Your Health Partnership

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 a comprehensive inspection on 18 March 2015. The practice has registered with the Care Quality Commission to provide primary care services to its local population. This is the report of the findings from our inspection.

We have rated each section of our findings for each key area. The practice provided a safe, effective, caring, responsive and well led service for the population it served. The overall rating was good and this was because the motivated practice staff consistently provided good standards of care for patients.

Our key findings were as follows:

- Practice staff worked together as a team to ensure patients received the standards of care they needed. Practice staff were responsive to suggestions for improvements that lead to improved patient care. There was a clear leadership structure in place. Quality and performance were monitored and improvements made in service delivery.
- There were safe systems in place for ensuring patients received appropriate treatments and prescribed medicines were regularly reviewed to check they were still needed. The practice planned its services to meet the diversity of its patients. Appointments length were need specific. Longer appointments were offered to some patients. For example, patients with a learning disability or multiple health conditions.
- Patients were protected against the unnecessary risks of infections because staff adhered to appropriate hygiene practices and regular checks were carried out.
- The practice was able to demonstrate a good track record for safety. Staff understood and fulfilled their responsibilities to raise concerns, report incidents and near misses. Staff used these opportunities to learn from incidents to support improvements.

Summary of findings

- Patients were treated with respect and their privacy was maintained. Patients informed us they were very satisfied with the care they received. The feedback we received from patients was without exception positive. There was a strong patient centred culture and motivated staff provided kind and compassionate care.
- The practice facilitated eight hospital consultants held regular clinics at the practice for a range of specialties for patient's convenience. For example, gynaecology, memory clinic and dermatology. These sessions were for the practice's own patients only.

We saw several areas of outstanding practice including:

- The practice employed a specialist dementia nurse who visited patients in their own homes. The specialist nurse and a visiting hospital consultant held a monthly dementia clinic at the practice.
- There were systems in place to identify and provide appropriate treatment to patients who had specific mental health needs. This included prompt review and regular and follow up to ensure their condition did not deteriorate. A GP with a specialist interest maintained a register and monitored patients who had been diagnosed with mental health problems. There were 112 patients on the significant mental health register.
- The practice provided a weekly drop-in clinic for sexual health advice.

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. There were systems in place to address incidents and to protect children and adults and other vulnerable patients. Patients we spoke with told us they felt relaxed and comfortable with practice staff during their appointments. Staff took action to learn from incidents and made appropriate safeguarding referrals when required. Staff understood and fulfilled their responsibilities to raise concerns and report incidents. Appropriate checks had been carried out before staff commenced working with vulnerable patients.

Are services effective?

Good

The practice is rated as good for providing effective services. There were systems in place to ensure improved clinical services were provided for patients. Clinicians were up to date with both the National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines which were influencing improved outcomes for patients. Clinicians carried out and learnt from clinical audit cycles and learning was shared with relevant practice staff. The advanced nurse practitioners had a wider range of responsibilities than practice nurses in contributing to provision of holistic patient care. They provided care for patients who had long term conditions such as diabetes and asthma.

Are services caring?

Good

The practice is rated as good for providing caring services. Feedback from discussions with patients during the inspection and the comment cards we received provided positive comments about the standards of care they received. Staff we spoke with were aware of the importance of providing patients with privacy and information was available to help patients understand the care available to them. We observed that staff interacted with patients in a polite and helpful way and they greeted patients in a friendly manner.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Practice staff had reviewed the needs of their local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. There was evidence that staff listened and responded to suggestions made by patients and the Patient Participation Group (PPG). These resulted in adjustments to meet the needs of patients. There was a

Summary of findings

complaints procedure that staff followed. Staff responded appropriately and promptly to any complaints received and brought them to resolution. There was evidence of learning from the outcomes of complaints.	
Are services well-led? The practice is rated as good for providing well led services. All staff had designated lead roles for delivery of an effective service. There was a clear set of values which were understood by staff and evident in their behaviours. There was a defined leadership structure in place and staff communicated well at all levels. A range of staff meetings were held where possible improvements were discussed and agreed. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice.	**Good** 

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 older people. Patients over the age of 75 years had been informed of their named and accountable GP. Staff were able to recognise signs of concerns or abuse in older patients and knew how to escalate concerns. The practice kept a register of carers to ensure their needs as well as the patient's care needs were met. Patients who were unable to go to the practice were routinely visited so they could be given information and advice to prevent unplanned admissions to hospital. Those patients who had difficulty in accessing the practice could request telephone consultations to enable GPs to determine if a face to face appointment was needed. If necessary GPs would carry out home visits on the same day they were requested. Staff were responsive to the needs of older people, including offering rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for people with long term conditions. Patients had annual reviews and if necessary more regular reviews of their condition and their medicine needs were also checked. When needed longer appointments and home visits were available. Practice staff had developed a re-call system for patients who failed to attend for the health check or medicine review. They were contacted by phone or letter until the review had been carried out. Patients identified to be at risk had care plans in place and these were regularly reviewed. Regular multidisciplinary meetings were held to ensure patients received integrated care. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health.

Families, children and young people

Good

The practice is rated as good for care of families, children and young people. Practice staff had good working relationships with health visitors, school nurses and social workers to provide support to this population group. Requests for young children's appointments were booked for the same day. Systems were in place for identifying and following up children who were at risk of harm. Childhood immunisation was provided at the practice and there had been a good uptake of this service. Weekly 'drop in' sexual health clinics were well attended and cervical screening was offered to female patients.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for care provided to working age people (including those recently retired and students). There was a proactive system in place offering on-line services for making appointments and ordering repeat prescriptions. There were extended opening hours to assist patients in accessing the practice. Appointments were available from 7.10am on Thursdays and between 6.30pm and 7.30pm alternating between Tuesday and Wednesday each week. Patients could also access the nearby branch practice on Saturdays between 8am and 11am.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances. Care plans of vulnerable patients were updated every three months. Registrations for temporary patients were accepted at the practice. There was a GP with a special interest in substance misuse who provided shared care with the drug treatment service. Patients who had a learning disability were offered annual health checks. The nurse who was the lead for these health checks contacted or went out to see patients if they did not attend the practice. Patients who did not wish to have health checks were discussed with a GP and the learning disability community team were informed.

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). Staff knew how to recognise and manage referrals of patients with complex health needs.There were systems in place to identify and provide appropriate treatment to patients who had specific mental health needs. This included prompt review and regular and follow up to ensure their condition did not deteriorate. A GP with a specialist interest maintained a register and monitored patients who had been diagnosed with mental health problems. There were 112 patients on the mental health register. Patients showing signs of memory loss or dementia were given assistance. Information was shared with other health and social care professionals who could help these patients. The practice employed a specialist dementia nurse who visited patients in their own homes. The specialist nurse and a visiting hospital consultant held a monthly dementia clinic at the practice.

Summary of findings

What people who use the service say

We spoke with 11 patients during our inspection who varied in age and clinical needs. Some had been registered with the practice for many years. They informed us that staff were polite, helpful and knowledgeable about their needs. Patients told us they were given enough explanations so they understood about their health status and felt they were encouraged to make decisions about their care and treatment. They all gave us positive feedback about the standards of care they received. We were told it was easy to obtain repeat prescriptions. Patients said they did not have a problem in obtaining an appointment.

We collected 30 Care Quality Commission comment cards left at the practice prior to the inspection. All comments made about care and staff attitudes were positive. The comments included staff efficiency and how professional they were and the good standards of care provided. Four comment cards informed us patients had problems in obtaining appointments and one said it was difficult to get through by telephone.

The Patient Participation Group (PPG) had carried out an annual survey. PPG's are a way for patients and practices to work together to improve services and promote quality care. We met with 10 members, including the chair person and deputy chair on the day of the inspection.

They commented positively about how they had influenced changes and the good standards of care they received. The patient survey report dated 11 March 2015 informed us that the overall results were positive. The PPG members we spoke with told us they discussed recommended improvements from the report during their meetings and how these would be approached. For example, to improve the telephone access for patients and appointments to enable patients to book them at appropriate times.

The National Patient Survey latest results informed us that the results were average or above average for the practice:

- 88.7% of respondents would recommend the practice,
- 91.9% satisfaction when patients wanted to speak with or see a GP or nurse and get an appointment,
- 88.7% were satisfied with the opening times,
- 83.3% had good or very good experience for making an appointment,
- 93.2% reported their overall experience was good or very good.

These results were rated as being amongst the best nationally.

Outstanding practice

We saw several areas of outstanding practice including:

- The practice employed a specialist dementia nurse who visited patients in their own homes. The specialist nurse and a visiting hospital consultant hold a monthly dementia clinic at the practice.
- All patients who are diagnosed with anxiety were regularly followed up to prevent escalation of their mental health condition. Any patients who had self-harmed were reviewed within one week. A GP with a specialist interest maintained a register and monitored patients who had been diagnosed with mental health problems.
- The practice provides a weekly drop-in clinic for sexual health advice. We were told this clinic is well attended.

Your Health Partnership

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor, a specialist advisor who had experience in practice management and an expert by experience who had personal experience of using primary medical services.

Background to Your Health Partnership

Your Health Partnership serves approximately 15000 patients. The practice delivers primary medical care under a Primary Medical Services contract between themselves and NHS England. The practice has a higher than national average of patients suffering with depression. There is also a higher than average number of people with chronic obstructive pulmonary disease (COPD).

There was a branch surgery located at 19 Rowley Village, Rowley Regis, B65 9EN. We did not visit the branch surgery as part of this inspection.

At the time of our inspection there were a mixture of female and male GP partners and one salaried GP was employed at the practice. Other clinical staff consisted of the head of nursing and patient services, a lead nurse/advanced nurse practitioner an advanced nurse practitioner, two specialist nurse practitioners, four practice nurses and two health care assistants. The outlet operations manager was supported by an operations support lead, reception supervisor, receptionist staff and administrators who work varying hours.

The practice offers a wide range of services including chronic disease management, diabetes, cervical smears, contraception, minor surgery, injections and vaccinations.

The practice had opted out of providing out-of-hours services to their own patients. Patients were advised to use the local walk-in centre when the practice was closed or to contact NHS 111 if it was an emergency. This information was available in the waiting area, in the patient leaflet, via the practice telephone and on the website.

The Care Quality Commission had not received information of any performance issues by NHS England or the Clinical commissioning Group prior to our inspection.

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:

Detailed findings

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

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

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

Before 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 inspection on 18 March 2015. During our inspection we spoke with a range of staff including two GPs, the salaried GP, two advanced nurse practitioners, one practice nurse, one health care assistant , the outlet operations manager, the operations support lead, two receptionists and one administrator. We also spoke with 11patients who used the service and received 30 comment cards from patients. We observed how patients were being cared for and staff interactions with them. We looked at relevant documentation in relation to patient care and treatment.

Good

Are services safe?

Our findings

Safe track record

We spoke with 11 patents about their experience at the practice. None of the patients we spoke with reported any safety concerns to us.

Practice staff 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, emergency treatment was provided to a patient. Following this the written emergency procedure was reviewed to ensure it was pertinent. The revised procedure was sent to all staff.

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

The management team, clinical and non-clinical staff discussed significant events at a range of monthly staff meetings so that all relevant staff learnt from incidents and reduced the likelihood of recurrences.

Learning and improvement from safety incidents

There was a system in place for reporting, recording and monitoring significant events. A recent significant event had been recorded where a patient had not been followed up from their visit to an out-of-hours service. A system was put in place to highlight these events and prevent delays in any necessary follow up.

The practice was in partnership with two other practices. The senior GP's from each practice met monthly to discuss to share information, learn from events and make any necessary improvements. Following these a range of staff meetings were held monthly to include all practice staff. Relevant information and learning was cascaded through these meetings so that all staff were made aware.

There was a written protocol for discussion, dissemination, recording significant events and clinical audits. Significant events that we reviewed showed the dates and descriptions of incidents. The recordings included investigations and what could be done differently to prevent similar occurrences. From speaking with staff we were informed that the team recognised the benefits from identifying events and learning from them.

Reliable safety systems and processes including safeguarding

Safeguarding policies for children and vulnerable adults were regularly reviewed and accessible to all staff. One of the GPs took the lead for safeguarding and all the staff we spoke with were aware of who the lead was. Staff had access to the contact details of child protection and adult safeguarding teams in the area.

All staff had received safeguarding training to the level that was commensurate with their roles. Staff we spoke with were able to tell us the action they would take if they were concerned about a patient's safety or suspected abuse. Staff demonstrated they would take appropriate and prompt action.

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

There was a chaperone policy available to staff, a poster was on display in clinical rooms and in the patient leaflet. When chaperoning took place this was recorded in the patient's records. Clinical staff carried out chaperone duties, non-clinical staff did not carry out this role. Staff had received training before they were permitted to chaperone patients. We asked a range of staff how they would carry out this duty. They demonstrated appropriate knowledge and understanding of their role to maintain patient's safety.

Medicines management

There were clear systems in place for medicines management. Medicines management was routinely discussed every three months during the 'Clinical Operations Group' (the three partnership) meetings. Acute and repeat prescribing was in line with the General Medical council (GMC) guidelines. Patients received medicine reviews at least annually and more often if required before prescriptions were re-authorised.

Good

Are services safe?

All prescriptions were printed and there were checks in place to ensure they were kept secure. Reception staff were aware of the questions to ask for proof of identity when prescriptions were collected.

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

Vaccines were stored in line with national guidance. We saw recordings that confirmed daily fridge temperatures were recorded to ensure the vaccines were stored at suitable temperatures according to manufacturer's instructions. There was an effective rotation system in place to reduce the likelihood of vaccines going out of date before administration.

Arrangements were in place to check medicines were within their expiry date and safe for use. All the medicines we checked were within their expiry dates.

GPs kept medicines for use in an emergency in their bags for when they visited patients in their own homes. For example, treatment for anaphylaxis. The medicines had been routinely checked to ensure they remained safe for use and within their expiry date.

Cleanliness and infection control

We observed all areas of the practice to be visibly clean, tidy and well maintained. The practice had an infection prevention and control (IPC) policy with a responsible lead. We saw evidence that staff had received training in IPC to ensure they were up to date in all relevant areas. Aprons, gloves and other protective equipment were available in all treatment areas as was hand sanitizer and safe hand washing guidance.

The IPC lead told us they attended conferences and study days for IPC to keep them updated. As well as an annual audit of the premises the lead carried out monthly spot checks of each clinical room and recorded the findings. Any areas where improvements were needed were brought to the attention of the relevant staff member.

Environmental cleaning of the whole building was undertaken by an external contractor and monitored by the IPC lead and practice manager. We saw that cleaning schedules for all areas of the practice were in place.

We found that suitable arrangements were in place for the storage and the disposal of clinical waste and sharps. Sharps boxes were dated and signed with the date of use to enable staff to monitor how long they had been in place. A contract was in place to ensure the safe dispose of clinical waste.

A legionella risk assessment had been completed to ensure that any risks to patients had been acted on. Legionella is a term used for a particular bacteria which can contaminate water systems in buildings.

Equipment

We saw all equipment had been tested and that the provider had contracts in place for annual portable appliance testing (PAT).There were arrangements in place for routine servicing and calibration, where needed, of equipment such as blood pressure cuffs, weighing scales, and blood pressure monitoring equipment.

Staffing and recruitment

There was an up to date recruitment policy that covered all aspects of staff recruitment. We looked at a sample of personnel files for a range of staff. Some staff had been employed at the practice for several years. We saw that a complete work history was obtained, evidence of identity, references and a Disclosure and Barring Service (DBS) criminal record checks had been carried out for all staff including non-clinical staff.

The professional registration status of all clinical staff had been checked with the General Medical Council (GMC) for GPs and the Nursing and Midwifery Council (NMC) for nurses to ensure they were fit to practice.

Procedures were in place to manage staff absences. We were told that clinical staff worked across the three practices within the partnership to provide cover for each other. On the day of our inspection the practice had a locum advanced nurse practitioner working at the practice. Locum GPs were also used to maintain safe staffing levels in meeting patient's needs. Appropriate checks had been carried out before locum GPs worked at the practice.

Monitoring safety and responding to risk

Good

Are services safe?

There were systems in place to identify record and report risks identified within the practice. These included regular assessments and checks of clinical practice, medicines, equipment and the environment. We saw that staff had specific areas of responsibility but they told us they could request support at any time. This contributed to reduced risks and errors.

Staff we spoke with told us they would speak with the outlet operations manager if an accident occurred and they would record their findings. Events and incidents were discussed during staff meetings and staff said that reflection and learning from these was a routine part of their role. Staff told us that the management team were responsive to any concerns raised and open to ideas where areas of the practice could be developed.

There was a fire safety risk assessment in place. Staff had received regular fire safety training and participated in regular fire drills to maintain their knowledge of how to respond in an emergency.

There was a health and safety policy in place and staff knew where to access it.

Arrangements to deal with emergencies and major incidents

Patients were protected from the use of unsafe equipment in a medical emergency. The equipment was checked regularly to ensure it was in working condition and medicines were within expiry dates. We saw evidence of these checks. The checks also included the annual testing of fire protection equipment such as fire extinguishers. There were records which listed all equipment needing servicing and checks. This ensured that all equipment was maintained in good working order.

We saw that all staff had received training in basic life support and had attended regular updating courses. Staff knew where to find the emergency equipment and medicines. These had been regularly checked to make sure they were fit for use. Oxygen and an automated external defibrillator were also available. An Automated External Defibrillator (AED) is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore normal heart rhythm.

We saw a copy of the business continuity plan. It included the contact details of services that could provide emergency assistance. Senior practice staff kept a copy of the document off site to ensure there was access to it in any eventuality.

Staff we spoke with were aware of the action to take in an emergency and how they could access additional advice. They told us they were informed of any changes in emergency procedures during their monthly meetings.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

GPs and nurses demonstrated how they accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of a range of staff meetings where new guidelines were distributed and the implications for the practice's performance and patient's care had been identified. The GPs and nursing staff spoken with were aware of their professional responsibilities to maintain their knowledge and skills.

Nursing staff managed clinical areas such as diabetes, asthma and dementia care. Patients who had memory problems were identified and monthly memory clinics were held by a visiting hospital consultant and a practice nurse who specialised in this area.

GPs, nurses and health care assistants had the facility to offer longer appointments where they thought this would be helpful. It was normal practice for clinical staff to contact all patients and discuss the symptoms with the patient on the telephone prior to an appointment being arranged. Staff could therefore ensure longer appointments were provided where it was felt a more in-depth needs assessment was required. Longer appointments were made for patients with known long term conditions and patients who had a learning disability to ensure effective communications.

Care plans had been put in place for patients who required higher levels of care or were considered to be at risk. The care plans were reviewed regularly and shared with community professionals to promote co-ordinated care.

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

Management, monitoring and improving outcomes for people

There was a system in place for completing clinical audit cycles. We were provided with a list of the audits that had been carried out and those that would be repeated to monitor improvements in patient treatments. We were shown evidence of an audit completed in December 2014 concerning referrals for tonsillectomy and the lessons learnt from them. GPs ensured that adequate advice was given to patients that may lead to a reduction in referrals. Records told us that the audit was due to be repeated July 2016. Numerous audits about medicines had been carried out and changes made where identified to improve patients' treatments.

Some GPs undertook minor surgery procedures in line with National Institute for Health and Care Excellence (NICE) guidelines. The staff had been appropriately trained. Clinical audits were carried out and the results used as a learning tool.

Practice staff monitored the number of patients who attended for reviews of their long term conditions. Where patients had failed to attend they were contacted by telephone or letter up to three times requesting them to make an appointment.

GPs held regular clinical meetings. The minutes of the meetings that we looked at informed us patient care, significant events, complaints, hospital admissions and standards of patient care had been discussed. The recordings included learning from errors.

Effective staffing

We saw that all newly recruited staff were provided with an induction pack and a formal induction to Your Health Partnership We were shown templates for the induction that staff underwent before they worked independently. It was tailored for staff grades and was detailed.

All staff we spoke with were complimentary and happy with the training opportunities available to them for continuing professional development. For example, three senior nurses had completed academy training in leadership. Staff had undertaken training that was appropriate for their roles and had received refresher training as required. Further specialist training was made available for staff. For example, nurses had completed training in cervical screening and dementia.

The advanced nurse practitioners (ANP) and specialist nurse practitioners (SNP) had more responsibility than practice nurses so they were able to see a broader range of patients. These staff led specialist clinics. For example, memory clinics, diabetes and chronic obstructive pulmonary disease (COPD).

Good

Are services effective?

(for example, treatment is effective)

GP partners we spoke with had undergone external revalidation of their practice. Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise medicine.

All staff had annual appraisals to assess their knowledge and competency. Appraisals were carried out by line managers ensuring that clinical staff were assessed by clinical staff to ensure that knowledgeable assessments were carried out.

All patients we spoke with were complimentary about staff knowledge and we observed staff who appeared to be competent and comfortable within their roles.

Working with colleagues and other services

All practice staff worked closely together to ensure provision of an effective service for patients. They worked in collaboration with community services. As well the monthly partnership meetings minutes evidenced that district nurses and other community staff attended monthly meetings which were held at the practice. Complex cases and patients who had extra needs were discussed. The minutes gave evidence of good information sharing and arrangements for integrated care for those patients.

Palliative (end of life) care patients were cared for within the Gold Standards Framework. This is a national framework that staff work with to ensure patients receive a consistent and appropriate level of care. The practice ensured these patients had a named GP who carried out regular reviews of them and maintained communications with community staff who were also involved with patient's care. Practice staff had strong links with community staff, local hospices and other organisations that may be able to assist.

Letters received from hospitals including discharge letters and information received electronically from other health organisations were dealt with initially by administration staff. We were told this was a pilot and was being closely monitored by a GP to ensure staff fitness to carry out the role. We were told the result so far was that administration staff had identified actions that should have been dealt with previously, such as coding. Any information received where it was suggested that follow up was required were brought to the attention of GPs.

Staff at this practice and the other partnership practices knew each other due to crossover working arrangements and through meetings they attended together. Staff had their own base but were comfortable working at the other practices if they needed to.

Information sharing

There was a system in place to ensure the out of hours service had access to up to date treatment plans of patients who were receiving specialist support or palliative care.

Patients were discussed between clinical staff and also with other health and social care professionals who were invited to practice meetings.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to co-ordinate, document and manage patient care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The system included a facility to flag up patients who required closer monitoring such as children at risk.

There was a practice website with information for links to healthy living advice, signposting to specialist services and the latest practice news. The website also informed patients of the various clinics held and their right to have a chaperone during visits to the practice. The patient leaflet also provided a range of information about the services available to patients.

Consent to care and treatment

The clinicians we spoke with confidently described the processes to ensure that informed consent was obtained from patients whenever necessary. They were also aware of the requirements of the Mental Capacity Act 2005 used for adults who lacked capacity to make informed decisions.

Staff understood and were trained in requirements around consent and decision making for patients who attended the practice. GPs and nurses spoke about situations where best interests or mental capacity assessments might be appropriate.

They also knew how to assess the competency of children and young people about their ability to make decisions about their own treatments. Clinical staff understood the key parts of legislation of the Children's and Families Act

Good

Are services effective?

(for example, treatment is effective)

2014 and were able to describe how they implemented it in their practice. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged less than 16 years of age who have the legal capacity to consent to medical examination and treatment).

We spoke with 11 patients and they all confirmed they felt in control of their care because they had been well informed about their illnesses and treatment options. We were told that consent forms were signed only after full explanations had been given to patients. We saw evidence that patients who had undergone minor surgery at the practice had been properly informed of the risks and benefits of the procedure.

Health promotion and prevention

The outlet operations manager told us that all new patients were offered a health check, tests and a review of any illness and medicines they were taking. Patients were asked about their social factors, such as occupation and lifestyles. These ensured doctors were aware of the wider context of their health needs.

Patients were encouraged to take an interest in their health and to take action to improve and maintain it. A health care assistant ran a weight clinic for patients who were prescribed weight reduction medicines.

Patients with learning disabilities or mental health conditions were offered an annual health review. We saw that there had been a good uptake of this service.

Female patients were encouraged and monitored to ensure they attended for cervical screening. Records informed us that efforts were being made to capture all patients who required screening. By the end of the third quarter of the year 88.10% of patients had received screening.

Statistics produced by the practice staff told us that 90% of children had received their childhood vaccinations in line with their eligibility.

There was a weekly 'drop in' clinic offering patients sexual advice. We were told these were well attended.

The practice website signposted patients to places where they could obtain advice about specialist health conditions such as diabetes. Health promotion literature was readily available in the waiting area. The patient leaflet included information about the effects of alcohol consumption and steps towards leading healthier lifestyles.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients we spoke with told us they felt that all of their health matters were assessed and they were cared for by staff who were considerate of their needs. Patients told us that staff displayed empathy and were respectful when they were in contact with practice staff.

Privacy during consultations was maintained. Windows were screened, examination couches had privacy curtains and consultations took place behind closed doors. Patients spoke highly about how staff ensured their privacy and dignity was respected. The practice switchboard was located in an area away from patients so that conversation could not be overheard.

We observed that reception staff were courteous, helpful and spoke quietly with patients to prevent others from overhearing their conversations. Reception staff told us that if a patient wished to hold a private conversation the patient would be invited into an unoccupied room.

Some patients we spoke with confirmed they knew their rights about requesting a chaperone. They told us this service was offered to them by clinical staff. Some patients had used the chaperone service and reported to us they felt quite comfortable during the procedure. The practice had a chaperone policy in place and staff knew where to access it.

Care planning and involvement in decisions about care and treatment

Patients were encouraged to take responsibility for their health conditions and to be involved in decisions about medicines and other forms of treatments. They were empowered through discussions to acknowledge risks and make decisions about their treatments. All patients with complex needs or palliative (end of life) had care plans in place and these were regularly reviewed in line with patient's wishes. Patients we spoke with told us that clinical staff were good at involving them in making decisions.

Patients told us they were given the time they needed and were encouraged to ask questions until they understood about their health status and the range of treatments available to them. Patients we spoke with told us they were able to make informed decisions about their care and felt in control.

Administration staff carried out checks and identified patients with long term conditions who had not attended the practice for their annual health check. Three reminders were sent to patients via telephone or letter to encourage patients to have their care needs updated. During December 2014 staff had sent re-calls out to 94 patients who needed to have their blood pressure checked and 53 patients who required flu vaccination.

Patient/carer support to cope emotionally with care and treatment

Those patients who had carers were asked at registration with the practice to declare this. During consultation clinical staff routinely enquired if patients had carers. Clinical staff told us they discussed the help available to carers. Practice staff maintained a register of known carers.

The waiting area had a notice board aimed at 'young carers' and where they could obtain assistance. There were also signs providing advice about how to access support groups and agencies for carers.

A counselling service was provided at the practice. It was managed and run by a local hospital mental health team. Patients could be given referrals to this service.

Following bereavement the respective GP contacted the family by phone to offer them information about the various bereavement counselling services available to them. Counselling services were provided at the practice by external professionals.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was pro-active in contacting patients by phone or letter who have failed to attend for vaccinations and health screening. Patients who were unable to go to the practice received these services from district nurses. Practice staff followed up information they received about vulnerable patients.

The outlet operations manager and at least one GP attended each monthly Clinical Commissioning (CCG) meeting and cascaded information from those meetings to other staff. The NHS Area Team and CCG told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' and buying health and care services.

Practice staff worked collaboratively with other agencies, regularly updating shared information to ensure changes were communicated and acted on.

GPs met regularly and analysed all hospital admissions to check if any were avoidable and for identifying learning points. During palliative care meetings all patients on the list were reviewed and records updated to ensure they received co-ordinated care that was current for their needs.

The practice employed a specialist dementia nurse who visited patients in their own homes. The specialist nurse and a visiting hospital consultant held a monthly dementia clinic at the practice.

All patients who were diagnosed with anxiety were regularly followed up to prevent escalation of their mental health condition. Any patients who had self-harmed were followed up with a review within one week. A GP with a specialist interest maintained a register and monitored patients who had been diagnosed with mental health problems.

Outpatient clinics were held at the practice by visiting hospital consultants. Clinics were held fortnightly, monthly and bi monthly depending on the specialism. They included dermatology, cardiology, gastroenterology, gynaecology, ophthalmology, rheumatology, memory and ear, nose and throat clinics. We spoke with a patient who attended one of these clinics. They told us they were satisfied with their assessment and treatment needs.

Patients requiring specialist investigation or treatment were referred to hospitals. Patients could choose where they wished to be referred. Patients told us their referrals had been carried out effectively and promptly. There was a 'choose and book' system so that patients could review the waiting times at various hospitals before making their decisions about where they wanted to be seen. We asked administration staff how long it took to send out the referral letters. We were told they were completed within 24 to 48 hours and urgent ones on the day they were requested.

During our inspection we met with 10 members of the Patient participation Group (PPG) including the chair person and deputy chair person. They gave us examples of improvements that had been made following discussion between practice staff and the PPG. They told us how they had been consulted with and influenced the revised layout of the waiting area. Senior staff had accepted their recommendations and the work was completed with the PPG's suggestions incorporated. All of the members present told us that the practice staff were forward thinking and the outlet operations manager was approachable, professional, listened and where possible made suggested changes or explained why they could not be done.

Tackling inequity and promoting equality

Practice staff had recognised the needs of different groups in the planning of its services. For example arrangements were in place for temporary residents to register at the practice to ensure they had access to a GP when necessary.

The practice had access to a translation service when a patient's first language was not English. Some of the GPs spoke other languages. The name of the GP and the language they spoke was on display at the entrance to the practice so that patients could request appointments with those GPs.

The practice was fully accessible for patients with poor mobility. There were toilet facilities for patients who had restricted mobility. All consulting rooms were located on

Good

Are services responsive to people's needs?

(for example, to feedback?)

the ground floor with wide access corridors and doorways to accommodate wheelchairs. The recent refurbishment of the waiting area ensured it was accessible by wheelchair users.

Access to the service

The practice opened from 8am until 6:30pm each day and remained open during extended hours.

The extended hours included appointments available from 7:10am on Thursdays and between

6:30pm and 7:30pm alternating between Tuesday and Wednesday each week. Patients could

also access the nearby branch practice on Saturdays between 8am and 11am. Appointments

could be made in person, by telephone or on-line via a computer.

The outlet operations manager showed us the recent increase in the number of newly registered

patients. They told us they were monitoring the appointment arrangements and that they would

need to increase available appointments if the practice struggled to meet patient's needs. Most

patients told us they were able to make an appointment when they needed one but some said it

was difficult.

Comprehensive information was available to patients about appointments on the practice website and in the practice leaflet which included information about how to access care and urgent attention. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

The practice had opted out of providing out-of-hours services to their own patients. Patients were advised to use the local walk-in centre when the practice was closed. If they required emergency care patients were advised to contact Primecare who provided this service. This information was available in the waiting area, in the patient leaflet, via the practice telephone and on the website.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. The practice leaflet informed patients about how to make a complaint if they needed to.

We were shown a summary of the complaints received during the last 12 months. They had received 10 complaints during this time. We saw they had been investigated, responded to and there were instances where changes had been made to prevent recurrences. One complaint concerned poor communication by practice staff. This had been discussed with staff and the need expressed for prompt and appropriate communications with patients. Practice staff told us that the outcome and any lessons learnt following a complaint were disseminated to relevant staff and discussed during meetings. Complaints were also discussed during clinical meetings.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had published their patient charter on the website and it was also available in the patient leaflet. It concerned 12 pledges that had been made to patients concerning their standards of care and treating them with dignity and respect.

Staff we spoke with demonstrated an understanding of their areas of responsibility and they took an active role in ensuring that a high level of service was provided. They also told us they felt valued and they were able to contribute to the shaping of the practice for the benefit of patients.

The practice website and patient leaflet asked for patient's views about the services they received so that staff could consider how the service could be improved. We observed that staff were motivated in providing a good service for patients.

GPs and the outlet operations manager attended Clinical Commissioning Group (CCG) meetings and worked on identifying the needs of the local community and developing the services accordingly.

Governance arrangements

We saw that systems were in place for monitoring all aspects of services such as complaints, incidents and safeguarding. All staff had delegated roles and responsibly such as safeguarding, infection control and GPs and nursing staff had individual lead roles for a wide range of long term conditions. Staff were aware of each other's responsibilities and who to approach to provide feedback or request information.

The outlet operations manager took an active role in overseeing the effectiveness and consistency of systems. The GP partners were also proactive in that process. All policies and procedures that we saw had been regularly reviewed and kept up to date so that staff received appropriate guidance.

Leadership, openness and transparency

Staff were observed to follow the vision and values of the practice. There was an open and honest culture and all staff embraced the key elements of compassion, dignity and respect towards patients. They welcomed feedback from patients and if possible made improvements.

Staff told us that they were well supported in their roles and were able to speak with senior staff when issues arose. They also told us they would be happy to approach any of the GPs for advice when they needed to. Records demonstrated that a range of staff meetings were held regularly. Staff told us that there was opportunity for them to raise issues at meetings.

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

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

The practice had an active Patient Participation Group (PPG). The PPG had carried out annual patient surveys and they held meetings every two months. PPG's act as a representative for patients and work with practice staff in an effective way to improve services and promote quality care. The outlet operations manager showed us the analysis of the last patient survey which was considered in conjunction with members of the PPG. The results and actions agreed from these surveys and the recordings from each meeting were available on the practice website. The outcome was positive. The report included areas where improvement could be made and these were being dealt with where possible.

We spoke with 10 members of the PPG. They told us practice staff worked as a team and the PPG had positive working relationships with staff. They informed us that staff made on-going efforts to improve the quality of the service and constantly searched for ways to improve staff practices.

The practice was participating in the 'Friends and Family' survey where patients were asked to record if they would recommend the practice to others. The survey commenced 1 December 2014 and the outlet operations manager told us the responses received had been positive.

Management lead through learning and improvement

We saw a clear understanding of the need to ensure staff had access to learning and improvement opportunities.

Are services well-led?

Good

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

Learning objectives were discussed with staff during their appraisals and staff were openly encouraged to continue developing their knowledge and skills. Peer support was made available for staff.

The practice had completed reviews of significant events and other incidents and shared them with staff via meetings to ensure the practice improved outcomes for patients. For example incorrect vaccine details had been entered into a patient's records. This error was picked up immediately and a process put in place to prevent further errors of this kind.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.