Dr Ngozi Patrick

Quality Report

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Date of inspection visit: 13 May 2015
Date of publication: 02/07/2015

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Ngozi Patrick on 13th May 2015. Overall the practice is rated as good.

Specifically we rated the practice as good in providing safe, effective, caring, responsive and well-led care for all of the population groups it serves.

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

- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Patients confirmed they were treated with compassion, dignity and respect and were involved in care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Complaints were addressed in a timely manner and the practice endeavoured to resolve complaints to a satisfactory conclusion.
- Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

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

Importantly the provider should

- ensure that records are available to show when and what training staff had completed so as to monitor the training needs of the staff in general.
- staff who provide chaperone services must be given clear guidance and training on their role and monitored to ensure this is adhered to.
- ensure systems are in place to continually check the professional registration status of GPs and practice nurses each year to make sure they were still deemed fit to practice.

Summary of findings

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice 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 patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and there was evidence of appraisals in place for all staff.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. 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 England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients found it easy to make an appointment and that 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. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. Staff were clear about the vision and their responsibilities in relation to this. There

Summary of findings

was a clear 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. 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. All patients over 75 years of age had a named GP. There were systems in place for older people to receive regular health checks. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example in dementia and end of life care. 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. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and 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 living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were good for all standard childhood immunisations. The practice told us that all young children were seen on the same day as requested. 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 and health visitors.

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 been identified and the practice had adjusted the services it offered

Summary of findings

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 reflects the needs for 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 with a learning disability and had carried out annual health checks for all of these patients. They also offered longer and flexible appointments for people with a learning disability and ensured that they had access to both the GP and nurse to minimise number of attendances or number of visit times.

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. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had counselling services based at the practice and sign posted patients experiencing poor mental health to other support groups and voluntary organisations.

Summary of findings

What people who use the service say

In the most recent information from 2014 GP Patient Surveys showed 64% of people would recommend this practice to others and 90% were happy with the opening hours.

The practice had gathered feedback from patients through friends and family feedback, comments, complaints and surveys. We saw the 2014 GP Patient Surveys found that that 83% of all patients described the overall experience of their GP surgery as good or very good.

The practice had made attempts to form a Patient Participation Group (PPG). Unfortunately there had been no uptake from their patients. They were continuing to canvas the patient group and remained positive about forming an active group. In the interim however they had conducted their own survey regarding patient satisfaction. This confirmed that 72% patients had overall satisfaction with the practice and 90% of patients found access to the service good.

Areas for improvement

Action the provider SHOULD take to improve:

- ensure that records are available to show when and what training staff had completed so as to monitor the training needs of the staff in general.
- staff who provide chaperone services must be given clear guidance and training on their role and monitored to ensure this is adhered to.
- ensure systems are in place to continually check the professional registration status of GPs and practice nurses each year to make sure they were still deemed fit to practice.

Dr Ngozi Patrick

Detailed findings

Our inspection team

Our inspection team was led by:

The team included a second CQC inspector, a GP specialist advisor and a practice manager specialist advisor.

Background to Dr Ngozi Patrick

The medical services are provided to the local community in the Sheffield 6 area; this includes Loxley, Wadsley, Hillsborough, Stannington, Malin Bridge, Walkley, Crookesmoor and Upperthorpe. The building was purpose built in 1986 with good parking facilities and disabled access.

The practice is registered with the CQC to provide the following regulated activities: Maternity and midwifery services; Diagnostic and screening procedures; Treatment of disease, disorder or injury; and Surgical procedures. The practice provides Personal Medical Services (PMS) for a population of 1500 patients under a contract with Sheffield Clinical Commissioning Group (CCG). The practice also links with seven other local practices to form a local support group to share skills and services.

The practice has one GP, one practice nurse, one healthcare assistant and an experienced administration and reception team. The reception team consists of one practice manager and five reception staff.

The practice is open Monday to Friday from 8am to 6:30pm with extended opening hours on Monday evening until 7:30pm. On Thursday the practice opens at 08.00am and then closes at lunch time. When the practice is closed patients can access the out of hour's provider service.

The practice population is made up of a predominately younger and working age population between the ages of 20- 49 years. Forty one per cent of the patients have a long standing health condition.

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?

Detailed findings

- 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 longterm conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew.

We carried out an announced visit on 13th May 2015. During our visit we spoke with a range of staff including the practice manager, GP, practice nurse, health care assistant and four reception staff. We also reviewed patient survey information and information from the 'family and friends'survey.

We observed communication and interactions between staff and patients both face to face and on the telephone within the reception area. We looked at records relating to the management of the practice.

Good

Are services safe?

Our findings

Safe track record

We found the practice had systems in place to monitor all aspects of patient safety. Information from the Quality and Outcomes Framework (QOF), a national incentive and reward scheme that helps practices to focus on better outcomes for patients, showed that in 2013-2014 the practice was appropriately identifying and reporting incidents. The practice had an overall rating of 94%. Information from the Clinical Commissioning Group (CCG) and NHS England indicated the practice had a good track record for maintaining patient safety. Staff we spoke with understood their responsibilities to raise significant events. This included the process to report them internally and externally where appropriate.

Staff were able to give examples of the processes used to report, record and learn from incidents. They confirmed these were discussed in the clinical, team meetings and with relevant staff. 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 show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

There were effective protocols used to scrutinise practice. The practice had systems in place for reporting, recording and monitoring significant events, incidents and accidents. We looked at 12 records of significant events that had occurred during the last 12 months. We saw incidents were discussed at weekly GP and monthly practice meetings. For example, during an emergency incident it was found that the emergency trolley had out of date medication. Rigorous systems were then put in place to regularly audit the medication and equipment. We talked with staff who confirmed any important information was passed onto them either via email or directly at team meetings.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result, for example a patient's delayed referral. 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.

Staff told us they felt confident in raising issues with the GP and felt action would be taken. It was clear there was a culture of openness operating throughout the practice, which encouraged errors and 'near misses' to be reported.

Reliable safety systems and processes including safeguarding

The practice had systems in place to protect and safeguard children and vulnerable adults. The practice had a named lead GP for safeguarding and they had completed safeguarding training to an appropriate level. All staff we spoke with confirmed they had completed recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. This helped to ensure the protection of children and vulnerable adults.

We confirmed staff used appropriate codes on their electronic case management system for children and vulnerable adults. This identified these groups which were then reviewed. This system also flagged up where a patient (child or adult) was vulnerable or required additional support, for instance if they were a carer. The practice also had systems to monitor babies and children; for instance, where patients failed to attend for childhood immunisations, or who had high levels of attendances at A&E.

There were chaperone notices displayed and a chaperone policy in place. (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).There was evidence of patients being offered chaperone services during consultation and treatment. All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would occasionally act as a chaperone if nursing staff were not available. We found however that reception staff had not undertaken training for this role. We discussed this with the manager who said this training would be put in place with immediate effect.

Medicines management

There was a clear policy for ensuring medicines were kept at the required temperatures, which described the action

to take in the event of a potential failure. Staff confirmed the procedure to check the refrigerator temperature every day and ensure the vaccines were in date and stored at the correct temperature. The staff showed us their daily records of the temperature recordings and the correct temperature for storage was maintained. The cold chain for vaccines was audited and closely monitored by staff.

The practice was not a dispensing practice. The amount of medicines stored was closely monitored and medicines were kept in a secure store with access by clinical staff only. We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. 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. A pharmacist visited the practice one day per week to audit the prescribing and support the practice.

We saw records of practice meetings where any identified prescribing errors were reviewed. There were systems in place to ensure GPs regularly monitored patients' medication. Repeat issuing of medication was closely monitored, with patients invited to book a 'medication review', where required. Any changes in medication guidance were communicated to clinical staff.

The nurse and the health care assistant administered vaccines using Patient Group Directions (PGDs) produced in line with legal requirements and national guidance. We talked with staff who confirmed they had received appropriate training to administer vaccines. The data from 2013-14 NHS England showed 90% of children aged 24 months at the practice had received their vaccinations.

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

Cleanliness and infection control

We saw all areas throughout the practice were clean. We saw there were cleaning schedules in place and cleaning audit records were kept in each treatment room.

The GP patient questionnaire confirmed patients found the practice clean and had no concerns about cleanliness or infection control. Suitable arrangements were in place to help ensure the practice was cleaned to a satisfactory standard.

We saw liquid soap and paper hand towels were available in treatment rooms and public areas. Notices about hand hygiene techniques were displayed in staff and patient toilets.

We confirmed Personal Protective Equipment (PPE) was easily accessible to all staff. Single use equipment was available and safely managed. Sharps receptacles were in place in the treatment rooms and containers were provided for the disposal of cytotoxic and contaminated sharps such as used needles. The practice had a needle stick injury policy in place, which outlined what staff should do and who to contact if they suffered this injury.

We looked at the Infection Control Policy in place and noted it was up to date and regularly reviewed. The practice had a new lead for infection control who completed recent audits to ensure the treatment areas were safe. An infection control checklist was used to help identify any shortfalls or areas of poor practice. Where concerns were identified, an action plan was put in place. We confirmed infection control training had been completed by all the staff and refresher training was done on an annual basis.

The practice had a recent legionella assessment. We discussed this with the practice manager who told us that the action plan was in place, this was to help reduce the risk of infection to staff and patients.

Equipment

The practice had appropriate equipment for managing emergencies. Emergency equipment included resuscitation equipment. This equipment was based in a treatment room, with signage on the door. All staff we spoke with knew the location of the equipment. We confirmed equipment was checked regularly to ensure it was in working condition. A log of maintenance of clinical and emergency equipment was in place and staff recorded when any items identified as faulty were repaired or replaced.

Staff we spoke with told us they had 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. A schedule of testing was in place. There was evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer. We saw the practice had annual contracts in place for portable appliance tests (PAT), gas and electrical safety and also for the routine servicing where needed, of medical equipment.

Staffing and recruitment

The practice had a recruitment policy in place. The policy stated all clinical staff should have a Disclosure and Barring Service (DBS) check and two references from their previous employment. We looked at a sample of personnel files for clinical and non-clinical staff. We looked at the most recently recruited staff and confirmed pre-employment checks were in place. Checks such as obtaining a full work history, evidence of identity, references and a DBS check, had been carried out prior to staff starting work.

We noted that the provider checked the professional registration status of GPs, including locums and nurses against the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) upon recruitment. However, there were no checks after this of their ongoing status. The provider should have mechanisms in place to continually check the professional registration status of GPs, locums and nurses each year to make sure they were still deemed fit to practice. We discussed this with the practice manager who told us that this would be put into place alongside the appraisal system to ensure continuity.

We saw safe staffing levels had been determined by the provider and rotas showed these were maintained. Procedures were in place to manage and cover planned absences, such as training and annual leave, and unexpected absences such as staff sickness.

Monitoring safety and responding to risk

The practice management team looked at safety incidents and any concerns raised. They then looked at how this could have been managed better or avoided. They also reported to external bodies such as the Clinical Commissioning Groups (CCG), the local authority and NHS England in a timely manner.

The practice had arrangements for monitoring safety and responding to changes in risk to keep patients safe. For example, the practice had a health and safety policy setting out the steps to take to protect staff and patients from the risk of harm or accidents. There were arrangements in place to protect patients and staff from harm in the event of a fire. This included staff designated as leads in fire safety and carrying out appropriate fire equipment checks.

The practice was positively managing risk for patients. Newly diagnosed cancer patients or terminally ill patients were discussed at GP and multidisciplinary team (MDT) meetings, which allowed clinicians to monitor treatment and adjust support according to risk. We saw information regarding palliative care patients was made available to out of hours providers so they would be aware of changing risks.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw evidence clinical staff had received training in basic life support. All staff knew where emergency equipment was located. We had confirmation from the practice manager that reception staff were to complete training in this area in July 2015. There was resuscitation equipment and emergency medicines, such as for the treatment of cardiac arrest and anaphylaxis. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. The notes of the practice's significant event meetings showed staff had discussed a medical emergency concerning a patient and had learned from this appropriately.

We saw there were disaster/ business continuity plans in place to deal with emergencies that may interrupt the smooth running of the service such as power cuts and adverse weather conditions. The plans were accessible to all staff and kept in reception and hard copies kept at the GP and practice manager's homes. This provided information about contingency arrangements staff would follow in the event of a foreseeable emergency.

The practice had carried out a fire risk assessment, this included actions required to maintain fire safety. Records showed staff were up to date with fire training and they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice aimed to deliver high quality care and participated in the Quality and Outcomes Framework (QOF). The QOF aimed to improve positive outcomes for a range of conditions such as coronary heart disease and high blood pressure. The practice achieved 94% of the QOF framework points in year 2013-14, which showed their commitment to providing good quality of care.

We were told monthly practice meetings were held where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed.

The clinical staff demonstrated how they accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. For instance, they applied the NICE quality standards and best practice guidance in their management of conditions such as asthma and diabetes. We saw minutes of GP clinical meetings where new guidelines were disseminated and the implications for the practice's and the practice performance and patients were discussed. The GP interviewed was aware of their professional responsibilities to maintain their knowledge.

We saw patients were appropriately referred to secondary and community care services. The clinical staff we spoke with could clearly outline the rationale for their treatment approaches. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring each patient was given support to achieve the best health outcome for them.

There were systems in place to identify and monitor the health of vulnerable groups of patients. Specific coding was used for patients on their electronic records. This coding records the everyday care of a patient, including family history, relevant tests and investigations, past symptoms and diagnoses. This helped to improve patient care by ensuring clinicians base their judgements on the best possible information available at a given time. The clinical staff we spoke with were all familiar with read coding and its benefits when assessing patients' conditions.

Staff were able to demonstrate how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. The practice kept up to date disease registers for patients with long term conditions. These included asthma and chronic heart disease and were used to arrange annual, or as required, health reviews.

The clinical staff we spoke with told us they used personalised self-care management plans with patients as appropriate, raised awareness of health promotion and referred/signposted to other services when required. For example, retinopathy screening for people who have diabetes (retinopathy is commonly caused by diabetes and can affect vision). The practice nurse supported patients with diabetes and met monthly with the specialist diabetic nurse. This enabled patients to be assessed holistically during their diabetic review.

There were systems in place to identify and monitor the health of vulnerable groups of patients. We were told patients who had learning disabilities were given longer appointments, annual reviews were undertaken and consent documented.

Interviews with staff showed the culture of the practice was patients were cared for and treated based on need. The practice took into account a patient's age, gender, race and culture as appropriate and avoided any discriminatory practises.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. Clinical audit, clinical supervision and staff meetings were used to assess performance. The practice had an effective system in place for how they completed clinical audit cycles. Examples of clinical audits included; cervical smear testing, warfarin prescribing and myocardial infarction audit. After each audit, actions had been identified and changes to treatment or care had been made.

Staff regularly checked that all routine health re assessments were completed for long term conditions such as diabetes and that the latest prescribing guidance was being used. There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked patients receiving repeat prescriptions had been reviewed by the GP. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that,

Good

Are services effective?

(for example, treatment is effective)

after receiving an alert, the GP 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 overview and a good understanding of best treatment for each patients' needs.

The GP from the practice met regularly with the CCG and other practices. These meetings were used to look at national developments and guidelines for implementation and consideration and also sharing information and good practice.

Effective staffing

We observed staff were competent and knowledgeable about the roles they undertook. The practice was organised so there were enough staff to meet the fluctuating needs of patients.

There was a comprehensive induction programme in place for new staff which covered generic issues such as fire safety and infection control. We saw evidence staff had completed mandatory training, for example, safeguarding and infection control. Staff had been trained in areas specific to their role for example, epilepsy care, wound management, heart disease, diabetes and COPD.

We saw evidence of regular 'Target' training which the GP attended externally and other staff in house. We noted however the training plan did not keep an accurate account of training completed or updates. The practice manager informed us the style of recording would be amended to give an accurate account and ensure effective future planning.

The GP was up to date with their annual continuing professional development requirements and had been revalidated last year. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England). All nursing staff confirmed that they were up to date with their continuing professional development requirements.

The practice nurse was expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles e.g. seeing patients with long term conditions such as asthma, COPD, diabetes and coronary heart disease were able to demonstrate they had appropriate training. The nurse had their 'fit for practise' reviewed each year via the Nursing and Midwifery Council (NMC) registration web site.

Both clinical and non-clinical staff confirmed they had appraisals. They told us it was an opportunity to discuss their performance and any training concerns or issues they had. All the staff we spoke with were unanimous they were well supported in their role and confident in raising any issues with the practice manager or the GP.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the OOH service both electronically and by post.

We saw evidence the practice worked closely with other professionals. For example, they worked with palliative care nurses, health visitors, social services, community learning disability teams and community mental health teams to support patients.

The staff attended multidisciplinary team meetings every month to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the local out of hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from the hospital, to be saved in the system for future reference.

The staff told us they liaised closely with the health and social care providers to ensure any health needs of their

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Are services effective?

(for example, treatment is effective)

patients were promptly addressed, for example when someone was discharged from hospital. This was important to ensure integrated care and support was provided to the patients.

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 system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and action had been taken to address any shortcomings identified.

Consent to care and treatment

We found staff were aware of the Mental Capacity Act 2005 and Children Acts 1989 and 2004, although we could not find evidence staff had received training in this area. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. Staff told us they spent time discussing treatment options and plans with patients and were aware of consent procedures. They explained discussions were held with patients to assure their consent prior to treatment. They were aware of how to access advocacy services.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. There was a practice policy on consent in place. Staff were able to provide examples of how they dealt with a situation if someone was unable to give consent, including escalating this for further advice to a senior member of staff where necessary. We found clinical staff understood how to facilitate 'best interest' decisions for people who lacked capacity and would seek appropriate approval for treatments.

We saw clinical staff were familiar with the need for capacity assessments and Gillick competency assessments of children and young people. These assessments checked whether children and young people had the maturity to make decisions about their treatment.

Health promotion and prevention

The practice offered NHS Health Checks to all its patients aged 40 to 70 years and all patients over the age of 40 were offered a cardio-vascular disease (CVD) check. They were involved with national breast, bowel and cervical cytology screening programmes. The practice's performance for cervical smear uptake for 2013/14 was 83%, which was similar to other practices in the area.

They offered a full range of immunisations for children, flu vaccinations and travel vaccinations in line with current national guidance.

The practice had numerous ways they could identify patients who needed additional support. For example, they kept a register of all patients with a learning disability, long term condition or mental health problem. These patients were offered an annual physical health and well being check. Systems were in place to refer or signpost patients to other sources of support, for example smoking cessation or weight management clinics.

It was practice policy to offer a health check with the health care assistant 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.

The practice had met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

The practice raised patients' awareness of health promotion. This was in consultations, via links on their web site and leaflets in the practice. This information covered a variety of health topics including diabetes, smoking cessation, weight management, stroke and diabetes. Patients confirmed with us they had access to the information and staff regularly discussed health promotion with them during their consultations and on home visits.

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 2014. The evidence from this source showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was rated 86% in its satisfaction scores on consultations with nurses with the GP was good at listening to them and 70% said the GP gave them enough time. We also saw the friends and family surveys that had positive comments and results.

We observed that reception staff were courteous and spoke respectfully to patients. They listened to patients and responded appropriately. The practice switchboard was located in an area away from the reception so calls could not be overheard. The staff we spoke with told us they were always careful about what questions they asked patients at the reception desk and they were aware of the need to maintain confidentiality. In the GP patient survey 2014 the practice rated 100% of patients responding that they felt the reception staff helpful. We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private.

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

Care planning and involvement in decisions about care and treatment

Patients were supported to express their views and were involved in making decisions about their care and treatment. Of the patients who participated in the national GP patient survey in 2014, 86% of respondents said they had confidence in their GP.

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 patents this service was available.

Patient/carer support to cope emotionally with care and treatment

Patients' emotional needs were supported. Patients were offered information and support for areas such as; bereavement counselling, mental health support and also support with conditions such as cancer. There were a counselling support clinic based at the practice. 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. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice provided a service for all age groups. They covered patients with diverse cultural and ethnic needs and for those living in deprived areas. We found GPs and other staff had the overall competence to assess each patient and were familiar with individual's needs and the impact of their socio-economic environment.

The NHS England 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 found the practice was responsive to patient'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 in the way services were delivered. For example, longer GP and nurse appointments were available for patients who had complex needs or where they were supported by a carer. Patients with multiple long term conditions had a single health check to avoid the need for multiple appointments. Home visits were also available for patients who found it difficult to access the surgery.

We saw the practice held regular diabetic clinics and monthly sessions with a specialist diabetic nurse. We also found where patients could not attend the practice phlebotomy services were provided to patients at home.

We looked at how the practice met the needs of older people. We saw the practice had a named GP for over 75's and provided patients with an 'elderly health check' to support them with management of any long term conditions. This included a system that recalled patients annually for a comprehensive review. If patients had not attended for some time the practice actively contacted them and the GP offered them a consultation.

Staff understood the lifestyle risk factors that affect some groups of patients within the practice population. We saw the practice provided a range of services and clinics where the aim was to help particular groups of patients to improve their health. For example, the practice provided patients with access to smoking cessation programmes, and advice on weight and diet.

Patients with immediate, or life-limiting conditions, were discussed at the weekly clinical meeting to ensure all practitioners involved in their care delivery were up-to-date and knew of any changes to their care needs.

Tackling inequity and promoting equality

There was ramp access to the building and accessible toilets. There was a large waiting area on the ground floor and access additional surgeries and treatment rooms. We saw the ground floor waiting area was large enough to accommodate patients who used 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 baby changing facilities. An 'audio loop' was also available in the reception/ waiting room area for patients with an hearing impairment.

Staff told us translation services during consultations were available for patients who did not have English as a first language. We also noted that staff had different language skills to support people with making appointments and translating information where required.

The practice provided equality and diversity training. Staff we spoke with confirmed that they had completed the equality and diversity training and that equality and diversity was regularly discussed at staff appraisals and team events.

Access to the service

Of the patients who participated in the national GP patient survey in 2013-14, 97 % of patients reported a good overall experience of making an appointment 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 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.

The practice offered telephone and online pre-bookable appointments. Patients could also ring on the day for emergency appointments. Staff told us that patients always got an appointment the same day if it was an emergency.

Good

Are services responsive to people's needs?

(for example, to feedback?)

All children were seen the same day and usually within two hours of contacting the practice. Older patients were also seen the same day and home visits were available when required for housebound patients. A text messaging service was used to remind patients (who had consented to receive them) 24 hours prior to their appointment.

We saw that good systems were in place to help patients order repeat prescriptions. Patients could use the website, telephone or visit the surgery to order prescriptions.

Opening times and closures were stated on the practice website and in the practice leaflet with an explanation of what services were available.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England. There is a designated person, the practice manager, who handles all complaints in the practice.

We saw information was available to help patients understand the complaints system. Information on how to make a complaint was available in a practice booklet in reception and displayed in the reception area. The practice manager kept a log of complaints about the practice.

We looked at how complaints received by the practice in the last twelve months had been managed. The records showed complaints had been dealt with in line with the practice policy and in a timely way. Patients had received a response which detailed the outcomes of the investigations. We saw actions and learning from complaints were shared with staff. For example, a patient had complained about the length of appointment with the GP. It was agreed by the practice that staff should advise patients about booking longer appointments where required.

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

Staff we spoke with shared joint values about the practice and knew what their responsibilities were in relation to these. All staff spoke positively about the leadership and they felt valued as employees at the practice. Staff told us that central to their values was the needs of the patient. They said this was central to the practice in all their decision making, planning and development.

We saw there was input from key stakeholders, patients and staff which ensured the practice regularly reviewed their aims to ensure they were being met.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at three of these policies and procedures. All policies and procedures we looked at had been reviewed annually and were up to date.

There was clear leadership structures in place. Allocation of responsibilities, such as lead roles were in place. For example, there was a lead nurse for infection, prevention and control and a lead GP for safeguarding children and adults. The staff we spoke with all understood their roles and responsibilities and knew who to go to in the practice with any concerns.

We found effective monitoring took place, and this included audits to ensure the practice was achieving targets and delivering safe, effective, caring, responsive and well led care. The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw QOF data was regularly discussed at practice meetings.

The practice had a system in place for completing clinical audit cycles. Examples of completed clinical audits included asthma and cervical smear testing.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues, such as management and safety of medicines. We saw the risk log was regularly discussed at clinical meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented, for example in relation to the management of medicines and vaccines.

The practice sought feedback from patients and staff to help improve the service. All the staff we spoke with felt they had a voice and the practice was supportive and created a positive learning environment. They all told us they felt valued, supported and knew who to go to in the practice with any concerns.

Leadership, openness and transparency

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment and safeguarding children and vulnerable adults which were in place to support staff. Staff showed us how they accessed these policies if required.

Systems were in place to encourage staff to raise concerns and a no blame culture was evident at the practice. We saw from minutes that weekly clinical meetings and monthly team meetings were held. Staff told us there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

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

The practice had gathered feedback from staff, through staff training days and generally through staff appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff confirmed they felt part of the decision making in the practice and their contributions mattered to the team.

The practice did not have an active patient participation group (PPG). The practice had, however, gathered feedback from patients through friends and family feedback, comments, complaints and surveys. We looked at the results of the annual patient survey and found action points had been determined to encourage improve patient access to the appointment system. For instance, they had taken action to change the phone system and introduce online access for patients.

Management lead through learning and improvement

Are services well-led?

Good

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

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring.

We looked at three staff files and saw that regular appraisals took place which included a personal development plan. Staff told us the practice was very supportive of training and they were given protected time to undertake further training.

The practice used information such as the Quality Outcome Framework (QOF) and patient feedback to continuously improve the quality of services. Staff were able to take time out to work together to resolve problems and share information which was used proactively to improve the quality of services. The practice had completed reviews of significant events and other incidents and shared the information at team meetings to ensure the practice improved outcomes for patients.