A J Cole and Partners

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at A J Cole and Partners on 9 June 2015. The practice achieved an overall rating as good.

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

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and were involved in care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

We found areas of outstanding practice:

- The practice had a robust unplanned hospital admission system where high risk patients were identified and intensive support was provided, which included education, individualised care planning and referral to other health and social care services and voluntary organisations.
- The practice advised and supported relevant diabetic patients to manage their condition during the period of Ramadan.

Summary of findings

- The practice offered extended hours appointments from 7am three mornings per week.
- The practice had colour-coding in rooms and corridors which supported patients to find their way to consulting rooms, treatment rooms and toilets.

However, there was an area of practice where the provider should make improvements:

- Ensure all disposable curtains in consulting and treatment rooms are dated and changed in accordance with infection prevention and control guidance.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed.

Risks to patients were assessed and well managed. Patients who were identified as being at risk were monitored and the practice worked with other agencies to safeguard children, young people and adults whose circumstances may make them vulnerable. There were enough staff to keep patients safe. The premises were clean and well maintained and risks of infection were assessed and managed. There were effective processes in place for safe medicines management.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing mental capacity and promoting good health. There was evidence of appraisals, personal development plans and that staff had received training appropriate for their roles. Staff worked with multidisciplinary teams to provide effective care and support to patients. Care plans were used extensively with patients who had a long term condition or complex needs to help manage health needs and improve outcomes.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed patients rated the practice in line with other practices in the locality for several aspects of care. Patients who responded to CQC comment cards and those we spoke with during our inspection said they were treated with compassion, dignity and respect. They were involved in decisions about their care and treatment. Care planning templates were available for staff to use during consultation. Information to help patients understand the services was available and easy to understand. We observed staff treated patients with kindness, respect and ensured confidentiality was maintained.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Rotherham Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system and evidence showed the practice responded quickly to issues raised and learning from complaints was shared with staff.

The advanced nurse practitioners operated a triaged 'same day service' for patients every weekday morning. This ensured patients who most needed treatment received it the same day as their request.

Are services well-led?

Good

The practice is rated as good for providing well-led services. It had a clear vision and strategy and staff were clear about their roles and responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures in place and held regular practice meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from patients and staff. There was an established patient reference group (PRG) in place which was supported by the practice.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive and personalised care to meet the needs of the older people in its population. The practice was responsive to the needs of older people, offering home visits and longer appointments.

All patients over 75 years of age had a named advanced nurse practitioner (ANP) who worked in consultation with the GPs. These patients were offered an annual health check, where a holistic care approach was used to assess their physical, mental and emotional well-being. The practice worked closely with other health and social care professionals, such as the district nursing team and social workers, to ensure patients received the care they needed.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named advanced nurse practitioner who worked in collaboration with the GPs. Patients were offered a structured annual review to check their health and medication needs were being met. For those people with the most complex needs, the named clinician worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Patients who were identified as being a high risk for a hospital admission were managed and supported to reduce their risk of an unnecessary admission.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. For example, children and young people who had a high number of A&E attendances. The practice provided sexual health support and contraception, maternity services and childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. Baby changing facilities were available in both male and female patient toilets and a separate room was available for breastfeeding mothers.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people (including those recently retired and students). The needs of this population group had been identified and the practice offered early appointments from 7am on three mornings a week. Patients were able to book appointments and order prescriptions online which made it easier for those patients who found it difficult to access the practice during working hours. The practice was proactive in offering a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances, including those who had a learning disability. It carried out annual health checks and offered longer appointments for people with a learning disability.

There was a mixed ethnic population, some of whom were non-English speaking, had literacy difficulties or were transient and did not always find it easy to access health services in the traditional manner. The practice supported these individuals as required. For example, advising on the management of diabetes during Ramadan or offering same day appointments as needed.

Staff knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They 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. Any patients who were identified as being vulnerable, including looked after children and people who were of no fixed abode, were coded on the practice electronic system.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health, including people with dementia. The practice offered annual health reviews, longer appointments and home visits as needed for all patients who had poor mental health or dementia. The clinical staff actively screened patients for dementia and maintained a list of those diagnosed. The clinical staff regularly worked with multidisciplinary teams in the case management of people in this population group, particularly those patients who had severe mental health and resided in a care setting.

Summary of findings

One of the GPs was the lead for mental health and also worked for the local CCG with a responsibility for mental health and drugs misuse. Extended appointments for patients with severe mental health issues were available.

Summary of findings

What people who use the service say

We received 39 completed CQC comments cards where patients and the public shared their views and experiences of the service. We spoke with six patients on the day of our inspection and a member of the patient reference group (PRG).

All the patients who had completed the CQC comments cards and those we spoke with were complimentary about the level of care and treatment they had received. However, there were some negative comments about the appointment system. This was also reflected in the results of the NHS England GP Patient Survey published in January 2015. In several areas relating to access, the practice was below the local Clinical Commissioning Group (CCG) average. For example, out of 128 responses:

- 61% said they found it easy to get through to the surgery by telephone (CCG 72%)
- 45% usually waited 15 minutes or less after their appointment time to be seen (CCG 69%)
- 59% described their experience of making an appointment as good (CCG 74%)

Patients told us they were always treated with dignity and respect. They felt staff at the practice took time to listen to them and involved them in decisions about their care and treatment. One hundred percent of respondents to the GP Patient Survey said they had confidence and trust in the last nurse they saw or spoke with.

At the time of our inspection we saw the practice was extremely busy and there was also a baby clinic taking place. We noted several patients were non-English speaking. We observed how staff used a variety of methods to communicate in a way a patient with different communication needs could understand. We also saw how staff treated patients with care and concern. For example, a nurse walking through the reception area saw a mother was breastfeeding her baby and quickly offered them a place of privacy.

Areas for improvement

Action the service SHOULD take to improve

- Ensure all disposable curtains in consulting and treatment rooms are dated and changed in accordance with infection prevention and control guidance.

Outstanding practice

- The practice had a robust unplanned hospital admission system where high risk patients were identified and intensive support was provided, which included education, individualised care planning and referral to other health and social care services and voluntary organisations.
- The practice advised and supported relevant diabetic patients to manage their condition during the period of Ramadan.
- The practice offered extended hours appointments from 7am three mornings per week.
- The practice had colour-coding in rooms and corridors which supported patients to find their way to consulting rooms, treatment rooms and toilets.

A J Cole and Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector. The team included a GP specialist advisor, a practice manager specialist advisor and a second CQC inspector. A trainee CQC inspector was also in attendance.

Background to A J Cole and Partners

A J Cole and Partners are located at Woodstock Bower Surgery in a purpose built building which has recently been extended. It is situated near to Rotherham town centre and is part of Rotherham Clinical Commissioning Group (CCG). They have a Primary Medical Services (PMS) contract with NHS England for delivering services to a practice population of 11345 patients.

The practice has an ethnically mixed population, 10% of whom are non-English speaking. The practice has a cohort of transient migrant patients, predominantly from Eastern Europe. Many of these patients register temporarily with the practice before moving on to another area. The practice also has some patients who are resident in local nursing and care homes.

Woodstock Bower Surgery has five GPs (four male, one female). They are supported by four advanced nurse practitioners (ANPs), four practice nurses (PNs) and two health care assistants (HCAs), who are all female. There is an experienced team of administration and reception staff, including a business manager and a practice manager.

The practice opening times are Monday to Friday 8am to 6.30pm. They are closed one Thursday afternoon a month for staff training purposes. The ANPs also operate a triaged 'same day' service every morning Monday to Friday. In addition, extended hours appointments are available from 7am to 8am three days a week. Out of hours provision is provided by Care UK.

Patients can access the appointment system in person at reception, by telephone or online via the practice website. There are pre-bookable appointments available up to six weeks in advance. The practice also offers bookable appointments on the day, same day urgent appointments and home visits when needed. The practice offer a range of specialist clinics/services and these include family planning, baby clinic and child health, disease management such as asthma and diabetes and minor surgery.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service and to provide a rating for the service 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 CQC at that time.

Detailed findings

How we carried out this inspection

Before visiting the practice we reviewed information we hold about the practice and asked other organisations and key stakeholders, such as Rotherham Clinical Commissioning Group, to share what they knew about the practice. We asked the surgery to provide a range of policies, procedures and other relevant information before the inspection. We also reviewed the NHS England GP Patient Survey data for the practice.

We carried out an announced inspection on the 9 June 2015. During the inspection we spoke with a range of staff, including a GP, the business manager, practice manager, three advanced nurse practitioners (one of whom was the nurse manager) and two practice nurses. We also spoke with six patients and a member of the patient reference group (PRG) who used the service. We looked at 39 CQC comment cards where patients had shared their views and experiences of the practice.

We observed how staff responded to and treated patients whilst they were at the practice.

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. These included investigating reported incidents, checking national patient safety alerts and sharing comments and complaints received from patients. We reviewed safety records and incident reports.

Staff we spoke with were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. Staff told us there was an open and transparent culture at the practice and they were encouraged to report adverse events and incidents. Documented evidence confirmed incidents were appropriately reported. Records were available which showed the practice had managed these consistently and could demonstrate a safe track record over the long term.

Learning and improvement from safety incidents

There were systems in place for how the practice managed safety alerts, significant events, incidents and accidents.

Both the GP and practice manager showed us the reporting system the practice used to record, manage and monitor all clinical and non-clinical incidents. The forms were available on the practice's computer system for all staff to access. We reviewed a summary of incidents which had been reported over the past twelve months and saw they had been completed in a comprehensive and timely manner. There was evidence the practice had learned from these and the findings had been shared with the staff. We were told all incidents, actions and learning were discussed at the practice meetings. All the staff we spoke with confirmed this and could give us several examples.

Safety alerts were disseminated to staff by the practice manager or the nurse manager in their absence. These were discussed at practice meetings, or sooner, as to any actions the practice may be required to undertake.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children, young people and adults whose circumstances may make them vulnerable. We looked at training records which showed all the staff had received relevant role specific training on safeguarding. Staff we spoke with were aware of their responsibilities and knew how to share information, record safeguarding concerns and how to contact the relevant agencies in both working hours and out of hours. Safeguarding policies, procedures and the contact details of relevant agencies were available and easily accessible for all staff.

The practice had appointed designated GP leads for both safeguarding children and vulnerable adults. The leads had received training suitable for their role. All staff we spoke with were aware of who the lead was and who to speak to in the practice if they had a safeguarding concern. Both clinical and non-clinical staff gave us several examples where they had identified patients about whom they had safeguarding concerns. They could clearly tell us the circumstances, how they had reported it and any actions that had been undertaken. For example, an incident involving a child at risk.

There was a system in place to highlight vulnerable patients on the practice's electronic record. The practice held a monthly multidisciplinary meeting with other professionals, such as the health visitor, to discuss concerns and share information about children and any vulnerable patients who were registered at the practice. We were shown how these patients were flagged on the computer system to alert staff and how clinicians identified whether there were any children who may have a child protection plan in place. (A child protection plan is a plan drawn up by the local authority. It sets out how the child can be kept safe, how things can be made better for the family and what support they will need.)

There was a chaperone policy in place and notices in the reception area which highlighted the availability of a chaperone if required. Nursing or reception staff acted in the capacity of chaperone and had received appropriate checks through the Disclosure and Barring Service (DBS). They had undertaken chaperone training and could explain what their roles and responsibilities were. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure.) We were told patients' records were coded as to whether a chaperone was present.

Medicines management

There were processes in place regarding the storage and handling of vaccines and medicines. Guidance was

available for staff which explained what to do in the event of vaccine refrigerators being outside of the accepted temperature range and described the action to take in such an event.

We checked medicines stored in the treatment rooms and found they were stored securely and only accessible to authorised staff. We checked the refrigerators where vaccines were stored. We saw evidence of daily records being kept. We were told vaccines were checked for expiry dates on a monthly basis and disposed of in line with the practice protocol. We looked at a selection of vaccines and found they were within their expiry date.

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

The nurses used patient group directions (PGDs) to administer vaccines and other medicines. These had been produced in line with legal requirements and national guidance. We saw evidence relevant staff had received training to administer vaccines.

Some nursing staff were qualified as independent prescribers (trained staff who can prescribe medicines for any medical condition within their competence). They told us they received regular supervision and support in their roles, including updates in medicines management.

Cleanliness and infection control

We observed the premises to be clean and tidy. Patients we spoke with told us they always found the practice to be clean and had no concerns about cleanliness or infection control.

We saw there were cleaning schedules in place and records were kept. However, we observed not all disposable curtains were dated and those which had been were out of date for being change; in accordance with The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and National Patient Safety Agency guidance. The practice told us they would act on this immediately.

The practice had a lead for infection prevention and control (IPC) who was responsible for ensuring all areas of the practice were kept to the appropriate levels of cleanliness. The IPC lead showed us the system they had developed for identifying any IPC issues. This also included a copy of the most recent IPC audit (May 2015) and an action plan. We were also shown the policies and procedures which enabled the practice to plan and implement measures to control infection. These were made available to all staff. We saw staff who worked at the practice had received infection control and prevention training.

Personal protective equipment (PPE) including disposable gloves and aprons were available for staff to use. Hand washing sinks with hand soap, antibacterial gel and hand towel dispensers were available in treatment rooms. Sharps bins were appropriately located and labelled. The practice had access to spillage kits and staff told us how they would respond to blood and body fluid spillages in accordance with current guidance.

The practice had a risk assessment for the management of legionella (a bacterium which can contaminate water systems in buildings). The last assessment had been completed in May 2015; in line with Health and Safety Executive (HSE) guidance.

Equipment

Staff we spoke with told us they had sufficient and suitable equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us all equipment was tested and maintained regularly. We saw equipment maintenance logs, contracts and other records which confirmed this. A schedule was in place for annual checks of equipment, which included calibration and portable appliance testing (PAT). The sample of equipment we inspected had all been tested and was in date.

Staffing and recruitment

The practice had a recruitment policy which set out the standards it followed when they recruited clinical and non-clinical staff. There was a structured induction programme available for new starters. We looked at files for the two most recently recruited staff and saw evidence appropriate recruitment checks had been undertaken prior

to their employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal record checks through the Disclosure and Barring Service (DBS).

Staff told us the arrangements for how they planned and monitored the number and mix of staff required by the practice to meet the needs of patients. There was an arrangement in place for members of staff, this included clinical and non-clinical, to cover each other's annual leave and sickness. They 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.

GP locums were used on a regular basis to support clinical staff in providing patient care and treatment. We were told the practice tried to use the same locums to sustain patient continuity of care. Any new locums were inducted with a GP who was available on the day. There was a locum induction pack available.

The advanced nurse practitioners (ANPs) told us they used a 'buddy' system to cover for each other during annual leave, sickness or training.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, equipment and dealing with emergencies. The practice had a health and safety policy in place and information was available for staff.

Staff told us they would inform the practice manager if they identified any issues or risks. These were then dealt with in a timely manner and were included on a risk log. Each risk was assessed, rated and mitigating actions recorded to reduce and manage risk. We were told any identified risks were discussed at GP partners' meetings and within team meetings.

Areas of individual risk had been identified and steps taken to address any issues. For example, all staff had access to a panic button in three separate areas within a consulting room; which were on the computer system, on the phone and via a separate system which directly alerts reception.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed all staff had received training in basic life support. Emergency equipment was available, including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and how to use it. We saw records which confirmed it was checked on a monthly basis.

Emergency medicines were available in a secure area of the practice. Staff checked the medicines on a monthly basis and we saw records which corroborated this. We checked the medicines at the time of inspection and found them all to be in date.

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. Identified risks included power failure, adverse weather and access to the building. The document contained relevant contact details for staff to refer. For example, water, gas and electricity suppliers. A copy was available electronically and the lead GP, business manager and practice manager all had hard copies at their homes. We were told of a recent incident involving a computer server issue where the plan had been used successfully.

The practice had carried out a fire risk assessment in April 2015 which included actions required to maintain fire safety. We were told there were designated fire marshals and a fire drill had recently been undertaken. We saw evidence all staff were up to date with fire safety training.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The medical and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance. They accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We were told any updates were circulated to staff and, where appropriate, discussed at clinical meetings.

Staff described how they carried out comprehensive assessments in line with national and local guidance. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. There were systems in place to identify and monitor the health of vulnerable groups of patients. We were told patients who had learning disabilities were given longer appointments.

The practice employed four advanced nurse practitioners (ANPs), to clinically support all their registered patients who had a long term condition, required palliative care, were resident in a care home within the practice catchment area or were at risk of an unplanned hospital admission. The ANPs undertook comprehensive health needs assessment of these patients. Patients who had multiple conditions were given longer appointments. The ANPs initiated relevant tests and acted on them, monitored the health of the patients and reviewed their medication. These patients were reviewed in line with their individual needs. We were shown the system used to identify, review and recall any newly diagnosed patients.

The ANPs also clinically managed a 'same day' service which was offered by the practice five mornings a week. Patients who telephoned the surgery wanting a same day appointment were directed to a duty ANP who would undertake a clinical assessment. If needed, an appointment was made for the patient to be seen the same day either by an ANP or a GP as appropriate.

We were shown how the ANPs managed patients who were at risk of an unplanned hospital admission. There was a system in place to identify what level risk a patient may be (one being the lowest and three being the highest risk of a hospital admission). These patients were contacted, the role of the ANP and the service they offered was explained and, in conjunction with the patient, care was planned and managed to support to prevent an unnecessary hospital admission. We were shown data from March 2014 where the practice had identified 65 patients at level three risk. After ANP intervention, data from December 2014 showed this had reduced to 47 patients. We were given many examples of individuals whose risk level for an unplanned hospital admission had reduced significantly. For example, a patient had been ranked as being the 37th person in Rotherham most likely to be admitted to hospital. The patient had a comprehensive care plan in place, their family had been educated as to the condition of the patient's health and what to do if it deteriorated, and referrals to other relevant services had been made. As a result the patient's risk had reduced from level three to level two and their overall rank reduced to being the 2441th person in Rotherham most likely to be admitted to hospital.

The practice had achieved and implemented the Gold Standards Framework for end of life care. It had a register of patients who required palliative care. Regularly meetings to discuss these patients' care needs were held with health professionals, such as members of the district nursing team and palliative care nurses.

Interviews with staff showed the culture of the practice was patients were cared for and treated solely based on need.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in how they monitored and improved outcomes for patients. These roles included data input, scheduled clinical reviews, how they managed child protection alerts and medicines management. The information staff collected was then collated to support the practice to carry out clinical audits and other improvements to the service.

Information collected for the quality and outcomes framework (QOF) and performance against national screening programmes was used to monitor outcomes for patients. (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long term conditions and for the implementation of preventative measures.) In 2014 the practice was comparable to both the local CCG and England achievements, for many of the QOF domains but was

Good

Are services effective?

(for example, treatment is effective)

above average for the management of epilepsy, learning disability and osteoporosis. The practice discussed QOF in their meetings and we saw evidence in minutes to support this.

Clinical audit, clinical supervision and staff meetings were used to assess performance. The practice had an effective system in place for how they completed clinical audit cycles. We saw several audits had been undertaken in the past twelve months. After each audit, actions had been identified and changes to treatment or care had been made as appropriate.

We spoke with an advanced nurse practitioner (ANP) who gave us examples of how the use of care plans had a positive impact on the management of patient care. For example, one patient who had multiple conditions had taken their care plan with them on holiday. This had been used effectively when they had required health intervention from another locality.

Effective staffing

Practice staff included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw staff were up to date with attending mandatory training courses, such as annual basic life support and safeguarding adults and children.

All GPs were up to date with their continuing professional development requirements and all had either 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.)

The advanced nurse practitioners and practice nurses were registered with the Nursing and Midwifery Council (NMC). To maintain registration they had to complete regular training and keep their skills up to date. The nurses we spoke with confirmed their professional development was up to date and they had received training necessary for their role.

We were told all new staff underwent a period of induction. The induction programme covered a range of areas, including being introduced to other members of staff, health and safety information, fire safety and confidentiality. We saw completed induction programmes for two members of staff.

All staff had annual appraisals and staff we spoke with confirmed these had taken place. Some staff told us how they had been supported through training which had been identified through their personal development plans. All the staff we spoke with were unanimous in saying they felt very supported in their role by the GPs and managers.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those who had complex needs. It received letters, discharge summaries, blood test and X-ray results both electronically and by post from other services, such as the local hospital, out-of-hours GP services and the 111 service. There were systems in place for receiving, passing on, reading and acting on any issues arising from communications with other care providers. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held monthly multidisciplinary meetings to monitor patients at risk, review patients' needs and manage complex cases. We saw minutes which identified other health professionals who attended these meetings, for example health visitors, district nursing staff and palliative care nurses. The staff told us they liaised closely with other health and social care professionals to ensure the needs of their patients were promptly addressed, for example when someone was discharged from hospital.

The advanced nurse practitioners told us how they individually liaised with other services, such as social workers and voluntary organisations, to ensure patients who were elderly or had a long term condition were supported. Examples they gave included how patients had been supported to access relevant benefits or a befriending service for those who were lonely or isolated.

The practice also worked with a local support agency, specifically relating to dementia. With their consent, they referred patients who were carers for someone who had dementia to this service. Additional support, information and advice, including short term 'in the home' support could be accessed through the referral.

Information sharing

Good

Are services effective?

(for example, treatment is effective)

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to co-ordinate, document and manage patients' care. All staff were fully trained on the system and commented positively about the systems ease of use. This software enabled scanned paper communications, such as those from the hospital, to be saved in the system for future reference.

They were several electronic systems in place to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. The practice used the Choose and Book system for making referrals. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.) The practice had signed up to the electronic summary care record (summary care records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out-of-hours).

The practice worked collaboratively with other agencies and community health professionals. They regularly shared information to ensure timely communication of changes in care and treatment. This included liaison with health visitors, school nurses, district nurses and mental health services.

Consent to care and treatment

We found clinicians were aware of and understood the key parts of the legislation in relation to the Mental Capacity Act 2005. The Mental Capacity Act (MCA) is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. Staff could demonstrate instances where they had used the MCA and when best interest decisions needed to be made.

Clinical staff demonstrated an understanding of legal requirements when treating children under the age of 16, particularly in relation to the Gillick competency test. This is used to help assess whether a child under 16 has the maturity and understanding to make their own decisions and to understand the implications of those decisions.

The clinicians we spoke with described the process to ensure consent was obtained from patients when necessary. For example, when patients required minor surgery. We were told verbal consent was recorded in patient records. Patients we spoke with confirmed their consent was obtained before they received treatment.

The practice used online translation services, both written and verbal, to help patients who were non-English speaking to understand in order to express their consent.

Health promotion and prevention

The practice supported patients to manage their health and well-being and offered NHS health checks to all its patients over 40. It was involved with national breast, bowel and cervical cytology screening programmes. They offered a full range of immunisations for children, flu vaccinations and travel vaccinations in line with current national guidance.

The practice identified patients who needed ongoing support with their health. They kept up to date registers for patients who had a long term condition, such as diabetes or asthma, which were used to arrange annual health reviews. Registers and annual health checks were also available for vulnerable patients, such as those with a learning disability, and the over 75s.

Healthy lifestyle information was available to patients via leaflets and posters in the waiting room and also accessible through the practice website. This included smoking cessation, weight management and travel health. Patients were signposted to other services as the need arose, for example voluntary support groups.

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 NHS England GP Patient Survey (January 2015), where from a sample of 361 questionnaires, 128 (36%) responses were received. Data from this survey showed the practice to be average for the following satisfaction scores:

- 92% said the last nurse they saw/spoke with was good at listening to them
- 84% said the last GP they saw/spoke with was good at listening to them
- 100% said they had confidence or trust in the last nurse they saw/spoke with
- 92% said they had confidence or trust in the last GP they saw/spoke with

We received 39 comment cards which were all positive about the service patients experienced. Many of the comments described staff as being caring and professional and treating them with dignity and respect.

We also spoke with six patients on the day of our inspection who all told us they were satisfied with the care they received.

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

We observed reception staff were courteous, spoke respectfully to patients and were careful to follow the practice's confidentiality policy. We observed conversations between patients and staff in the reception were not easily overheard. We were told there was a room available for patients who wished to speak privately to a member of reception staff.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour, or where a patient's privacy and dignity was not being respected they would raise these concerns with the practice manager. The practice manager told us they 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 GP Patient Survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. For example, 80% of respondents said the GP involved them in care decisions and 90% felt they had enough time to make an informed decision about the choice of treatment they wished to receive. These were both higher than the local CCG average; being 75% and 83% respectively.

Patients we spoke with on the day or our inspection told us health conditions were discussed with them, treatments were explained and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff. Patient feedback on the comment forms we received were also positive and aligned with these views.

The practice worked closely with some of the local residential care homes to ensure patients who lived there had care plans in place, which would be discussed and reviewed with the care home staff, the patient and/or their next of kin.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated them at or above average, compared to the local CCG. For example, 89% of respondents said the last nurse they saw or spoke with was good at treating them with care and concern (CCG 80%).

The patients we spoke with on the day or our inspection and the comment cards we received were also consistent with the survey information. They told us staff were kind, caring and considerate and provided support when needed.

Good

Are services caring?

Notices in the patient waiting area and on the practice website provided information on how to access a number of support groups and organisations. Written information was available for carers to ensure they understood the various avenues of support available to them. The practice website had links to a variety of information which related to being a carer. The practice also worked with a local support agency, specifically relating to dementia. With their consent, they referred patients who were carers for someone who had dementia to this service. Additional support, information and advice, including short term 'in the home' support could be accessed through the referral.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. Systems were in place to address identified needs in the way services were delivered. For example, the same day service clinics and extended hours appointments.

The practice provided a service for all age and population groups. Registers were maintained of patients who had a learning disability, a long term condition or required palliative care. These patients were discussed at the weekly clinical and monthly multidisciplinary meetings to ensure practitioners responded appropriately to the care needs of those patients.

The practice cared for a number of patients who lived in local residential care homes, who were elderly, had severe mental health issues or a diagnosis of dementia. Clinical staff undertook regular visits to review care plans and medicines, assess new patients and to ensure end of life care planning was in place. They also responded when patients had deteriorated or had an episode of increased ill health. These patients were fast tracked to ensure care and treatment was applied in a timely manner to avoid an unnecessary hospital admission and improve outcomes.

Tackling inequity and promoting equality

The practice had recognised the needs of patients in the planning of its services. For example, longer appointment times were available for patients who had complex needs or required interpreting services.

The premises had been designed to meet the needs of people with disabilities. There was ramp access to the building and we saw the ground floor waiting area was large enough to accommodate patients who used wheelchairs. There was easy access to the treatment and consultation rooms, which were on the ground and first floors. Access to the first floor was via a lift. Accessible toilet facilities were available for all patients who attended the practice. There were baby changing facilities available in both the male and female toilets.

We saw there was braille signage on all treatment and consulting room doors and also on male and female toilet doors. In addition, the practice had colour-coding in rooms and corridors which supported patients to find their way to consulting rooms, treatment rooms and toilets. There was a notice board at the entrance to reception explaining the colour coordination system.

At the time of our inspection we observed several patients to be of a non-English speaking origin. We saw instances where staff treated them with care and concern and communicated in a way those individuals could understand. For example, a member of staff saw a non-English speaking patient was breastfeeding their child in the waiting area. The staff member offered the patient a private room to maintain their privacy and dignity.

Staff told us they used a variety of sources to support patients in their understanding. For example, the British Red Cross emergency multilingual phrasebook, flash cards and accredited internet based verbal and written translation websites. A member of the nursing team had also learned several key questions in a variety of languages to help them engage with patients.

Access to the service

The practice was open from 8am to 6.30pm Monday to Friday. Appointments were available from 8.30am to 10.30am and 2pm to 6pm each weekday. In addition, the practice offered extended hours appointments between 7 to 8am three days a week.

Comprehensive information regarding the practice opening times and how to book appointments was displayed in the reception area, the practice leaflet and on the website. Information was available in the practice and their website regarding out-of-hours care provision when the practice was closed.

Patients could book appointments by telephone, online or in person at the reception. Appointments were pre-bookable up to six weeks in advance and some were available on the day. Home visits were offered for patients who found it difficult to access the surgery.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We saw the next routine bookable appointment was for four weeks following the inspection. We were informed patients who required to be seen urgently would be accommodated on the same day. Nursing staff told us the same day service they offered was utilised frequently and they could 'fit' patients into their surgeries if required. The GP told us they also had a high number of home visits at the end of each surgery.

We reviewed the most recent data available for the practice on patient satisfaction regarding access to the practice and appointments. This included information from the NHS England GP Patient Survey published in January 2015. In some areas the practice was below the local Clinical Commissioning Group (CCG) average. For example, out of 128 responses:

- 61% said they found it easy to get through to the surgery by telephone (CCG 72%)
- 45% usually waited 15 minutes or less after their appointment time to be seen (CCG 69%)
- 59% described their experience of making an appointment as good (CCG 74%)

Patients we spoke with on the day or our inspection had a mixed response to how easy it was to get an appointment, but overall the feedback on the comment cards was positive. The practice informed us they monitored demand for appointments and felt they were offering as many appointments and access to clinicians as was feasible.

At the time of our inspection there was a baby clinic taking place and we saw patients were dealt with in a timely and courteous manner. We also observed the practice to be extremely busy with a high patient influx throughout most of the day.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The 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 information was available to help patients understand the complaints system. The patients we spoke with told us they would speak to a member of staff, the practice manager or write to the practice if they wished to make a complaint. None of the patients we spoke with had made a complaint about the practice.

We looked at the complaints summary covering the last 12 months. The practice had identified what the complaint was, the actions and learning and whether the complaint had been resolved. There was also information as to whether an apology had been given and whether the case had been referred to the health ombudsman. It was noted in all cases an apology had been given, the patient had been satisfied and a referral to the ombudsman had not been necessary.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the practice vision and values were part of their strategy and five year business plan.

The practice told us their plans for developing the practice team, which included employing a pharmacist to support them with medicines management. They explained the difficulty experienced in recruiting GPs and had made a decision to employ a further advanced nurse practitioner to support delivery of patient care.

Staff we spoke with knew and understood the visions and values and what their responsibilities were in relation to these. They told us they had been involved in the decision making process regarding increasing the clinical team.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were accessible to staff. We looked at several of these and saw they had all 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 for infection prevention and control and a lead for safeguarding. The majority of staff we spoke with were all clear about their own roles and responsibilities. There was some overlap in roles and responsibilities between the business manager and practice manager. This had been identified by the practice and measures were in place to resolve the issue.

The GPs, business manager and practice manager took active roles for overseeing the systems in place to monitor the quality of the service were being used consistently and effectively. These included using the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw QOF data was regularly discussed at practice meetings.

The practice had an ongoing programme of clinical audits which were used to monitor quality and to identify where any action should be taken. Evidence from other data sources, including incidents and complaints, was used to identify where improvements could be made. Additionally, there were processes in place to review patient satisfaction and action taken in response to feedback from patients or staff. The practice regularly submitted governance and performance data to Rotherham Clinical Commissioning Group (CCG).

The practice identified, recorded and managed risks. Risk assessments had been undertaken, for example fire, infection prevention and control and legionella. The practice monitored risks and discussed any issues at the practice meetings.

Leadership, openness and transparency

The GP partners were visible in the practice and staff told us there was an open culture and all members of the management team were approachable, supportive and appreciative of their work. Systems were in place to encourage staff to raise concerns and a 'no blame' culture was evident at the practice.

The practice manager and GPs had a weekly meeting and staff meetings were monthly. We looked at the minutes from meetings and found performance, quality and risks were discussed. Staff told us they were happy to raise any issues, felt their opinions were listened to and were involved in discussions about how to develop and improve the practice.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients and staff. They had gathered feedback from patients through patient surveys, the NHS friend and family test, complaints and compliments.

The practice had a small active patient representative group (PRG) of eight members and 50 virtual members. A PRG is a group of patients registered with the practice who work with the practice to improve services and the quality of care. Engagement with the PRG was through face to face meetings, email and telephone. The group consisted of an equal mix of males and females. The ethnicity ratio was 76% white British and 24% from other ethnic origins. Some of the members also had mobility difficulties, hearing or visual impairment.

The practice told us how they sought the views of patients who had disabilities when planning the extension of the practice building. For example, ensuring areas were wide

Are services well-led?

Good

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

enough for wheelchair and pushchair access, access at reception being at a suitable height for wheelchair users and the use of braille on consulting and treatment rooms doors.

We were shown the analysis of the last patient survey, which was considered in conjunction with the PRG. The results and actions agreed from these surveys were available on the practice website.

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

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. They told us annual appraisals took place, which included a personal development plan. This was evidenced in the staff files we looked at. Staff told us the practice was very supportive of training and they had regular training sessions where guest speakers and trainers attended.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and training events to ensure the practice improved outcomes for patients. We saw evidence of this in minutes of meetings and logs of events.

During our inspection we observed good team working and it was evident staff were supported by the GPs and management team. The practice informed us team working and the skills of the staff were the strength of the practice; this supported delivery of a good service for patients.