Dr David Shurmer

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr David Shurmer on 27 May 2015. Overall the practice is rated as good.

We found the practice to be good for providing caring, safe, effective, well-led and responsive services. It was also rated as good for providing services for all population groups.

Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and to report incidents. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and managed, including those relating to recruitment checks.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Complaints would be addressed in a timely manner and the practice endeavoured to resolve complaints to a satisfactory conclusion.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients.

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 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 patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely. Patient'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. The practice carried out regular appraisals and put in place personal development plans for staff.

Are services caring?

Good

The practice is rated as good for providing caring services. Patient surveys showed that the practice compared favourably with other practices in the area. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Readily available information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice reviewed the needs of their local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice, a named GP and continuity of care, with urgent appointments available on the same day. The practice was well equipped to treat patients and meet their needs. The practice had an effective complaints system.

Are services well-led?

Good

The practice is rated as good for being well-led. The leadership team were effective and had a clear vision and purpose. There were systems in place to drive continuous improvement. Governance

Summary of findings

structures were in place and there was a robust system that ensured risks to patients were minimised. The practice gathered feedback from patients, and it was developing a virtual patient participation group (PPG).	

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 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 care. The practice was responsive to the needs of older people and where appropriate provided home visits.

People with long term conditions

Good

The practice is rated as good for the care 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 and home visits were available when needed. 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 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. Systems were in place for identifying and following-up children living in disadvantaged circumstances and those who were at risk. 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 were suitable for children and babies. We were provided with good examples of joint working with midwives and health visitors. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care 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 offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflected the needs for this age group.

Summary of findings

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 record of patients living in vulnerable circumstances including homeless people, travellers and those with learning disabilities. The practice offered longer appointments for people with learning disabilities. 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)

Good

The practice is rated as good for the care of people experiencing poor mental health including people with dementia. The practice regularly worked with multidisciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had advanced care planning in place for patients with dementia. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with five patients on the day of our visit. We spoke with people from different age groups, who had different physical needs and had varying levels of contact with the practice. We received 39 completed CQC comment cards. All of these were complimentary about the practice and staff.

The patients were complimentary about the care provided by the staff and their overall friendliness and behaviour. They felt the doctors and nurses were competent and knowledgeable about their treatment needs and the practice provided a professional and efficient service. They told us that long term health conditions were well monitored and supported.

Patients reported they felt that all the staff treated them with dignity and respect. Patients told us staff listened to them and were well informed.

Patients said the practice was very supportive and felt their views were valued by staff. They were complimentary about the appointments system, its ease of access and the flexibility it provided.

Patients told us the practice was clean and tidy.

We reviewed the most recent data available for the practice on patient satisfaction. The evidence from these sources showed patients were satisfied with how they were treated with compassion, dignity and respect. For example, data from the GP patient survey showed 95% of respondents describe their experience of making an appointment as good. The local CCG average was 70%.

Dr David Shurmer

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team consisted of a CQC Lead Inspector and two specialist advisors (a GP and a practice nurse).

Background to Dr David Shurmer

Dr David Shurmer is registered with CQC to provide primary care services, which includes access to GPs, family planning, surgical procedures, treatment of disease, disorder or injury and diagnostic and screening procedures. It provides GP services for patients living in the Stannington area of Sheffield. The practice has two GPs (one male and one female), a management team, practice nurses and healthcare assistants, administrative staff and a cleaner.

The practice is open 8am to 6pm on Monday to Friday with later appointments available up to 8pm on Tuesdays. Patients can book appointments in person, via the phone and online. Appointments can be booked in advance for both the doctor and nurse clinics. When the practice is closed patients can access the out of hours NHS 111 service.

The practice has a General Medical Services (GMS) contract. This is the contract between general practices and NHS England for delivering services to the local community.

The practice is part of NHS Sheffield Clinical Commissioning Group (CCG). It is responsible for providing primary care services to just under 4000 patients. The practice is meeting the needs of an increasingly elderly patient list size that is generally comprised of an equal number of women and men.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme covering Clinical Commissioning Groups throughout the country.

We carried out an announced 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 registered 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 in accordance with the Care Act 2014.

Please note 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 CQC at that time.

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?

Detailed findings

- Is it well-led?

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

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problems

Before our inspection we carried out an analysis of the data from our intelligent monitoring system. We also reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service.

We reviewed the policies, procedures and other information the practice provided before the inspection. The information reviewed did not highlight any significant areas of risk across the five key question areas.

We reviewed all areas of the practice including the administrative areas. We sought views from patients through face-to-face interviews. We spoke with a GP, the practice manager, clinical nurses, an improving access to psychological therapy counsellor, a cognitive behavioural therapist, administrative staff and receptionists.

We observed how staff treated patients when they visited or phoned the practice. We reviewed how the GP made clinical decisions. We reviewed a variety of documents used by the practice to run the service.

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. For example, reported incidents, national patient safety alerts as well as comment cards received from patients. Staff we spoke with were aware of their responsibilities to raise concerns and how to report incidents and near misses.

Staff who identified incidents told us they would inform the practice manager or a GP. Incidents were prioritised so urgent action could be taken if required, otherwise they were discussed at a monthly meeting where minutes were kept and actions managed. We saw there was an issues log kept for matters such as medication issues and complaints.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. This showed the practice had managed these consistently over time and so could evidence a safe track record.

We looked at several audits, for example cytology and Cefalexin.

A recent cytology (cytology is the medical and scientific study of cells. Cytology refers to a branch of pathology, the medical specialty that deals with making diagnoses of diseases and conditions through the examination of tissue samples from the body) audit showed that 165 liquid based samples were taken. Only one was inadequate.

Reduced prescriptions of Cefalexin had been achieved over the last 6 months. The GPs continued to use Cefalexin only when no other option was available. Cephalexin is used to fight bacteria in the body. It works by interfering with the bacteria's cell wall formation, causing it to rupture, and killing the bacteria. Cefalexin can be used to treat infections caused by bacteria, including upper respiratory infections, ear infections, skin infections, and urinary tract infections.

We saw notes where these audits were discussed at a clinical meeting on 23 January 2015.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events, which had occurred during the last year and these were made available to us. A slot for significant events was on the practice meeting agenda and a dedicated meeting occurred every week to review actions from past significant events and complaints. There was evidence appropriate learning had taken place and the findings were disseminated to relevant staff. A recent audit was implemented to identify records that had not been kept and a resolution to this was implemented. All staff now recorded in a more effective way. Staff including receptionists, administrators and nurses were aware of the system for raising issues to be considered at the meetings.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed all staff had received relevant role specific training on safeguarding. We asked members of the 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 regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours.

The practice had named GPs and nurses appointed as leads in safeguarding vulnerable adults and children; they had received level three safeguarding training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak to in the practice if they had a safeguarding concern. There was a monthly meeting that considered safeguarding incidents with local social services teams. The practice also had a family at risk policy which was understood by all staff.

There was a chaperone policy which was visible at reception. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. All staff had been trained to be a chaperone so provided this service.

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 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. Medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Patients were routinely informed of common potential side effects at the time of starting a course of medicine. The IT system allowed for 'on screen' messages which were discussed with the patient. Side effects of medicines were explained and patients reassured.

There was a repeat prescribing protocol in place. Requests for repeat prescriptions were taken in person at the reception desk. We were informed about checks that were made to ensure the correct patient was given the correct prescription. All prescriptions were reviewed and signed by a GP before they were issued to the patient.

Cleanliness and 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.

The practice had nurse leads for infection prevention and control (IPC). They had undertaken further training to enable them to provide advice on the practice IPC policy and carry out staff training. All staff received induction training about IPC specific to their role and had annual updates. We saw evidence the lead nurse had carried out IPC audits for the last year and that any improvements identified for action were completed on time. We saw copies of completed audit reports.

An online infection control policy and supporting procedures were available for staff to refer to via the Stannington library (this was an on line and paper based system which kept all the practices systems and policies), which enabled them to plan and implement control of infection measures. Personal protective equipment including disposable gloves and aprons were also available for staff to use.

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

Sharps bins were appropriately located and labelled.

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 all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records which 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 peak flow meters and vaccine fridge thermometers.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service (DBS).

Staff told us about the arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. There was an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Some staff were designated fire wardens and had completed relevant training. Staff received annual appraisals, The staff felt their suggestions were listened to and, where possible, acted upon.

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. Health and safety information was displayed for staff to see.

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 risks were discussed at GP partners' meetings and within team meetings.

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

Good

Are services safe?

external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and how to use it. We saw records which confirmed these were checked regularly.

The practice had developed a comprehensive business continuity plan specifying the action to be taken in relation to a range of potential emergencies which could impact on the daily operation of the practice.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients' needs were assessed and care and treatment considered, in line with current legislation, standards and evidence-based guidance. We spoke with the GP who told us they used relevant and current evidence-based guidance such as the National Institute for Health and Care Excellence (NICE) guidelines. These were applied during assessment, diagnosis, referral to other services and management of long term conditions or chronic conditions such as diabetes.

The GP told us they lead in specialist clinical areas such as diabetes 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. The GP told us this supported all staff to continually review and discuss new best practice guidelines for the prescribing of medicines. Our review of the clinical meeting minutes confirmed this happened.

Discrimination was avoided when making care and treatment decisions. Interviews with the GP and nurse showed the culture in the practice was patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

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 managing child protection alerts 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 clinical audits which had been undertaken in the last year. These completed audits enabled the practice to demonstrate the changes since the initial audit. The practice had a system in place for completing clinical audit cycles. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. An example audit we looked at in detail was for the use of Methotrexate. Methotrexate is used to treat certain types of cancer of the breast, skin, head and neck, or lung. It is also used to treat severe psoriasis and rheumatoid arthritis. Methotrexate is usually given after other medications have been tried without successful treatment of symptoms. The aim of the audit was to ensure all patients prescribed medicine were being managed appropriately. The audit was conducted in November 2013 and a follow up audit was conducted in January 2015 which showed improvement from the first audit. Recommendations included, staff training, improved correspondence with the local hospital and enhancing the recall on the IT system every three months for patient's medication reviews.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked patients receiving repeat prescriptions had been reviewed by the GP. They also checked 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 was prescribing medicines. We saw evidence to confirm that, after receiving 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 the GPs had oversight and a good understanding of best treatment for each patient's needs.

Effective staffing

Staff had the skills, knowledge, qualifications and experience to deliver effective care and treatment. Staff received appropriate training to meet their learning needs and to cover the scope of their work. Staff we spoke with told us newly employed staff were supported in the first few months of working in the practice. We were able to review staff training records and saw this covered areas such as safeguarding vulnerable adults and children, health and safety, fire and first aid.

Good

Are services effective?

(for example, treatment is effective)

Staff told us they felt they had opportunities to develop and were able to take study leave and protected time to attend courses. Multidisciplinary training and an open supportive culture were evident at this practice.

Working with colleagues and other services

The practice had clear arrangements in place for referrals to other services. Patients told us they were given a choice of which hospital they would like to be referred to. It was the GP's responsibility to follow up on the referrals.

Staff worked together to assess and plan on-going care and treatment in a timely way when patients were discharged from hospital. We spoke with the practice manager who told us discharge letters were scanned on to the patient's record (about half of hospital letters were received electronically). This enabled the practice to have an effective means of ensuring continuity of care and treatment for those patients discharged from hospital.

The practice worked with district nurses, case managers for long term conditions via community matrons, health visitors, midwives and community psychiatric nurses.

Information sharing

Systems were in place for making 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. The practice manager reported this system was easy to use.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record 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 IT system for future reference.

Consent to care and treatment

We found staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing where possible. These care plans were reviewed annually or more frequently if changes in clinical circumstances required it. Staff gave us examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision.

All clinical staff demonstrated a clear understanding of Gillick competencies. These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Health promotion and prevention

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

It was practice policy to offer a health check with the practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering diabetes checks and smoking cessation advice as appropriate.

There was a variety of information available for health promotion and prevention throughout the practice; specifically in the waiting area. Information on the NHS and Ebola was also on display.

We were told that the practice offered a range of health promotion and prevention services. These included child immunisation, diabetes, chronic obstructive pulmonary disease (COPD), asthma, hypertension, coronary heart disease (CHD), cervical screening and travel vaccination appointments.

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 GP patient survey tool and feedback from patients undertaken by the practice via the families and friends test. The evidence from these sources showed patients were satisfied and that they were treated with compassion, dignity and respect. For example, data from the GP patient survey showed 98% of all respondents said their last appointment was convenient for them. All respondents reported that they were satisfied with the service and help they received at the practice and this is significantly better than practices in the area.

Over the period of January 2015 to April 2015 the practice received 177 comments from patients. Of these 94% said that they were likely to recommend the practice to others.

We also spoke with 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. Patients said they felt the practice offered a good service and staff were efficient, helpful and caring.

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

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order to maintain confidentiality. The practice switchboard was shielded by partitions which helped keep patient information private.

Staff told us 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 practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff. There was evidence of learning taking place as staff meeting minutes showed issues had been discussed. For example the practice would no longer decline a home visit request if deemed appropriate.

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. For example, data from the GP patient survey showed 90% of practice respondents said the last GP they saw or spoke to was good at explaining tests and treatments and 94% said the last GP they saw or spoke to was good at giving them enough time. Both these results were comparable or better to the local CCG and national averages.

Patients we spoke with on the day of our inspection told us 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 translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

The 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, staff responded compassionately when they needed help and provided support when required.

In the recent GP survey, 85% of respondents said they usually got to see their preferred GP. The local CCG average was 58%.

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 people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs.

The NHS Area Team and Clinical Commissioning Group (CCG) told us 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 challenges to its population.

There had been very little turnover of staff during the last twenty years which enabled good continuity of care and accessibility to appointments with a GP of choice. The practice had achieved and implemented the gold standard framework for end of life care.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice had access to translation services and staff who spoke other languages. The practice provided equality and diversity training.

The practice had a stable register of patients. The practice manager told us they had a very small number of patients from different ethnic backgrounds, for example Eastern Europeans. The majority of these patients could speak English but interpreting services were available if required. The practice had a hearing loop system in place for use by patients with hearing difficulties.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. All consulting and treatment rooms were on the ground floor of the building.

Access to the service

Appointments were available from 8am to 6pm on weekdays with later appointments available up to 8pm on Tuesdays. Multiple pre-bookable appointments were available up to two weeks in advance. No one was turned away everybody was seen who turned up on the day. Patient survey data showed 98% of respondents found it easy to get through to this surgery by phone as compared to local CCG average of 71%.

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.

Information was available to patients about appointments in reception. This included how to arrange urgent appointments and home visits. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. For example, if patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was also provided to patients.

The practice operated a flexible appointment system to ensure all patients who needed to be seen the same day were accommodated. Patients we spoke with were happy with the appointment system. This ensured patients were able to access healthcare when they needed to. Patients told us they could see another GP if there was a wait to see the GP of their choice. Patients told us when they needed urgent attention they were able to see a GP on the same day.

The practice used a telephone based system to organise appointments. The practice also catered for 'walk in' cases. Reception staff were the first point of contact for patients. They were trained to take brief medical details. Patients could be offered a routine appointment, a same day or an urgent appointment.

Patients could directly book a nurse appointment or were contacted by reception to book appointments for chronic disease management.

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. The practice manager was the designated responsible person who handled all complaints in the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice had recently responded to inappropriate prescription, the practice apologised to the patient and they accepted the apology.

We saw information was available to help patients understand the complaints system. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

The practice manager responded to complaints, offering the patient the option to come in and discuss the issue. The manager contacted the GP concerned and the item was discussed at team meetings. We looked at the summary of complaints which highlighted the category of the complaint actions and any learning outcomes for the practice.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We were told details of the vision and practice values were part of the practice's business plan. These values were at the heart of the practice's way of providing services to patients.

We spoke with members of staff who knew and understood the vision and values and knew what their responsibilities were in relation to these.

The GP partners had agreed the strategic approach of the business and we saw evidence of documented planning which supported their decision making.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the IT system. All the policies and procedures we looked at had been reviewed annually and were up to date.

The practice held monthly governance meetings. We looked at minutes from the last meeting and found performance, quality and risks had been discussed.

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

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example, there was a lead nurse for infection control and the GP was the lead for safeguarding. We spoke with 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.

The GPs fulfilled a leadership role within the practice, providing highly visible, accessible and effective support.

The practice had implemented a comprehensive schedule of meetings which provided staff with the opportunity to discuss concerns and disseminate information. Staff told us that there was an open and transparent culture within the practice. They had the opportunity to contribute to the agenda of team meetings, to raise issues within team meetings and on a more informal basis and felt well supported in doing so. We saw from minutes that team meetings were held regularly; at least monthly.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies which were in place to support staff. Staff we spoke with knew where to find these policies if required.

The practice manager reported staff morale was good. There was a very low staff turnover, people cared about each other and the reported sickness rates were low.

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

The practice had gathered feedback from patients through annual patient surveys, suggestion box and complaints received. We looked at the results of the annual patient survey and were shown a report on comments from patients.

The practice was developing a virtual patient participation group which would contribute and feedback customer satisfaction.

Recent improvements made to the practice as a direct result of the patient feedback included offering a bell and telephone outside the surgery main door.

The practice had gathered feedback from staff. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

The practice had a whistle blowing policy which was available to all staff within the practice.

Management lead through learning and improvement

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

The practice offered GPs and the nurse time to develop their skills and competencies. Staff who we spoke with confirmed this study time was made available to them.

Systems were in place for recording and monitoring all staff training needs. We reviewed staff training records and saw

Are services well-led?

Good

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

staff were up to date with attending mandatory courses such as annual basic life support, infection control and safeguarding of children and vulnerable adults. Staff told us they also had opportunities for individual training and development.

The practice completed reviews of significant events and other incidents and shared the learning with the staff team to ensure the practice learnt from incidents to improve outcomes for patients. Significant events and incidents were discussed within weekly clinical meetings, GP meetings and monthly practice staff meetings.