Meir Park Surgery

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 inspected this service on 5 December 2014 as part of our new comprehensive inspection programme.

The overall rating for this practice is good. We found the practice to be good in the safe, effective, caring, responsive and well led domains. We found the practice provided good care to older people, people with long term conditions, families, children and young people, people whose circumstances may make them vulnerable and working age people but requires improvement for people experiencing poor mental health.

Our key findings were as follows:

- There were arrangements in place for staff to report and learn from key safety risks. The practice had a system in place for reporting, recording and investigating significant events but needs to develop a system to monitor significant events over time.
- There were systems in place to keep patients safe from the risk and spread of infection however, a system should be put in place to ensure the cleaning of portable screens used to maintain patient's dignity and privacy. Systems were in place to monitor and make required improvements to the practice when required.
- Patients were satisfied with how they were treated and this was with compassion, dignity and respect.
- Most patients told us they were satisfied with the appointments system and that it met their needs.

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

The provider should:

- Introduce a system to review significant events and complaints overtime to detect themes or trends.
- Ensure that all staff receive training in safeguarding vulnerable adults.
- Introduce a system to ensure that patients who require a follow up appointment following abnormal test results are appropriately followed up.
- Introduce a system to ensure that the portable screens used to provide privacy during an intimate examination are cleaned regularly.

Summary of findings

- Introduce a system to check that professional registrations are current and in date.
- Ensure that patients experiencing poor mental health and patients with dementia are provided with an annual health review.
- Introduce a system for reviewing policies to ensure they are current and up to date.
- Develop a long term business plan incorporating potential risks to the practice

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to 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.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed most patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included promoting good health. Staff had received training appropriate to their roles apart from the Mental Capacity Act 2005 and any further training needs have been identified and planned. The practice could identify all appraisals and the personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easier to make an appointment with a named GP since the introduction of the new telephone system and that there was continuity of care, with urgent appointments available the same day.

Summary of findings

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand. Learning from complaints with staff and other stakeholders was shared at clinical and team meetings.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care patients receive. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in 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 end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. All these patients had a structured annual review to check that 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.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

To engage and involve children and young people in decisions about their care, the practice had established a page on 'You Tube' where short educational videos were available addressing the health needs of young people. They were also in the process of establishing a 'Facebook' page to support young people to access their service.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had

Summary of findings

been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs of this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability and offered longer appointments for people with a learning disability.

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

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia). Only 40% of people with dementia registered with the practice had received a health review. The practice worked with multi-disciplinary teams in the case management of people experiencing poor mental health but not always those with dementia. Only 75% of patients experiencing poor mental health had an agreed care plan in place.

The practice had a system in place to follow up patients who had attended A&E where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

Four of the five patients we spoke with on the day of our inspection were complimentary about the care and treatment they received. We reviewed the 11 patient comments cards from our Care Quality Commission (CQC) comments box that had been placed in the practice prior to our inspection. We saw that comments were mostly positive. Patients told us the staff were respectful, helpful, efficient and caring. They said the nurses and doctors listened and responded to their needs and they were involved in decisions about their care. Patients told us that the practice was always clean and tidy. Some patients told us it could be difficult getting an appointment but others told us access to appointments had recently improved.

The results from the National Patient Survey showed that 78% of patients said that their overall experience of the practice was good or very good and that 61% of patients would recommend the practice to someone new to the area. This was below the regional Clinical Commissioning Group (CCG) average. Ninety-three per cent of patients who responded to the survey said they found the receptionists helpful.

Areas for improvement

Action the service SHOULD take to improve
Action the provider SHOULD take to improve:

The provider should introduce a system to review significant events and complaints overtime to detect themes or trends.

All staff should receive training in safeguarding vulnerable adults.

The provider should introduce a system to ensure that patients who require a follow up appointment following abnormal test results are appropriately followed up.

The provider should introduce a system to ensure that the portable screens used to provide privacy during an intimate examination are cleaned regularly.

The provider should introduce a system to check that professional registrations are current and in date.

Patients experiencing poor mental health should be provided with an annual health review.

The provider should introduce a system for reviewing policies to ensure they are current and up to date.

The provider should develop a long term business plan incorporating potential risks to the practice.

Meir Park Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

a Care Quality Commission (CQC) lead inspector. The lead inspector was accompanied by a GP specialist advisor and an expert by experience who had personal experience of using primary medical services.

Background to Meir Park Surgery

Dr Sarin & Partners provide primary medical services to patients living in Stoke-on-Trent at their main practice, Meir Park Surgery and their branch practice based in Meir Primary Care Centre.

A team of two GP partners, three nurses, a health care assistant, a business manager, a deputy practice manager, seven receptionists and one administrator provide care and treatment for approximately 4700 patients. Both of the GPs are male. The practice is a training practice for medical students to gain experience in general practice and family medicine. The practice do not provide an out-of-hours service to their own patients but they have alternative arrangements for patients to be seen when the practice is closed.

Why we carried out this inspection

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

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

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before carrying out our inspection, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. Prior to our

Detailed findings

inspection we spoke with a spokesperson from the Patient Participation Group (PPG) and a representative from the Integrated Local Care Team (ILCT). PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care patients receive. We carried out an announced visit on 5 December 2014. During our inspection we spoke with two GPs, one medical student, one nurse, three receptionists, one administrator, the business manager, the deputy practice manager and five patients. We observed how patients were cared for. We reviewed 11 comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, staff told us how procedures had been changed following an incident where a delivery of vaccines to the practice had not been put into the fridge to ensure they were stored in line with the manufactures' guidelines.

We reviewed safety records, significant event reports and minutes of meetings where these were discussed over the last year. The practice had only recorded and investigated significant events since 2013 so could not demonstrate 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. There were records of significant events that had occurred during the last 12 months and we reviewed these. Significant events were a standing item on the practice meeting agenda and we saw minutes of dedicated significant events meetings that had been held following each significant event. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff knew where to locate significant event forms and sent completed forms to the deputy practice manager. The deputy practice manger showed us the system they used to manage and monitor these. We tracked five significant events and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, a policy had been developed clarifying the responsibilities of the receptionists when receiving parcels. This was to ensure that vaccines were placed in the vaccine fridge immediately to ensure they were stored in line with the manufactures' guidelines. Receptionists we spoke with were aware of the changes. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by the deputy practice manager to practice staff. Staff we spoke with gave examples of recent alerts such as the Ebola crisis that were relevant to the care they were responsible for. They also told us of alerts they received from the local Clinical Commissioning Group (CCG) regarding which type of diabetic blood monitoring machine to use. They told us alerts were discussed within clinical meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

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

The practice had appointed a dedicated GP as the lead for safeguarding vulnerable adults and children. We saw certificates that demonstrated the GP had received the higher level three training in safeguarding children and young people. However, there was no evidence confirming that the GP had received training in safeguarding vulnerable adults and they were unable to confirm if they had. All the staff we spoke with were aware who the lead was and who to speak to in the practice if they had a safeguarding concern.

There was a chaperone policy in place at the practice. Posters were on display on the waiting room noticeboard and in consulting rooms informing patients of their right to have a chaperone present during an intimate examination. Nursing staff told us they had received chaperone training as part of their nurse training and kept themselves up to

date by reading latest guidance and nursing journals. Health care assistants who chaperoned told us they had received chaperone training. Staff we spoke with who chaperoned clearly understood their responsibilities when acting as chaperones, including where to stand to observe the examination and what to do if they had any concerns regarding the examination. Safeguarding checks had been completed for all clinical and administrative staff who carried out chaperoning duties.

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system, EMIS web, which collated all communications about the patient including scanned copies of communications from hospitals and results from tests and X-rays. Patients were informed to contact the practice for their test results. If urgent action was identified by a GP, a receptionist was contacted and informed to contact the patient to arrange a follow up appointment. However, there was no follow up system in place to identify that this had been done and that the patient had been seen.

There was a system to highlight vulnerable adults and children on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments.

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 that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy. We checked the home visit bag of one of the GPs. We saw that the bag contained appropriate medicines to deal with emergencies they may have to deal with on a home visit and that all of the medicines were in date. The GPs did not carry prescription pads when they went on home visits but carried one blank prescription to reduce the chance of theft.

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.

Medicines were administered safely. We saw there were signed Patient Group Directions (PGD) in place to support the nursing staff in the administration of vaccines. A PGD is a written instruction for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. All of the PGDs were in date and fit for purpose. We reviewed the latest data available from NHS England and saw that the practice was inline or above the CCG regional average in the delivery of all childhood immunisations.

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 generated prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were appropriate and necessary.

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

Cleanliness and infection control

We observed the premises to be clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. We saw there were cleaning schedules in place and cleaning records were kept. We saw that the cleaning schedules did not include a procedure for the regular cleaning of the portable screens used to provide privacy during an intimate examination. The deputy practice manager told us that they would purchase a steam machine to clean the screens on a regular basis.

The practice had an infection control lead. All staff received induction training about infection control specific to their role and received three yearly updates. We saw evidence that infection control audits had been carried out in August 2014 but they had not identified the need for the portable screens to be cleaned at regular intervals.

An undated infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. 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 to comply with the practice's infection control policy. There was also a policy for needle stick injury, There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We saw evidence that their disposal was arranged through a suitable company.

The practice had taken reasonable steps to protect staff and patients from the risks of health care associated infections. We saw that clinical staff had received the relevant immunisations and support to manage the risks of health care associated infections. We saw that an in-house legionella risk assessment had been completed in November 2014 to protect patients and staff from harm. Legionella is a virus found in the environment which can contaminate water systems in buildings. Staff described to us the procedures they followed to prevent the growth of the virus and knew where to locate the legionella policy if they needed to refer to it for support and guidance. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

Equipment

Patients were protected from unsafe or unsuitable equipment. Emergency equipment such as a defibrillator (an electronic device that applies an electric shock to restore the rhythm of an irregular heart) was available for use in a medical emergency. We saw that the equipment was checked monthly to ensure it was in working order and fit for purpose. Staff we spoke with told us they had enough 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 had been tested in November 2014 and displayed stickers indicating the last testing date. We saw evidence that calibration of relevant equipment, for example weighing scales and blood pressure monitoring devices, had been completed in February 2014.

Staffing and 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 through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff although it did not include checking for gaps in employment history. Whilst the practice had checked that professionals were registered with their appropriate professional body at the time of their recruitment, there was no on going system in place to check that their registrations remained current and in date. We looked in the records of one of the nursing staff and saw that it was documented that their registration had expired in September 2014. During our inspection we asked the deputy manager to check on-line that all nursing and GP professional registrations were in date and that staff were fit to practice and we saw that they were.

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 that enough staff were 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 however some staff told us this was sometimes difficult to manage. We saw that at times there was only one receptionist at the practice's branch practice meaning they had to leave the reception area unattended when taking comfort breaks. On one occasion a patient had become abusive and the receptionist had to rely on staff from another practice in the building to support them. The deputy practice manager said that they would review this arrangement to ensure that staff were not left on their own at the branch practice.

Monitoring safety and 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 and had completed Control of Substances Hazardous to Health (COSHH) risk assessments.

There was a system to highlight vulnerable patients on the practices' electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. The practice used an urgent care dashboard to identify and monitor the number of A&E attendances for children and vulnerable adults. They told

us if they identified a child or vulnerable adult with a high A&E attendance they would call the patient/parent in to educate them in the appropriate use of the A&E department. They told us that if they had any concerns about a patient they would liaise with the appropriate support agencies.

There were emergency processes in place for identifying acutely ill children and young people and staff gave us examples of referrals made. All the staff we spoke with told us that children were always provided with an on the day appointment if required. The practice had started to use a risk assessment tool to help them to identify and support patients with complex long term conditions. This included closer working with the Integrated Local Care Team (ILCT), a team that included health and social care staff such as community matrons and social workers. We spoke with a member of the ILCT who confirmed that the practice worked closely with them in managing risks to patients although sometimes it was difficult to get to speak to a GP as soon as they needed to.

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 (an electronic device that applies an electric shock to restore the rhythm of an irregular heart). All staff we spoke with knew the location of this equipment and records we saw confirmed these were checked on a monthly basis to ensure they were fit for purpose.

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, anaphylactic shock and low blood sugar. 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.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included loss of domestic services, flood, staff shortages and IT failure. However, there were no contact numbers in the business continuity plan to provide a quick reference of who to contact in an emergency.

A fire risk assessment had been carried out in June 2014 that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken. The practice had a Health and Safety policy that included fire prevention and safety and this was covered during new staff inductions. Staff we spoke with clearly described their roles and responsibilities in keeping patients safe in the event of a fire.

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 approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines. However, the practice did not have a systematic way of reviewing and evaluating which NICE guidelines were appropriate for their patients or that NICE guidelines had been implemented.

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

A GP partner showed us data from the local Clinical Commissioning Group (CCG) of the practice's performance for antibiotic prescribing. We saw that the practice had over prescribed the antibiotic Co-amoxiclav. We saw that an audit of the prescription of this antibiotic had been carried out and recommendations had been made to reduce the use of this antibiotic. However, a second audit had not been carried out to demonstrate if the changes made had been effective.

The practice used a risk profiling tool to identify frail and elderly patients with complex needs. We saw that an action plan had been put in place by the practice to help to address their needs. The practice also worked closely with the Integrated Local Care Team (ILCT) to support patients with long-term complex needs. We spoke with a member of the ILCT who confirmed this.

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 ethnicity was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing medicines management. The information staff collected was then collated by the business manager and deputy 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 two years. Two of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, an audit of the number of patients with chronic kidney disease (CKD) registered with the practice had been carried out. As a result of the audit, the practice had identified additional patients with CKD who were not on the practice's CKD register. These patients were added to the practice's CKD register so that they received the most appropriate treatment and received timely health reviews. The audit was repeated and action plans put in place to provide ongoing monitoring of their condition.

The practice also used the information collected for the quality and outcomes framework (QOF) to monitor outcomes for patients. QOF is a national performance measurement tool. For example, the practice was an outlier for the percentage of patients diagnosed with dementia whose care had been reviewed in a face-to-face review in the preceding 12 months. The practice also participated in the local Clinical Commissioning Group's (CCG) Quality Improvement Framework (QIF). We saw that this supported these findings with only 40% of patients diagnosed with dementia who had received a face-to-face health review in the preceding 12 months. Only 75% of patients experiencing poor mental health had an agreed care plan in place. The registered manager told us many of these patients were housebound so patients did not always attend their appointments when needed. As a result of this, the GPs had started to carry out home visits to ensure health reviews were carried out and care plans were put in place.

The practice used an urgent care dashboard to identify and monitor the number of A&E attendances for children and vulnerable adults. They told us if they identified a child or vulnerable adult with a high A&E attendance they called

the patient/parent in to educate them in the appropriate use of the A&E department. They told us that if they had any concerns about a patient they would liaise with the appropriate support agencies.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as chronic obstructive pulmonary disease and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

The practice worked towards the gold standards framework for end of life care. It had a palliative care register and held three monthly multidisciplinary meetings with district and palliative care nurses to discuss the care and support needs of patients and their families. We saw minutes that confirmed this. As a consequence of staff training and better understanding of the needs of patients, the practice had increased the number of patients on the register to 18.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar practices in the area. This benchmarking data showed the practice had outcomes that were comparable with other services in the area for the monitoring of blood pressure, cholesterol and retinal screening in patients with diabetes.

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 courses such as annual basic life support, however they had not attended training in the mental capacity act 2005. All the GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice provided training and funding for relevant courses although some staff told us they had to undertake training in their own time. The practice was a training practice for medical students. We spoke with one medical student who spoke positively about the support and education they received from the practice.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, the administration of vaccines and the performing of cervical screening. Those with extended roles were also able to demonstrate that they had appropriate training to fulfil these roles. We saw training certificates and other documentation demonstrating that one of the nurses had completed training in long-term conditions such as diabetes and asthma.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw 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 held regular multidisciplinary team meetings with other services to discuss the needs of complex patients, for example those with end of life care needs or patients with complex long-term conditions. District and palliative care nurses attended meetings for patients near the end of their life and decisions about care planning were documented in their care record. They also held weekly meetings with the midwife.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Staff reported that this system was easy to use.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient

Good

Are services effective?

(for example, treatment is effective)

record in their computer system, EMIS web, to co-ordinate, document and manage patient's 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 (MCA) 2005 and their duties in fulfilling it. Mental capacity is the ability to make an informed decision based on understanding a given situation, the options available and the consequences of the decision. People may lose the capacity to make some decisions through illness or disability. We looked at the training records for three members of staff and saw that staff had not received formal training in the MCA 2005 so they could not be sure they were up to date with current guidance.

All clinical staff demonstrated a clear understanding of Gillick competence. A Gillick competent child is a child under 16 who has the legal capacity to consent to care and treatment. They are capable of understanding implications of the proposed treatment, including the risks and alternative options. Nursing staff told us how they considered Gillick competence when a young person attended for contraceptive advice. Nursing staff described to us how they ensured that parents who bought their children for immunisations were provided with information to enable them to make an informed decision when providing consent.

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. Two of the patients we spoke with on the day of our inspection confirmed that they had been asked to provide consent when receiving immunisations and treatment.

Health promotion and prevention

The practice had met with the CCG to discuss the implications and share information about the needs of the practice population. They used the data from QIF and QOF to help to identify these needs.

It was practice policy to offer a health check with a GP to all new patients registering with the practice. Information about how to register with the practice was available on the practice's website and at the reception desk. The practice offered NHS Health Checks to all its patients aged 45-75 and travel vaccinations when needed. Patients over 75 years of age had a named GP to provide continuity of care. Walk-in 'flu vaccination sessions were held twice weekly at the practice for older patients and those with certain long term conditions. Childhood vaccinations and child development checks were offered in line with the Healthy Child Programme. Last year's performance for all immunisations was in line with the CCG regional average. The nursing team offered additional health promotion services including lifestyle consultations, family planning and smoking cessation.

The practice had several ways of identifying patients who needed additional support. For example, the practice kept a register of 309 patients with asthma. We looked at the QIF data and saw that 76% of these patients had received an annual health review. We saw that the practice nurse used a template when reviewing the health of patients with asthma to ensure they received a robust assessment in line with NICE guidelines.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey published on 3 July 2014 and a survey of 122 patients undertaken by the practice's patient participation group (PPG). PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care patients receive.

The evidence from all these sources showed that not all patients were satisfied with how they were treated. For example, data from the national GP patient survey showed that 78% of respondents said their overall experience was good and 61% of respondents would recommend the surgery. These results were below the regional Clinical Commissioning Group (CCG) average. We saw that the practice had reviewed the reasons for this and identified dissatisfaction with access to appointments as the main cause of concern. As a result of this, they had changed their telephone system to improve access to appointments by the telephone. They had also extended their opening times to provide more appointments. Most patients we spoke with on the day of our inspection and the comment cards that we reviewed confirmed there had been improvements in access to appointments. The practice was also below the CCG regional average for its satisfaction scores on consultations with doctors. Eighty-five per cent of practice respondents said the GP was good at listening to them and 82% said the GP gave them enough time. In contrast to this, the practice was above the CCG average with a satisfaction score of 93% of respondents who found the receptionists helpful. The PPG survey showed that 86% of respondents felt that they were treated with dignity and respect.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 11 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered a good service and staff were respectful, helpful, efficient and caring. They said staff treated them with dignity and respect. Three comments were less positive but there were no common themes to these. We also spoke with five patients on the day of our inspection. All told us 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. Portable screens were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We saw that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

The position of the reception desk at the main practice made it difficult for confidential conversations to take place. A member of the PPG told us that this was an issue they had raised with the practice. We saw that to address this issue, the practice switchboard had been re-located away from the reception desk and was shielded by a partition to help to keep patient information private. Reception staff that we spoke with were aware of the difficulties. We saw they were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. There was a poster displayed in the waiting room informing patients that they could request a private room if they needed to hold a private conversation with a receptionist. The poster was not clearly visible however when standing at the reception desk. The deputy practice manager told us that they planned to introduce small laminated cards at the reception desk that patients could discreetly hand to the receptionist if they required a confidential conversation.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the deputy practice manager. The deputy practice manager told us they would investigate these and any learning identified would be shared with staff. The practice's website clearly stated the practice's zero tolerance for abusive behaviour. We saw that there was a violent and aggressive patient's policy for staff to refer to for support and guidance.

We saw that staff had received training in equality and diversity and that there was a policy for them to refer to. Staff described how they supported patients to access the practice without fear of stigma or prejudice.

Good

Are services caring?

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded less positively to questions about their involvement in planning and making decisions about their care and treatment than patients in other practices in the region. For example, data from the national patient survey showed 72% of practice respondents said the GP involved them in care decisions and 78% felt the GP was good at explaining treatment and results. However, the results from the practice's own satisfaction survey showed that 83% of patients said the GPs were good at explaining their care and treatment and 84% said they felt that the GPs listened to them. The comment cards we reviewed and the patients we spoke with on the day of our inspection told us they felt involved in decisions about their care.

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

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. The two GPs spoke three different languages too. To engage and involve children and young people in decisions about their care, the practice had established a page on 'You Tube' where short educational videos were available addressing the health needs of young people. They were also in the process of establishing a 'Facebook' page to support young people to access their service. Patients with long-term conditions such as asthma and chronic obstructive pulmonary disease (COPD) were provided with double appointments to carry out an annual review of their health needs. We saw evidence that care plans had been completed for these patients and that they were involved in agreeing these.

Patient/carer support to cope emotionally with care and treatment

The PPG survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 82% of respondents to the PPG survey said they felt the clinical staff were concerned about their well-being. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. The practice held a register of 18 carers. Once a carer was identified by either a new patient registration or through the practice's risk profiling tool, they were contacted by the senior receptionist to inform them of avenues of support and the telephone numbers to access them.

Patients nearing the end of their life had their care and support reviewed at three monthly multidisciplinary meetings which included practice staff, district and palliative care nurses. A GP told us that as a result of working closely with the families of patients nearing the end of their lives, they had developed a strong rapport with them. When a patient died, the GPs rang the families to offer an appointment or a home visit.

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 to most patients' needs and was adapting systems to meet the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS England Local Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery changes to its population. For example, we saw that the practice had been in discussion with the CCG regarding their Quality and Outcomes Framework (QOF) and Quality Improvement Framework (QIF) results. QOF is a national performance measurement tool and QIF is a local performance measurement tool. They had identified that the practice needed to address how they delivered services to patients with cancer, dementia and depression. As a result of this, GPs had started to carry out home visits for patients diagnosed with dementia whose care had not been reviewed in the preceding 12 months. Additional nursing hours had also been put in place to meet the needs of patients. We saw that only 75% of patients experiencing poor mental health had an agreed care plan in place. The practice told us that they had updated their recall system for these patients and if patients were unable to attend the practice, they would be provided with home visits. They also told us that patients experiencing poor mental health were guaranteed same day consultations.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care patients received. For example, following concerns raised by the PPG regarding access to appointments, a new telephone system had been put in place to enable easier access to the practice and appointments could be booked on line.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. There were extended opening hours twice a week to support working age patients and school age children to access the practice outside of normal working hours. In addition to this, the practice had recently started to open on Saturday mornings. To engage with young people, the practice was developing social media outlets through Face Book and You Tube. The practice population was mainly English speaking but the practice staff had access to a telephone translation service if patients could not speak English. The practice did not have any registered homeless patients but they told us they had a policy to accept homeless patients and any patient who lived within their practice boundary irrespective of ethnicity, culture, religion or sexual preference.

We saw training certificates confirming that staff had received training in equality and diversity. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months. They were aware of where to locate the equality and diversity policy if they needed to refer to it for guidance and support.

The premises met the needs of patients with disabilities. There was disabled parking available and step free access to the entrance doors. A wheelchair was available for patients upon request. The practice was situated on the ground floor of the building with easy access to the reception area. We saw that the waiting area was quite small but managed to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including disabled toilets.

Access to the service

Appointments were available from 8am to 6 pm on weekdays except Thursday afternoons when the practice was closed. There were extended opening times till 7.45pm at the main practice on Wednesdays and the branch practice on Mondays. The practice also opened on Saturday mornings. This supported working age patients and school age children to access appointments at the practice.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and

Good

Are services responsive to people's needs?

(for example, to feedback?)

how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were available for patients who needed them and for those with long-term conditions or learning disabilities. Home visits were available upon request or to house bound patients.

Data from the national GP patient survey showed that 66% of respondents found their experience of making an appointment as good. This was below the CCG regional average. Most patients we spoke with and the comment cards that we reviewed showed that patients were generally satisfied with the appointments system. They commented that access to appointments had improved following the introduction of the new telephone system and the extended opening hours. The practice had not carried out an audit of appointments however, to determine if the changes they had made had improved patient satisfaction with the appointment system. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, one patient we spoke with told us they rang at 8.10am on the day of our inspection and had been given an appointment the same day.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system through information available in the waiting room and on the practice website. However, this information only informed patients of who to contact at the practice and not of other agencies they could go to for support. Most patients we spoke with were not aware of the process to follow if they wished to make a complaint but none of them had needed to complain.

We looked at four complaints received in the last 12 months and found complaints were handled satisfactorily and there was openness and transparency in dealing with the complaints. However, the timeframes identified in the practice's complaints policy were not always kept to. For example, the response to one complaint was longer than the 10 days described in their policy.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice told us they had a vision to deliver high quality care and promote good outcomes for patients by putting them at the centre of the service. We found details of the vision and practice values were part of the practice's statement of purpose. We saw no evidence however that the vision and values had been shared with patients either in the waiting room or on the practice's website. The business manager told us of the plans they had for the future of the practice however, there was no short or long term business plan in place outlining these plans, identification of potential risks to the practice or how they would be managed.

We spoke with 10 members of staff and they all demonstrated an understanding of the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the intranet on any computer within the practice or as paper copies. We looked at 12 of these policies and saw that there was no formal structure in place for reviewing the policies to monitor that they were current and up to date. Most of the policies had not been reviewed since the beginning of 2013.

There was a leadership structure with named members of staff in lead roles. For example, there was a lead for day to day operational matters, a lead for strategic issues and the senior partner was the lead for safeguarding. We spoke with 10 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns. We saw that the deputy practice manager had identified the risk to the service if a member of staff left the practice taking with them their knowledge and experience. To manage this risk, all reception staff were trained in all areas of reception work to ensure a sharing and understanding of roles and responsibilities.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. QOF is a national performance measurement tool. We saw that the practice was performing slightly below national standards scoring 92 points out of a possible 100 points. We saw that the percentage of patients diagnosed with dementia whose care had been reviewed in a face-to-face review in the preceding 12 months was below the national average. The practice also participated in the local Clinical Commissioning Group's (CCG) Quality Improvement Framework (QIF). We saw that this supported these findings with only 40% of patients diagnosed with dementia who had received a face-to-face health review in the preceding 12 months. The registered manager told us many of these patients were housebound so patients did not always attend their appointments when needed. As a result of this, the GPs had started to carry out home visits to ensure health reviews were carried out and care plans were put in place.

The practice had completed clinical audits to monitor quality and systems to identify where action should be taken. It was not always clear however if the changes needed had been carried out or if the impact of the changes were monitored. For example, the practice had carried out an audit into the prescribing of an antibiotic, Co-amoxiclav. The medicines management team had identified that this antibiotic was being over prescribed by the practice. Co-amoxiclav should be a second choice antibiotic for most infections because of potential side-effects. We were shown a table of results for one of the GPs at the practice which demonstrated an alternative antibiotic should have been prescribed as a first line choice. We saw that recommendations had been made advising which alternative antibiotics should be used. However, a second audit had not been carried out to demonstrate if changes to the frequency of prescribing this antibiotic had been implemented.

The practice had arrangements for identifying, recording and managing some risks. The deputy practice manager showed us their risk log which addressed a wide range of potential issues, such as the loss of domestic services or information technology; the Control of Substances Hazardous to Health (COSHH); fire safety; buildings maintenance and the prevention of the legionella virus. We looked at the minutes of clinical and team meetings and saw that they were discussed on an ad hoc basis.

Regular meetings were held between clinical and reception staff and we saw minutes confirming this. The business manager told us that the GP partners held governance

Are services well-led?

Good

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

meetings but these were informal. There were no minutes to evidence this and we saw no systems in place to demonstrate how the overall governance of the service was managed.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The deputy practice manager was responsible for the human resource policies and procedures. We reviewed a number of policies, for example, recruitment and confidentiality, which were in place to support staff. Staff we spoke with knew where to find these policies if required. The practice had a whistle blowing policy which was available to all staff to access by the internal computer system. Whistle blowing occurs when an internal member of staff reveals concerns to the organisation or the public, and their employment rights are protected. Having a policy meant that staff were aware of how to do this, and how they would be protected.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, analysis of the national GP survey and complaints received. We looked at the results of the annual patient survey and saw that in response to patient concerns, a new telephone system had been installed to improve telephone access to the practice. A text reminder system had also been introduced to try to reduce the number of patients who failed to attend for appointments. Staff told us this had helped to reduce the high number of patients who failed to attend for their appointment. However, they were unable to support this with audits of appointments.

The practice had an active patient participation group (PPG) which had steadily increased in size. PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care patients receive. The PPG included representatives from various population groups including a patient age range from 20 to 70 plus years and an even distribution of male and female members. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at two staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was supportive of training although training was often completed in their own time.

The practice was a GP training practice for medical students. We spoke with a medical student who told us they felt supported at the practice and that there was a structured process to support their learning at the practice.

The practice had completed reviews of significant events and other incidents and we saw minutes confirming that learning was shared with staff at dedicated significant events meetings and staff meetings. For example, following an incident where a delivery of vaccines to the practice had not been put in to the fridge to ensure they were stored in line with the manufactures' guidelines, a policy had been developed clarifying the responsibilities of the receptionists when receiving parcels. All the staff that we spoke with were aware of these changes. We saw minutes from clinical and team meetings that demonstrated the practice had discussed complaints after they had happened to learn and improve the service they provided to patients. However, there was no system in place to annually review complaints to detect themes or trends.