Lisson Grove and Woolwell Medical Centres

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 The Lisson Grove Surgery on 23 June 2015.

Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for the population groups of older people; people with long term conditions; families, young people and children; people experiencing poor mental health; people in vulnerable circumstances; working age people and those recently retired.

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 and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- 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.
- Patients said they found it easy to make an appointment with a named GP 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.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

Summary of findings

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

Importantly the provider should

- Ensure that staff undertaking chaperone duties should receive training in this role.

Ensure that patients are aware of the chaperone service.

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. Medicines were stored, managed in line with national guidance. There were safeguards in place to identify children and adults in vulnerable circumstances. There was enough staff to keep people safe. Recruitment procedures and checks were completed as required to ensure that staff were suitable and competent. The practice was clean, tidy and hygienic. We found that suitable arrangements were in place that ensured the cleanliness of the practice was maintained to a high standard.

Are services effective?

Good

The practice is rated as good for providing effective services. Supporting data obtained both prior to and during the inspection showed the practice had systems in place to make sure the practice was effectively run. The practice had a clinical audit system in place and audits had been completed. Care and treatment was delivered in line with national best practice guidance. The practice worked closely with other services to achieve the best outcome for patients who used the practice. Staff employed at the practice had received appropriate support, training and appraisal. GP appraisals and revalidation of professional qualifications had been completed. The practice had extensive health promotion material available within the practice and on the practice website.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions.

Accessible 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 and understood the needs of their local

Summary of findings

population. The practice identified and took action to make improvements. Patients reported that they could access the practice when they needed. Patients reported that their care was good. The practice was well equipped to treat patients and meet their needs.

There was an accessible complaints system with evidence demonstrating that the practice responded appropriately and in a timely way to issues raised. There was evidence that learning from complaints was shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision and strategy to deliver quality care and treatment and they were looking for ways to improve. Staff reported an open culture and said they could communicate with senior staff. The practice had a number of policies and procedures to govern activity and regular governance meetings took place. There were systems in place to monitor and improve quality and identify risks. There were systems to manage the safety and maintenance of the premises and to review the quality of patient care.

The practice had an active patient liaison group (PLG) which was involved in the core decision making processes of the practice.

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 providing care to older people.

All patients over 75 years had a named GP. Health checks and promotion were offered to this group of patients. There were safeguards in place to identify adults in vulnerable circumstances. Each of the 11 local care homes had a named GP.

The practice worked well with external professionals in delivering care to older patients, including end of life care. The practice worked with other community staff to help patients stay within their own homes and avoid hospital admission where possible.

Pneumococcal vaccination and shingles vaccinations were provided at the practice for older people on set days as well as during routine appointments. A nurse visited a local care home to administer flu and shingles vaccinations. Patients could obtain their medicines from a local pharmacy.

People with long term conditions

Good

The practice is rated as good for providing care to people with long term conditions.

The practice managed the care and treatment for patients with long term conditions in line with best practice and national guidance. Health promotion and health checks were offered to patient with specific conditions, such as diabetes and asthma. Practice nurses did not have separate clinics for patients with long-term conditions but run mixed clinics with varying appointment times, allowing greater flexibility.

The practice had a carers' register and all carers were offered an appointment for a carers' check with nursing staff. The practice worked with other health professionals to help patients stay within their own homes and avoid hospital admission where possible.

Families, children and young people

Good

The practice is rated as good for families, children and young people.

Staff worked well with the midwife to provide antenatal and postnatal care. The practice provided baby and child immunisation programmes to ensure babies and children could access a full range of vaccinations and health screening. Patients could book appointments online and these were available before and after school hours. Patients were sent a text reminding them of their appointment.

Summary of findings

Information relevant to young patients was displayed and health checks and advice on sexual health for men, women and young people included a full range of contraception services and sexual health screening including chlamydia testing and cervical screening. The GPs training in safeguarding children from abuse was at the required level three.

Working age people (including those recently retired and students)

Good

The practice is rated as good for providing care to working age people.

The practice provided appointments or telephone consultation on the same day. Emergency appointments were available. The practice operated early opening and extended hours each day.

Smoking cessation and lifestyle consultations and appointments were available. The practice website invited all patients aged between 40 years to 75 years to arrange to have a health check with a nurse if they wanted. A cervical screening service was available. Patients could order repeat prescriptions on line.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for people whose circumstances may make them vulnerable.

The practice had a vulnerable patient register to identify these patients. Vulnerable patients had their cases reviewed at team meetings. Referral to a counselling service was available. The practice did not provide primary care services for patients who were homeless as none were known, however, staff said they would not turn away a patient if they needed primary care and could not access it.

Patients with language interpretation requirements were known to the practice and staff knew how to access translation services. A portable computer device was available at reception for interpreter purposes.

Patients with learning disabilities were offered a health check every year during which their long term care plans were discussed with them and their carer if appropriate. Reception staff were able to identify vulnerable patients and offer longer appointment times where needed.

The practice provided services for patients on the violent patient register; this ensured that there were sufficient arrangements in place to provide primary medical services to patients who have been subject to immediate removal from a patient list of a primary medical services contractor because of an act or threat of violence.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for people experiencing poor mental health, including people with dementia.

The practice was aware of their ageing patient population group, particularly in relation to those with dementia. Staff were aware of the safeguarding principles and GPs and nurses had access to safeguarding policies. All staff had received training in the Mental Capacity Act (MCA) 2005 and were aware of the principles and used them when gaining consent. The practice worked closely with the primary care dementia support practitioner and district nurses to help patients retain enough independence to remain at home. There was signposting and information available to patients.

The practice referred patients who needed mental health services and community psychiatric nurses visited the practice. Support services for patients with depression were provided at the practice, such as counselling. Patients suffering poor mental health were offered annual health checks as recommended by national guidelines.

Summary of findings

What people who use the service say

We looked at patient experience feedback from the national GP survey from 2014-15 The patient's survey showed 88% of the 107 patients that responded found that GPs gave them the time they needed. 84% said that GPs were good at explaining treatment and tests to them. We found that 86% of patients said that the nursing staff were very helpful and explained their treatment well, and 94% of the patients found the reception staff helpful.

We spoke with four patients during the inspection. Comment cards had been left in the reception area for patients to fill in before we visited. No comment cards had been completed. We received one email from a patient who wanted to tell us their views but was unable to visit the practice on the day of inspection. All their comments were positive.

Patients told us the staff were friendly, they were treated with respect, their care was very good, and they were always able to get an appointment.

Patients were satisfied with the facilities at the practice. Patients commented on the building being clean and tidy. Patients told us staff used gloves and aprons where needed and washed their hands before treatment was provided.

Patients found it easy to get repeat prescriptions from the practice and nursing staff had been very helpful following the closure of a nearby pharmacy.

Areas for improvement

Action the service SHOULD take to improve

Ensure that staff undertaking chaperone duties should receive training in this role.

- Ensure that patients are aware of the chaperone service.

Lisson Grove and Woolwell Medical Centres

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector, a GP specialist advisor and a practice manager specialist advisor.

Background to Lisson Grove and Woolwell Medical Centres

The Lisson Grove Surgery provides primary medical services to people living in the Mutley area of Plymouth. They also had a branch medical centre in Woolwell which is located on the outskirts of Plymouth. The staff work across both sites and patients are able to be seen at either practice. We did not inspect the Woolwell branch on this inspection.

At the time of our inspection there were approximately 9,100 patients registered at The Lisson Grove Surgery. There were three GP partners, two female and one male, who held managerial and financial responsibility for running the business. There was also two male GPs, currently working within the practices joining as partners on 1 July 2015. The GPs were supported by a Nurse practitioner, four registered nurses, and two healthcare assistant, a practice manager, and additional administrative and reception staff. Patients using the practice also had access to community staff including district nurses, health visitors, and midwives.

The Lisson Grove Surgery is open from 8 am until 1pm and then 2pm until 6pm Monday to Friday. Appointments are available from 8am to 1pm and then from 2pm until 6pm. During evenings and weekends, when the practice is closed, patients are directed to an Out of Hours service delivered by another provider.

The Practice is actively involved in teaching medical students from the Peninsular Medical School and is also a GP training Practice.

The practice had a general medical service contract that outlined core services to be provided to patients. The practice had not signed up for the provision of enabling patients to consult a health care professional, face to face, by telephone or by other means at times other than during core hours.

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.

How we carried out this inspection

Before conducting our announced inspection of the Lisson Grove Surgery, we reviewed a range of information we held

Detailed findings

about the service and asked other organisations to share what they knew about the service. Organisations included the local Health watch, NHS England, and the local Devon Clinical Commissioning Group.

We requested information and documentation from the provider which was made available to us either before, during or 48 hours after the inspection.

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 23 June 2015. During our visit we spoke with a range of staff and spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients.

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, a patient was given correspondence belonging to another patient in error. All staff received training in confidentiality and additional measures were put in place to establish patient's identity prior to handing over information.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last two years. 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

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during 2014/15 and we were able to review these. Significant events were a standing item on the practice meeting agenda. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. We were shown the system used to manage and monitor incidents. We tracked an incident and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, an older patient had not received a blood result in a timely way as they had not contacted the practice for their results. The system for reading results changed following this incident to include an inform list for patients that were considered vulnerable. Where patients had been affected by something that had gone wrong, in line with practice policy, patients were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by the practice manager. Non medicine alerts were e mailed to all practice staff. Medicines alerts were e mailed to the GPs and if action was required this was documented and recorded. All alerts were discussed at practice meetings.

Reliable safety systems and processes including safeguarding

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

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained to level three and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

There was a chaperone policy, which was visible in the reception area, but not in the consulting rooms. (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). Not all nursing staff, including health care assistants, had been trained to be a chaperone so did not understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

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 that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

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.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. A member of the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

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 two leads for infection control, a nurse and the practice manager who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates with practical exercises such as hand washing and how to use the spillage kits. We saw evidence that the leads had carried detailed bi- monthly audits for the practice and met with the practice partners to discuss findings.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

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

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water).We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date was March 2015. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer had been tested in March 2015.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. All staff worked part time and had

adjusted shifts for work/life balance. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix met planned staffing requirements.

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 regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the log. The meeting minutes we reviewed showed 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. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a telephone company to contact if the telephones system failed.

The practice had carried out a fire risk assessment in December 2014 that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills, most recently in June 2015.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

The GPs told us they lead in specialist clinical areas such as minor surgery, drug dependency, dermoscopy (examinations of skin lesions) substance misuse and family planning. 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.

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

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and 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 that had been undertaken in the last two years. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of antibiotics in young children. Following the audit, the GP carried out medicine reviews for patients who were prescribed these medicines. The practice altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes. These were discussed at the monthly governance meetings.

The practice's prescribing rates were also similar to national figures. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check 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 that the latest prescribing guidance was being used. The computer system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence 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 practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 73.89% of patients with diabetes had an annual foot examination, and the practice met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease) and treating patients with osteoporosis. This practice was not an outlier for any QOF clinical targets.

Good

Are services effective?

(for example, treatment is effective)

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups such as patients with learning disabilities. Structured annual reviews were also undertaken for people with long term conditions for example diabetes, and heart conditions.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix amongst the GPs. They had specialism areas in minor surgery, drug dependency and dermatology. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. The practice had introduced 360-degree feedback which included direct feedback from the employee's subordinates, peers (colleagues), and supervisor(s), as well as a self-evaluation. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example up dates in wound care.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines, and cervical cytology. Those with extended roles for example, seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

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 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising these communications. Out-of hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up.

The practice had daily contact with other healthcare professionals to discuss patients. They also held multidisciplinary team meetings three monthly to discuss patients with complex needs. For example, those with multiple long term conditions, mental health problems, people from vulnerable groups, 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. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

Information sharing

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

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 that action had been taken to address any shortcomings identified.

Good

Are services effective?

(for example, treatment is effective)

Regular meetings were held throughout the practice. Information about risks and significant events were shared openly at meetings and all staff were able to contribute to discussions about how improvements could be made.

There was a practice website with information for patients including signposting, services available and latest news. Information leaflets and posters about local services were available in the waiting area. The practice used a text messaging service to remind patients of any significant things and appointment times.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children's Act 1989 and 2004 and their duties in fulfilling their legal duties under this legislation. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it.

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. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. Staff gave 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 the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

Health promotion and prevention

The practice used information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA) undertaken by the local authority to help focus health promotion activity. The JSNA pulls together information about the health and social care needs of the local area.

It was practice policy to offer a health check 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 opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 35.5% of patients in this age group took up the offer of the health check. We were shown the process for following up patients if they had risk factors for disease identified at the health check and how further investigations were scheduled.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had identified the smoking status of 42% of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to 62% of these patients. There was evidence these were having some success as the number of patients who had stopped smoking in the last 12 months was 50%.

The practice's performance for the cervical screening programme was 80.6%, which matched the national average. There was a policy to offer telephone, texts and written reminders for patients who did not attend for their cervical screening test. A practice nurse had responsibility for following up patients who did not attend. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

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 patient survey2014/2015 undertaken by the practice's patient liaison group (PLG). (A PLG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example,

- 84% said the GP was good at listening to them compared to the CCG average of 92% and national average of 89%.
- 88% said the GP gave them enough time compared to the CCG average of 91% and national average of 87%.
- 96% said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and national average of 95%.

We also spoke with three patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was shielded by glass partitions which helped keep patient information private. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained. Additionally, 94% said they found the receptionists at the practice helpful compared to the CCG average of 91% and national average of 87%.

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 national patient survey showed 86% of practice respondents said the GP involved them in care decisions and 71% felt the GP was good at explaining treatment and results.

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

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

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. The patients we spoke to on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Good

Are services caring?

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs.

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 patients' 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.

The practice welcomed feedback from patients and external bodies and used significant events, complaints and near misses to improve the services provided. To obtain additional feedback from patients, a patient's liaison group (PLG) undertook surveys and these were to consult about opening times, making routine and urgent appointments, telephone access, environment and the overall opinion of the practice.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient liaison group (PLG). For example, the practice was experiencing increased usage of the telephone system resulting in longer waits for patients. As a result of this feedback the practice changed its working practice and numbers of staff answering the telephones at different times throughout the day which has improved the service.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Staff said no patient would be turned away. The practice staff knew how to access language translation services if information was not understood by the patient, to enable them to make an informed decision or to give consent to treatment. The practice had used the Prime Ministers challenge fund to purchase portable computer devices that could be used for translation

The practice had level access for patients using wheelchairs and patients with pushchairs. The front door and corridors were wide and there were consultation and treatment rooms on the same floor level allowing easy access for pushchairs and wheelchair users. The practice also had treatment and consultation rooms on the first floor for patients that were able to access them. Toys were available for younger children. We saw that the waiting area was large enough to accommodate patients with wheelchairs and push chairs 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.

The practice had the medical equipment it required to provide the services it offered. Clinical treatment rooms had the equipment required for minor surgery and other procedures which took place.

Access to the service

Opening times and out of hours arrangements were displayed on the front door of the practice and in all Practice leaflets and relevant posters, practice website, and on NHS Choices website. Appointments were available from 8am to 1pm and then from 2pm until 6pm.

The practice had not signed up for the provision of enabling patients to consult a health care professional, face to face, by telephone or by other means at times other than during core hours.

Patients were able to telephone to pre-book an appointment with a GP, nurses and healthcare assistants up to four weeks in advance. Patients could also book an appointment in advance on-line via the practice website using 'The Waiting Room'; which was available 24 hours a day. Patients were able to telephone the practice to make an appointment on the day with a GP, nurse or health care assistant.

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.

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to local care homes by a named GP to those patients who needed one.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example:

- 77% described their experience of making an appointment as good compared to the CCG average of 83% and national average of 73%.
- 90% said they could get through easily to the surgery by phone compared to the CCG average of 84% and national average of 73%.
- 94% said that they were able to get an appointment or speak to someone the last time they tried, compared to the CCG average of 91% and the national average of 85%.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a GP on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another GP if there was a wait to see the GP of their choice. Routine appointments were available for booking four weeks in advance. Comments received from patients also showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

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.

We saw that information was available to help patients understand the complaints system. The procedure was displayed as well as information about advocacy services. Complaints forms were readily available on the reception desk. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and observed that themes had been identified, for example, difficulty in making an appointment at the practice. The practice had acted on this information and reviewed their appointment systems, this remains under review.

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 were able to describe the vision, values, strategic and operational aims of the practice; these were hope, help, and healing. Their aim was to provide a service that treated people with dignity and respect, Staff said one of the main strengths of the practice was the morale and team atmosphere. There were clear lines of accountability and areas of responsibility. Staff knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at these policies and procedures and most staff had completed a cover sheet to confirm that they had read the policy and when. All the policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a partner 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 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 that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had an on going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, the practice was auditing medicines being prescribed in the practice.

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

Leadership, openness and transparency

We saw from minutes that team meetings were held; at least monthly. These were used to review complaints, incidents, and areas of concern and for training purposes.

Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. For example, staff felt able to suggest moving the telephones to an area where they could not be overheard and the practice supported this.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example disciplinary procedures, induction policy, and management of sickness which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through patient surveys and complaints received. We looked at the results of the annual patient survey and patients were making reference to the sometimes delay in being able to get through to the practice by telephone and make an appointment. We saw as a result of this the practice had looked into the reasons why this might have happened and introduced new systems for reception staff to allow for more time and people to answer the telephones. The practice also altered their appointments to allow for additional GP and nurse slots.

The practice had patient liaison group (PLG). These members were regularly asked to comment on areas where they believed the practice could improve upon the services they deliver. The results and actions agreed from these surveys are available on the practice website.

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

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files chosen at random

Are services well-led?

Good

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

and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and they had protected time to carry out any learning.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. For example one significant event affected the GPs, nursing team and administration team. All staff were reminded of correct procedures and measures put in place to prevent the situation arising again.