Marden Medical Practice

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	Outstanding ☆
Are services safe?	Outstanding ☆
Are services effective?	Good ●
Are services caring?	Good ●
Are services responsive to people's needs?	Good ●
Are services well-led?	Outstanding ☆

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We inspected this service on 24 October 2014 as part of our new comprehensive inspection programme. This provider had not been inspected before.

The overall rating for this service is outstanding. We found the practice to be good in the responsive, caring and effective domains. We found that the practice was outstanding in the safe and well led domains. We found the practice provided outstanding care to older people, people with long term conditions, people in vulnerable circumstances, families, children and young people, working age people and people experiencing poor mental health.

Our key findings were as follows:

- Patients were kept safe because there were arrangements in place for staff to report and learn from key safety risks. The practice had a system in place for reporting, recording and monitoring significant events over time.
- The practice was using innovative approaches to patient care including tele-health.
- Patients were extremely satisfied with the service they received from the practice and there was a well regarded patient participation group.
- Staff were all clear about their own roles and responsibilities, and felt valued and well supported.
- There was strong leadership of the practice with great emphasis on communication and training and education.
- There was a strong relationship between the practice and its very active patient participation group.

We saw several areas of outstanding practice:

- The practice employed a community and care co-ordinator to help patients by co-ordinating support and signposting or referring to other services.
- The practice used tele-dermatology to send pictures of patients' skin conditions to hospital based specialists to speed up and improve diagnosis and treatment.
- There was a comprehensive programme of education and training for all staff using expert external speakers.

Summary of findings

- The practice had a formal buddying system in place to ensure that patients experienced good continuity of care between part time doctors.
- The practice used Myers Briggs personality testing when recruiting new doctors to the practice.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Outstanding 

The practice is rated as outstanding for providing safe services. The practice was safer than other similar practices and was improving consistently. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice used every opportunity to learn from internal and external incidents, to support improvement. Information about safety was highly valued and was used to promote learning and improvement. Risk management was comprehensive, well embedded and recognised as the responsibility of all staff. There were enough staff to keep patients safe.

Are services effective?

Good 

The practice is rated as good for providing effective services. Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both NICE guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing practice for patients. Data showed that the practice was performing highly when compared to neighbouring practices in the CCG. The practice was using innovative methods such as tele-dermatology and tele-health to improve patient outcomes. It linked with other local providers to share best practice.

Are services caring?

Good 

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

Are services responsive to people's needs?

Good 

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

Patients told us it was easy to get an appointment and a named GP or a GP of choice, with continuity of care and urgent appointments available the same day. The practice had good facilities and was

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well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Outstanding ☆

The practice is rated as outstanding for being well-led. The practice had a clear vision with quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff and teams worked together across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The practice carried out proactive succession planning. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice gathered feedback from patients using new technology, and it had a very active patient participation group (PPG). The practice GPs met daily to discuss any issues and share experiences. There was a comprehensive programme of education and training for all staff. The practice used Myers Briggs personality testing when recruiting new doctors to 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

Outstanding ☆

The practice is rated as outstanding for safe and well led overall and this applies to older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. Medical Records were flagged with sensory impairment, length of appointment and requests for a downstairs consulting room. Patients could order medication by telephone and have it delivered to their home. The practice sent correspondence to patients in large print when necessary.

People with long term conditions

Outstanding ☆

The practice is rated as outstanding for safe and well led overall and this applies to people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Outstanding ☆

The practice is rated as outstanding for safe and well led overall and this applies to families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Outstanding ☆

The practice is rated as outstanding for safe and well led overall and this applies to working age people (including those recently retired and students)The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in

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offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. Extended opening hours were available outside of the normal working day. The practice offered support to patients returning to work.

People whose circumstances may make them vulnerable

Outstanding ☆

The practice is rated as outstanding for safe and well led overall and this applies to people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability and 95% of these patients had received a follow-up. It offered longer appointments for people with a learning disability.

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

People experiencing poor mental health (including people with dementia)

Outstanding ☆

The practice is rated as outstanding for safe and well led overall and this applies to people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. Co-morbidities were considered at health checks and opportunistic consultations. The practice worked in partnership with local mental health teams and made referrals to crisis intervention teams for acute circumstances where appropriate.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia. The practice's patient participation group supported carers of patients with dementia.

Summary of findings

What people who use the service say

We looked at the results of the national GP survey and the practice's own patient survey. We looked at 30 CQC comment cards completed by patients prior to our inspection. We received a written submission from the Chair of the patient participation group (PPG).

The national GP patient survey results showed that patients at Marden Medical Practice were overwhelmingly positive about their experience at the practice. Nearly 97% of patients described their experience at the practice as at least good. Over 90% of respondents said they would recommend the practice to others. Both of these results were considerably higher than the local and national average.

Results from the practice's own survey confirmed this high level of satisfaction among patients. Over 95% of patients who responded to the survey said the GPs at the practice were good at listening to them and involving them in their care.

All 30 patient comment cards we looked at contained very positive comments about the staff and the service at the practice. Only one card also included a negative comment about the ease of obtaining appointments.

In a written submission, the chair of the patient participation group told us that the group had strong support from the practice with a keen, interested involvement. The PPG reflected the positive view of the practice we found throughout our inspection.

Outstanding practice

The practice employed a community and care co-ordinator to help patients by co-ordinating support and signposting or referring to other services.

The practice used tele-dermatology to send pictures of patients' skin conditions to hospital based specialists to speed up and improve diagnosis and treatment.

There was a comprehensive programme of education and training for all staff using expert external speakers.

The practice used Myers Briggs personality testing when recruiting new doctors to the practice.

Marden Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector who was accompanied by a GP Special Adviser.

Background to Marden Medical Practice

Marden Medical Practice provides a range of primary medical services from a modernised and extended building situated at 25 Sutton Road in Shrewsbury. There are three male and five female doctors at the practice as well as three nurses, two health care assitants and a team of receptionists and administrators. The practice is managed by a Managing Partner. The patient population group is of a slightly higher average age than the national average. The patient group is relatively affluent compared to the national average. The practice is an accredited training practice for doctors intending to become GPs. the practice holds a General Medical services contract with Shropshire Clinical Commissioning Group. It has opted out of providing out of hours services for its patients. Out of hours services are provided by Shropdoc.

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 was 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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 24 October 2014. 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 family members. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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. These groups are:

- Older people
- People with long-term conditions
- Families, children and young people

Detailed findings

- 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)

Outstanding ☆

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents 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.

The manager showed us a log of significant events (SE) and incidents from November 2013 to October 2014. There were 40 recorded incidents, which were colour coded red (potential for significant harm), amber (caused no harm but a point of learning), and purple (to be shared with an external party such as a hospital). There was a relatively high number of events because the practice was keen to record and potentially learn from even minor incidents. This showed the practice had managed incidents and events consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

A doctor showed us a more detailed record of the discussion, action points and subsequent review of each significant event which demonstrated that each one was thoroughly investigated and any action points raised were acted upon. For example, when a hospital failed to confirm an urgent cancer referral appointment for a patient, the patient contacted the surgery. The practice quickly resolved the problem, but the doctors now routinely ask patients who are referred on an urgent basis to ring the surgery if they have not heard from the hospital in within two weeks about an appointment with the specialist.

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.

The practice responded to safety alerts by disseminating e-mail messages around the clinicians and raising awareness at their regular clinical meetings. Each doctor was assigned an area of clinical responsibility such as diabetes, sexual health, and asthma. The relevant clinician was responsible for responding to an alert by, for example , ensuring a search was made of relevant patients who may be at risk and taking any action taken to minimise that risk.

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 and could demonstrate they had the necessary training to enable them to fulfil this role. All the staff we spoke with were aware of who these leads were and who to speak to 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. GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and demonstrated good liaison with partner agencies such as the police and social services.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. All nursing staff, including health care assistants, had been trained to be a chaperone.

Medicines management

We looked at the refrigeration facilities for vaccines and other temperature sensitive medicines. There were four

fridges in the practice and all were locked. It was clear who was responsible for daily checks on the fridge temperatures and the checks were recorded and retained. All the checks were up to date and satisfactory. We looked at samples of vaccines in each fridge and these were all in date.

There were two 2 well-stocked doctors' bags with in-date medical equipment and supplies appropriate for home visits. The bags were checked regularly by a nurse and out of date medicines and supplies replaced in anticipation of their expiry date. The emergency box of drugs and the doctors' bags had "date last checked" labels prominently attached. Checks were performed every 3 months. One doctor had their own personal medical bag which we found to contain large quantities of out-of date medicines that had been returned to them by patients. We did not consider there was a risk of these being administered to patients and by the end of the inspection the medicines had been safely disposed of.

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

Cleanliness and infection control

We observed the premises to be clean and tidy. 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 a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. The lead nurse for infection control also attended infection prevention and control meetings organised by the local clinical commissioning group (CCG). All staff received induction training about infection control specific to their role and received annual updates.

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 a kit for dealing with spillages of hazardous fluids and staff had been trained in its use. There was also a policy for needle stick 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.

Equipment

We checked doctors' rooms and found that they contained all the appropriate equipment for performing medical examinations. This included pulse oximeters, digital thermometers, sphygmomanometers, and peak flow meters. All measuring and electronic equipment was checked annually for calibration and safety purposes. Labels were checked and found to be in date.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw the planning tool which was used to plan and manage staffing levels. Annual leave was monitored and discussed at team meetings. There were arrangements 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.

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. We saw that the practice had used forms from the Health and Safety Executive (HSE) to complete a room by room risk assessment in the practice.

Outstanding ☆

Are services safe?

The fire alarm was tested weekly and regular fire drills were held. Issues about the premises was a standing item on the partners regular meetings.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies.

The practice held an emergency drugs box for use in a medical emergency box. It was appropriately stocked with all the essential drugs that might be needed in an emergency such as anaphylaxis treatment and intra venous antibiotics for suspected meningitis. There was a defibrillator (which provides an electric shock to stabilise a life threatening heart rhythm), a pulse oximeter (to measure the level of oxygen in a patients' bloodstream) and an oxygen cylinder alongside the emergency drug box. Every clinician and staff member was trained in basic life support annually and records maintained of their training.

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.

The practice had carried out a fire risk assessment 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.

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. All computers had NICE guidelines accessible from the desktop, along with other clinical support tools such as Mentor and Map of Medicine. Evidence-based practice was reinforced at clinical meetings attended by outside experts and in-house clinical leads.

We saw minutes of practice meetings attended by external experts where best practice guidelines were considered, 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 practice used tele-dermatology to send pictures of patients' skin conditions to hospital based specialists to speed up and improve diagnosis and treatment.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients with suspected cancers referred and seen within two weeks. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

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

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 and deputy practice manager to support the practice to carry out clinical audits.

The practice provided three examples of completed audit cycles, all of which demonstrated changes made following the first cycle and the results of those changes. For example, we saw the results of an audit of the use of certain antibiotics being prescribed at the practice. The aim was to reduce the level of prescribing for certain antibiotics linked to an increased risk of antibiotic resistance. The final outcome was a significant reduction in the quantity of antibiotics prescribed. We also saw audits of the effectiveness of gout treatment and of emergency admissions among the practice's care home patients.

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 national performance measurement tool.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice achieved high QOF scores in diabetes, asthma and chronic obstructive pulmonary disease (lung disease). The practice was not an outlier for any QOF (or other national) clinical targets.

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

Good

Are services effective?

(for example, treatment is effective)

The practice was keen to innovate. It participated in a local tele-dermatology initiative. GPs were able to photograph certain skin conditions and share the images with consultants in other locations. This helped to speed up diagnosis and improve treatments for patients. The practice also used Telehealth to monitor patients with high blood pressure or weight issues. Telehealth is a personal, self- monitoring and alerting tool which uses mobile phone text messaging to collect patient observational data and offers real time advice or guidance to the patient according to the information sent in. The practice was also discussing setting up a chronic disease management programme around cancer survivorship.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

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 training such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by 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 had been documented. Staff confirmed that the practice was proactive in providing training and funding for relevant courses. For example, staff told us they were able to access on line training courses as well as vocational courses as these became available. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior or duty GP throughout the day for support.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology, travel vaccines, ear syringing, quit smoking programme and lifestyle advice. Those with extended roles as in monitoring patients with long-term conditions such as asthma, diabetes and heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

The practice checked the professional registration status of GPs and practice nurses against the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) register to make sure that they were remained fit to practice.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries that were not followed up appropriately.

Three of the GPs at the practice also worked for the local out-of-hours service. This helped to improve understanding between the practice and the out-of-hours service.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by GPs, practice nurses, and palliative care nurses. Decisions about care planning were documented in a shared care record. Staff felt this system worked well.

Good

Are services effective?

(for example, treatment is effective)

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. Electronic systems were also in place for making referrals, and the practice made most referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

The practice has also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record, known as Emis Web, to coordinate, document and manage patients' 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. 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.

Consent to care and treatment

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

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. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18-25 and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40-75. A GP showed us how patients were followed up if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability these patients were offered an annual physical health check. The practice also offered nurse-led smoking cessation clinics to patients who smoked. There was a clear pathway in place for patients who were nearing the end of their life.

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

The practice's patient participation group (PPG) was actively engaged in a compassionate community project and actively assisted staff by providing support to recently bereaved patients and to carers of patients with dementia.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a survey of 262 patients undertaken in association with the practice's patient participation group (PPG). The evidence from all these sources showed patients were very satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was also above average for its satisfaction scores on consultations with doctors and nurses with 96% of practice respondents saying the GP was good at listening to them and 95% saying the GP gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 30 completed cards and all were very positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. One patient commented that they sometimes waited longer than they wished for a routine appointment.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Washable 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 and 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 located away from the reception desk which helped keep patient information private.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

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 85% of practice respondents said the GP involved them in care decisions and 94% felt the GP was good at explaining treatment and results. Both these results were above average compared to the local CCG area. The results from the practice's own satisfaction survey showed that 98% of patients said they were sufficiently involved in making decisions about their care.

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

Notices in the patient waiting room, on the TV screen and practice 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. The practice's care co-ordinator was also able to help patients to access additional support services.

Staff told us that if families had suffered a 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 and/or by giving them advice on how to find a support service.

The practice's patient participation group had provided an information folder in the waiting room specifically aimed at helping bereaved families. The PPG also ran coffee mornings for carers at the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example we were shown how improvements were made to the practice car park following suggestion from the PPG.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice had access to online and telephone translation services for patients who did not speak English.

The practice provided equality and diversity training through e-learning. The practice leaflet included a commitment to equal rights for all patients.

The premises and services had been adapted to meet the needs of people with disabilities. The practice was accessible to patients using wheelchairs and there were automatic doors at the entrance. There designated disabled parking spaces.

The practice operated over three floors with most services for patients on the ground floor. However, there were two GP consulting rooms on the first floor. Patients were able to see any of the clinicians on the ground floor of the practice if they needed to.

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

There was a portable hearing aid loop available which patients could take into consultations with them if required.

Access to the service

Appointments were available from 8am to 6pm from Monday to Friday. The practice also opened one evening a week to provide a more flexible service to patients who worked during the day. Patients were able to make appointments in person, by phone or online. On the day of our inspection there were routine appointments available within 24 hours. Emergency appointments were always available on the same day if required.

Comprehensive information was available to patients about appointments on the practice website and in well presented practice booklet. This included how to arrange urgent appointments and home visits and how to book appointments through the website. The practice published its own emergency number to ensure patients received urgent medical assistance when the practice was closed during lunch time. 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 people who needed them and those with long-term conditions. This also included appointments with a named GP or nurse.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. This included information in the waiting room, in the practice booklet and on the practice website.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We looked at several complaints received in the last 12 months and found that these were satisfactorily handled and dealt with in a timely way that demonstrated openness and transparency in dealing with the complaint.

The practice reviewed complaints to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on. We saw from minutes of team meetings that complaints were discussed to ensure all staff were able to learn and contribute to determining any improvement action that might be required.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality patient centred holistic care based on respect, honest and empathy. The vision was enthusiastically embraced by all the partners and GPs at the practice.

We spoke with six members of staff and they all knew and understood the vision and knew what their responsibilities were in relation to it. Staff we spoke with told us that the vison was an integral part of the culture of the practice. All the staff we spoke with took pride in providing the best possible service to their patients.

The partners met monthly to discuss matters affecting the practice and to consider any strategic issues for the future. We saw from the minutes of these minutes that there were regular well considered discussions about the future of the practice. For example, the practice had developed a care home strategy when it agreed to take on patients in two additional care homes in the area.

The practice had produced its own local version of the NHS list of patients' rights and responsibilities and this was readily available to patients in the practice booklet and on its website.

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 six of these policies and found that they 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 the senior partner was the lead for safeguarding. Each partner had a designated lead role in different clinical areas. We spoke with eight 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.

All of the GPs at the practice worked on a part time basis. The practice had a formal buddying system in place to ensure that patients experienced good continuity of care between doctors.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing better than the national average. 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 ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example we saw recent audits of antibiotic prescribing, the effectiveness of a treatment for gout, and emergency hospital admissions.

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

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

All the members of the team we spoke with had confidence in the GP partners as trustworthy leaders and competent clinicians. It was also emphasised to us that the structure of the practice was non-hierarchical and that everyone was approachable and accessible. Staff described the working conditions as harmonious and happy.

We saw from minutes that team meetings were held regularly, at least monthly. We also noted that all staff had the opportunity to attend away days and team building events. Some of the team building events also included the families of staff working at the practice.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example induction policy and recruitment 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.

Are services well-led?

Outstanding ☆

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

The partners placed great emphasis on communication within the practice. We saw lots of evidence of regular practice meetings with comprehensive agendas and full minutes.

The practice was very innovative and keen to participate in new initiatives to improve patients' experience. For example, it participated in a local tele-dermatology initiative. GPs were able to photograph certain skin conditions and share the images with consultants in other locations.

The GPs met over lunch in the practice every day. This was regarded by the team as an important part of the day and gave clinical staff the opportunity to discuss current any current concerns and to learn from each other.

When the practice needed to recruit a new salaried doctor, they used Myers Briggs personality testing to assist the selection process. This also helped to identify how the new doctor and the existing team could work together more effectively.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through its own patient survey and by analysing the results of the national GP patient survey. We looked at the results of the national patient survey and saw that patients were overwhelmingly satisfied with the service they received from the practice.

The practice had an active patient participation group (PPG). The PPG included representatives from the local Health and wellbeing Board and the Assistive Technologies Group. The PPG met monthly and the Chair of the group told us that it was very well supported by the practice team. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website. We saw evidence that the practice took account of what the PPG told them. For example, we saw that the practice had re-marked the car park to create a safe passage for pedestrians.

The Chair of the PPG told us that the group had strong support from the practice with a keen, interested involvement. In addition to monthly meetings, the Chair of the group visited the practice one morning a week for an informal meeting with the patient services manager. The practice had also developed a patient reference group as a sounding board for new ideas.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff said that they were actively encouraged to suggest improvements at the practice. They said 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 five staff files 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 that they had staff education days where guest speakers and trainers attended. The partners told us that training and education was a key driver in delivering the best possible patient care. We saw that monthly education meetings had been planned for the whole year with guest speakers booked to talk about subjects such as mental health, diabetes and NH checks. There were separate monthly clinical meetings where GPs discussed clinical updates and emerging issues. Training and education events were organised in response to identified training needs.

The practice was a GP training practice and employed one part time registrar. Registrars are qualified doctors who undertake additional training to become qualified GPs.

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. We saw that significant events was a standing item on the agenda for every clinical, team and practice meeting.