raising issues to be considered and felt encouraged to do so.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. Clinical staff told us alerts were also received directly from the clinical commissioning group (CCG) and the National Institute for Health and Care Excellence (NICE). These were discussed at meetings to ensure all staff were aware of any changes that may be required.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We reviewed staff records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff were confident in their knowledge and understood how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible.

All the GPs had undertaken safeguarding to Level 3 and there was a safeguarding lead. There was a system to highlight vulnerable patients on the electronic patient records. GPs and nurses were aware of vulnerable children and adults in their patient population. Alerts on patient records included information so staff were aware of any relevant issues when patients attended appointments. However, not all staff were aware that the practice had a safeguarding lead, or who had the responsibility of that lead role.

A chaperone policy was in place and visible on the waiting room noticeboard and in consulting rooms. Chaperone training had been undertaken by all nursing staff. If nursing staff were not available to act as chaperone, receptionists would occasionally be asked to do this. However receptionists had no formal training to ensure they understood their responsibilities when acting as chaperones including where to stand to be able to observe the examination and how to record their attendance on patient records.

Medicines Management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. This was being followed by the practice staff, and the action to take in the event of a potential failure was described.

Good

Are services safe?

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The practice worked closely with the medicines management team to achieve their Quality, Innovation, Productivity and Prevention (QIPP) targets. We saw that actions required in response to review of prescribing data were discussed at practice meetings. Patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice were reviewed and the GPs acted quickly on advice provided by the medicines management team.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff who generate prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary. We saw evidence of a change in working practice where an error had been identified.

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

Cleanliness & Infection Control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

There was no clear lead for infection control. The three practice nurses were equally responsible and were passionate about cleanliness in their own areas and within the practice. Infection control training for all staff was on the practice agenda to implement.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these in order to comply with the practice's infection control policy. There was also a policy available to staff about needle stick injury, and spillage packs (including mercury spillages) with information on how to use them.

Hand hygiene techniques signage was displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, electrocardiogram equipment, used to detect abnormal heart rhythms (ECG) and the fridge thermometer.

All rooms were kept secure and computers were maintained by the Clinical Commissioning Group (CCG). There was a panic button in room for security and these were checked to ensure they remained effective.

Staffing & Recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure there was enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave. Although staff were multi skilled, only emergency duties of the person on leave were covered.

Good

Are services safe?

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there as an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed, rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager had shared the recent findings from an infection control audit with the team.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly. In the notes of the practice's significant event meetings, we saw that a medical emergency concerning a patient had been discussed and appropriate learning taken place.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. The GPs did not routinely carry stocks of medicines for the treatment of emergencies on home visits. However patient symptoms were reviewed before the visit and specific medicines would be taken if felt required, such as if a child had a sever temperature or unidentified rash. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training and that fire drills were undertaken. Risks associated with service and staffing changes (both planned and unplanned) were monitored. We saw that staff were able to cover each other when required and specifically saw that GPs had covered each other during long term unplanned absence.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as dermatology, heart disease, mental health, asthma and sexual health and the practice nurses supported this work which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us they supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. The review of the clinical meeting minutes confirmed this happened.

We saw data from the local CCG of the practice's performance for antibiotic prescribing which was comparable to similar practices. The practice had also completed a review of case notes for patients with serious mental illness to ensure health checks were being completed. Data also showed the practice had high rates for flu vaccination when compared with other practices. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients such as suspected cancers which were referred and seen within two weeks as required. We saw minutes from meetings where review of elective and urgent referrals were made, and that improvements to practise were shared with all clinical staff.

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

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, child protection alerts management and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The practice showed us three clinical audits that had been undertaken in the last 12 months. The practice were able to demonstrate that changes had taken place following results of the audit. For example current prescribing practice at the surgery was improved by alerts on records when patients were started on dual anti-platelet therapy. We saw that an anti-platelet agent prescribing audit had been undertaken in January 2013, reviewed in 2014 and was due for further review in 2015. We saw that full audit cycles were taking place and changes to practice were implemented to improve outcomes for patients. We saw that audits were often linked to medicines management information, safety alerts or at the request of the CCG from quality and outcome framework (QOF) information.

Staff regularly checked that patients receiving repeat prescriptions were being reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP went to prescribe medicines. We were shown evidence to confirm that following the receipt of an alert the GPs had reviewed the use of the medicine in question and where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory

Good

Are services effective?

(for example, treatment is effective)

courses such as annual basic life support. A good skill mix was noted amongst the GPs who were trained in obstetrics, family planning, child health surveillance, sexual health, minor surgery, drug and alcohol issues, diabetes, kidney disease and mental health. One of the nurses had a particular interest in diabetes to the benefit of the patients at the practice with this long term condition.

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses for example sexual health, domestic abuse and diabetes care. The practice was a training practice and doctors who were in training to be qualified as GPs were offered longer patient appointments and had access to a senior GP throughout the day for support.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and the management of long term conditions. Those with extended roles, such as sexual health were able to demonstrate they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, X-ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received both electronically and by post. The practice had a process relevant to all staff about how to pass on, review and/or action any issues arising from communications on the day they were received. The GP seeing these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services are services which require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect.

The practice communicated regularly with other health and social care professionals to discuss the needs of complex patents such as those with end of life care needs or children on the at risk register. The GPs and staff reported difficulty in getting district nurses, social workers and health visitors to attend the practice for meetings since they had moved into a community setting. However they explained how communication was maintained through telephone conversations and regular email communication to ensure patients continued to receive multidisciplinary care when required.

Information Sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that the system was easy for them to use but some patients, such as those with mental health conditions, dementia or old age forgetfulness, required assistance. We saw examples of where they were helped to access their appointments.

For emergency patients, there was a practice policy of providing a printed copy of a summary record for the patient to take with them to A&E. A member of staff showed us how straightforward this task was using the electronic patient record system, and highlighted the importance of this communication with A&E.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. The clinical staff we spoke to understood the key parts of the legislation such as patient's

Good

Are services effective?

(for example, treatment is effective)

best interests and ability to consent and were able to describe how they implemented it in their practice. However there was no mention of mental capacity in the practice's consent policy.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. A patient with learning disabilities attended for a health review on the day of our visit and we saw evidence of how this person was supported.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health Promotion & Prevention

It was practice policy to offer all new patients registering with the practice a health check with the practice nurse. The GP was informed of all health concerns detected and these were followed-up in a timely manner. We noted a culture amongst the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example by offering smoking cessation advice to smokers or weight management assistance and blood pressure and cholesterol checks to patients who were overweight. Chlamydia screenings were undertaken at the sexual health clinic.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance Last year's performance for all immunisations was average for the CCG, and there was a clear policy for following up non-attenders by the named practice nurse.

Diabetic patients were seen annually if their condition was well controlled and more often if required. If issues arose patients were given diet advice and more regular repeat appointments and they continued to be monitored until their condition was stable. If necessary, the patient would be referred on to specialist advisers and were usually seen within four to six weeks of referral.

The practice website and surgery waiting areas provided various up to date information on a range of topics and health promotion literature was readily available to support people considering any change in their lifestyle

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey where 119 patients responded. The national GP Patient Survey is an independent survey run by Ipsos MORI on behalf of NHS England. Full details of the practice results are available on the internet. Some comments about the appointment system reported that patients were frustrated but the practice had acknowledged this and were constantly reviewing access and the services offered.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 34 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We spoke with eight patients on the day of our inspection, all who said they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We saw that staff treated all patients equally. Help was given to those more vulnerable such as people with physical or mental disabilities and we saw patients in those circumstances being given appropriate assistance or advice by staff with appropriate knowledge and experience.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. 89% of respondents say the last GP they saw or spoke to was good at treating them with care and concern, 93% said the last GP they saw or spoke to was good at listening to them and 88% said that the last GP they saw or spoke to was good at explaining tests and treatments. These figures were all above average for the local CCG.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. Patients also told us they were satisfied with the services offered by the practice and felt able to make informed decisions about the choices of treatment they wished to receive.

Staff were knowledgeable about how to assist people whose first language was not English and they had access to translation services.

There was evidence of care plans and patient and carer involvement for older people and patients with long term conditions also had care plans and information about their treatment options. In particular one of the nurses at the practice was very passionate about diabetes care and showed us examples where she identified early diagnosis or possible triggers to prevent and care for patients with the condition. We also saw evidence of good explanation and empathy towards patients with learning disabilities.

Patient/carer support to cope emotionally with care and treatment

We saw evidence that all the staff were able to provide emotional support. Nurses described incidences when they had gone over and above expectation to support a person with their treatment. Patients we spoke to said they always had enough time to discuss their problems and could make longer appointments if they needed them. We saw that staff who carried out triage consultations were knowledgeable and helpful and were able to conclude some consultations without the need to bother a GP or nurse. These included discussions around repeat prescriptions, queries about test results and how to access secondary services or other support services available.

There was information on what to do in times of bereavement and patients we spoke with told us they were supported through all emotional circumstances. 94% of patients who responded to the GP survey said they had confidence and trust in the last GP they saw or spoke to.

During observation we saw that staff were careful to protect confidentiality. The triage system was located away

Good

Are services caring?

from the reception desk to maintain patient privacy during telephone consultation and discussion. We saw that there was no glass partition at reception and some conversations could be overheard when patients queued. However, none of the patients we spoke reported privacy as an issue and seating was far enough away from reception to maintain privacy when there was no queue.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive and had systems in place to maintain the level of service provided. They reviewed the needs of their local population and engaged with the Clinical Commissioning Group (CCG) to secure service improvements where these were identified. We saw minutes of meetings of discussions and actions agreed to make changes. For example new premises which was an ongoing issue for the practice was constantly discussed as was the appointments system. However, one of the GPs had reduced their clinical time at the practice to spend more time with the Clinical Commissioning Group and this had led to a reduction in some services previously offered by the practice, such as minor surgery.

There had been very little turnover of staff during the last three years which enabled good continuity of care and accessibility to appointments with a GP of choice. Longer appointments were available for people who needed them and those with long term conditions. This also included appointments with a named GP or nurse. Home visits were made to a local care home on a weekly basis in order to influence better communication with the staff and home manager and provide continuity of care for the people at the home.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG) For example the appointment system and a suggestion to use a smart phone application for managing repeat prescriptions. When required the practice put on extra sessions, for example during winter months.

Tackle inequity and promote equality

The practice worked collaboratively with other agencies and regularly shared information to ensure good, timely communication of changes in care and treatment. For example the practice regularly meeting with palliative care nurses and staff from the local hospice. We saw evidence where this communication made care and treatment more effective for patients at the end of their lives. In addition, the practice had a carer's register and kept constant communication with those people caring for either members of their family or other patients who required regular assistance. We saw that those patients with learning disabilities were offered specific clinics and one of the GPs was trained specifically in drug and alcohol treatment.

The practice had recognised the needs of different groups in the planning of its services. Staff reported that there was little diversity within their patient population. However they were knowledgeable about language issues and described a time where they had used an interpreter to the benefit of the patient. They also described awareness of culture and ethnicity and understood how to be respectful of patients' views and wishes. Staff were trained in equality and diversity and nursing appointments had recently been altered so that patients with long term illnesses could be reviewed at one annual appointment.

Doors were automated and there was enough space and the building complied with the Disability Discrimination Act 1995 (DDA). All consulting rooms were on the ground floor with corridors and doors wide enough for wheelchairs. Car parking and disabled car parking spaces were available on site.

Access to the service

Telephone consultations were available on a daily basis which led either to treatment over the telephone, a home visit or the offer of a longer appointment if required. Families, children and young people could access appointments outside of school house and a sexual health clinic was available on a Wednesday evening and a Saturday morning. We saw Saturday appointments being offered by the triage staff to people who telephoned and were unable to attend the surgery during working hours. We saw partnership working for those people whose circumstances may make them vulnerable and there were regular meetings offered for consultation with community matrons, district nurses and other teams such as drug and alcohol or mental health. However the practice reported that these meetings were becoming more difficult since local multi-disciplinary staff had moved into the community. In order to combat issues and promote joint working, telephone conferences were offered and carried out where ever possible.

The practice was open Monday to Friday (except Wednesday) from 8.30am until 6.30pm closing every day between 12.30pm and 2pm. On a Wednesday the practice closed at 1pm. Consultations were by appointment from

Good

Are services responsive to people's needs?

(for example, to feedback?)

8.30am until 11.30am and 2pm until 6pm every day (except Wednesday when they did not re-open in the afternoon). The practice also opened on a Saturday morning from 9.30am until 12.30pm for patients who worked or had difficulty attending during the week. In addition on a Saturday morning and Wednesday evening there was a sexual health clinic which offered a service to all patients in the community and not just practice patients.

There were five GPs (three male and two female) offering medical consultations and three female practice nurses. An administration team of eight and a full time practice manager were employed in the running of the practice.

Comprehensive information was available to patients about appointments in the practice leaflet and on the practice website. Information included details on how to access urgent appointments and home visits. It also promoted the triage service. If patients called the practice when it was closed they received detailed information on how to access the out of hours service.

Some patients were frustrated with the triage and appointment system. The practice had recognised this and were continually reviewing their appointment system and trying to improve accessibility. On the day of our inspection they secured funding for the whole of the CCG to have their appointment system reviewed by an outside consultant.

Listening and learning from concerns and complaints

The practice listened to patients' concerns about the appointment system and were constantly reviewing this to make improvements. The telephone system had recently been updated to provide feedback so that auditing could be carried out. On the morning of our inspection the practice received 289 incoming telephone calls. They were able to assess that 82 of those calls had been abandoned and 103 had required call back. They explained that they would continue to use this information to analyse and review the services they provided. They were also able to record all calls for training purposes.

There was a system in place for handling complaints and concerns. The complaints policy and procedure was in line with recognised guidance and contractual obligations for GPs in England with a designated person responsible for handling complaints in the practice. We saw information available to help patients understand the system such as leaflets and posters in reception. Staff were aware of the process and were able to advise and direct patients appropriately. Staff we spoke to gave us examples where concerns or complaints had been escalated and resolved. We saw examples where complaints received had been dealt with appropriately and learning had been shared.

Are services well-led?

Good

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

Our findings

Vision and Strategy

Discussions and evidence we reviewed identified that the management team had a clear vision and purpose to provide an appropriate and rewarding experience for their patients whenever they needed support. Their values included openness, fairness, respect and accountability . The GPs we spoke with demonstrated an understanding of their area of responsibility and they took an active role in ensuring that a high level of service was provided on a daily basis. All the staff we spoke with said they felt they were valued and their views about how to develop the service were acted upon.

The practice website stated that the practice were interested in the views of their patients and carers and these views were used to consider how the service could be improved. We spoke with 11 of the staff available on the day of our inspection and they all knew and understood the vision and values and their responsibilities thereto. We observed respect and openness throughout and staff who helped each other to achieve good service delivery.

GPs and the practice manager attended neighbourhood and Clinical Commissioning Group (CCG) meetings to identify needs within the community and tailored their services accordingly. They worked with local safeguarding, domestic violence and young people's organisations to make sure they were aware of the requirements within their patient population.

Governance Arrangements

We saw systems in place for monitoring all aspects of the service such as complaints, incidents, safeguarding, risk management, clinical audit and infection control. Each topic had a practice lead and reception and administration staff were included in areas of responsibility such as monitoring appointments and introducing systems to improve the smooth running of the practice. All staff we spoke with were aware of each other's responsibilities and who to approach to feedback or request information. Those systems and feedback from staff showed us that strong governance structures were in place.

The practice manager took an active role for overseeing the systems in place to ensure they were consistent and effective. The GP partners were also pro-active in that process. The practice manager was also responsible for ensuring that policies and procedures were kept up to date and that staff received training appropriate to their role. There was evidence that feedback from patients was discussed with all staff and learning was applied.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice nurse told us about a local peer review system they took part in with neighbouring GP practices and doctors used information from their appraisals to inform and improve their clinical practice and share learning with all staff.

Leadership, openness and transparency

The practice welcomed input from patients and staff and acted on feedback received. Staff understood their roles and were clear about the boundaries of their abilities. They told us they felt supported in their roles and were able to speak with the practice manager or any of the GPs and nurses at any given time about personal or work related concerns. Staff were given lead responsibilities and opportunities for progression and the practice manager was planning on giving out more lead roles to make the practice more effective. Staff told us they felt valued and rewarded for the good work they provided.

Appraisals for reception and administration staff were undertaken by the practice manager and the nursing staff were appraised jointly by the GPs and the practice manager. Appraisals for all staff were due again in February 2015 and we saw evidence in staff files of completion in 2014.

Staff meetings were held weekly and monthly, dependent on the requirement and there was an open culture with an opportunity for all staff to raise concerns, good practice and general information sharing.

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

The practice had gathered feedback from patients through national surveys, patient participation group (PPG) questionnaires and comment cards. We looked at the results of the annual patient survey and saw that 90%

Are services well-led?

Good

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

described their overall satisfaction of the practice as good. The practice did less well when it came to patient experience of accessing appointments, and they were continually changing their systems so as to improve this. We saw comments received following a PPG questionnaire and saw that these were all positive. We also saw ongoing negotiations with the Clinical Commissioning Group about lack of space and what could be done to make improvements.

A whistle blowing policy was available to all staff in the staff handbook and electronically on any computer within the practice. Staff understood the policy and the process to raise concerns. The staff we spoke to said they would not feel uncomfortable if they were faced with a need to raise a concern and initially would go to the practice manager. Two staff we spoke with gave us examples where their feedback had been listened to and changes made to working practice in order to make improvements.

Management lead through learning & improvement

We saw a clear understanding of the need to ensure that staff had access to learning and improvement opportunities. Newly employed staff had a period of induction as did any locum staff. Learning objectives for existing staff were discussed during appraisal and mandatory training was role relevant. E-Learning was carried out and one member of staff showed us how they could access information on the internet to improve their knowledge. A core set of training was provided by the local area team for all staff and this was monitored on an annual basis with all staff requiring update or renewal at the same time.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals included a personal development plan. Staff told us that the practice was very supportive of training and that they were encouraged to develop.

One of the GPs had recently become a trainer and this had enabled the practice to become a training practice. The GPs also held regular in-house peer review to review outcomes for patients, share learning and improve their clinical practice.