Dr Smith & Partners

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Smith & Partners on 5 February 2015.

The practice achieved an overall rating of Good. This was based on our rating of all of the five domains. Each of the six population groups we looked at achieved the same good rating.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- 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.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

Importantly the provider should:

- Introduce a system that confirms medicine stocks were checked periodically to ensure they were within their expiry date and suitable for use.
- Introduce a system so blank electronic prescription forms are tracked through the practice and kept securely.
- Review the infection control policy so control measures and lead roles are made explicit to practice staff.
- Introduce suitable measures to audit the effectiveness of the infection control policy.

Summary of findings

- Ensure any recommended remedial work for ensuring legionella water safety is completed when the risk assessment report and recommendations are received from the external contractor.
- Ensure recruitment arrangements include all necessary employment checks for all staff as specified in Schedule 3 of Health & Social Care Act 2008 (Regulated Activities) Regulations 2010.
- Provide appropriate information to patients and other users of the practice on how they can make a complaint

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients could make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their 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 to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

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

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. 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. We saw good examples of joint working with midwives and health visitors.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population and those recently retired 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 offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

Summary of findings

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 with a learning disability. It had carried out annual health checks for people with a learning disability. 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)

Good

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

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND. 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.

Summary of findings

What people who use the service say

We spoke with eight patients during our inspection. They were from different backgrounds and with different health needs.

We reviewed 21 CQC comment cards which had been completed by patients prior to our inspection.

All but one were complimentary about the practice, staff who worked there and the quality of service and care provided. They told us the staff who worked there were very caring and helpful. They also told us they were treated with respect and dignity at all times and they found the premises to be clean and tidy. One card was less complimentary and noted they felt rushed and uncared during their consultation.

Patients told us they found the extended opening times and appointments very useful, especially being able to fit in their appointment around work times without having to take time off work.

Areas for improvement

Action the service SHOULD take to improve

- Introduce a system that confirms medicine stocks were checked periodically to ensure they were within their expiry date and suitable for use.
- Introduce a system so blank electronic prescription forms are tracked through the practice and kept securely.
- Review the infection control policy so control measures and lead roles are made explicit to practice staff.
- Introduce suitable measures to audit the effectiveness of the infection control policy.
- Ensure any recommended remedial work for ensuring legionella water safety is completed when the risk assessment report and recommendations are received from the external contractor.
- Ensure recruitment arrangements include all necessary employment checks for all staff as specified in Schedule 3 of Health & Social Care Act 2008 (Regulated Activities) Regulations 2010.
- Provide appropriate information to patients and other users of the practice on how they can make a complaint

Dr Smith & Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team also included a GP acting as specialist adviser.

Background to Dr Smith & Partners

Dr Smith & Partners provide a range of personal medical services for people of Bletchley in Milton Keynes, Buckinghamshire and serve a registered population of approximately 10250 patients. The practice population is predominantly white British but the practice also serves patients from the ethnic minority groups.

Clinical staff at this practice include five GP partners, one trainee GP, five practice nurses (including three part time nurses), four physiotherapists and two healthcare assistants. Management, administration and reception staff support the practice. Community nurses, health visitors and a midwife from the local NHS trust also provide a service at this practice. A mix of male and female clinical staff is available.

Dr Smith & Partners is a training practice for GPs

When the surgery is closed out of hours care is accessed through the NHS 111 service

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

We carried out this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This provider had not been inspected before and that was why we included them.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?
- 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
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable

Detailed findings

- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 5 February 2015.

During our visit we spoke with a range of staff including GPs, reception staff, nurses, the practice manager and other practice staff and spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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, national patient safety alerts and complaints. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example staff had reported a safety issue with dealing with a patient presenting with a medical emergency and saw that the practice had acted on it and changed its system for dealing with such instances.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the past year. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred in the past year and we were able to review these. They related to a variety of issues including patient safety, clinical care and information security. Our review showed how incidents were investigated with a focus on the issue with actions identified to address the risk and to minimise or prevent future occurrences. Lessons learnt and actions from analysis of significant events incidents and accidents were shared and discussed at staff meetings and we saw evidence of this. Receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

National patient safety and medicines alerts were reviewed by the practice manager on receipt and shared with staff appropriately to ensure they were noted and acted upon.

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 and referral pathways were clearly visible in each consultation room.

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children. All staff we spoke with were aware who the safeguarding lead was and who to speak to in the practice if they had a safeguarding concern.

We saw that the practice team had regular monthly meetings with the health visitor, and other clinical and relevant staff to discuss ongoing safeguarding issues and agree plans for keeping patients safe. Issues discussed included those affecting children, elderly and other vulnerable groups and domestic abuse. The safeguarding lead or a nominated representative attended child protection case conferences and reviews where appropriate.

A chaperone policy was available and staff we spoke with confirmed that chaperoning was carried out by clinical staff.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

A nurse told us that medicines were checked every other month to ensure they were within their expiry date and suitable for use. However we did not see any documentary evidence to confirm that these checks had been made. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

A review of prescribing data, for example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice showed that the practice performance was in line with national trends.

Are services safe?

Vaccines were administered in accordance with directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of these directions.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Individual blank prescription sheets were tracked through the practice and kept securely at all times. We did not see a documented system that assured us that blank forms that were used to issue computerised prescriptions were handled in accordance with national guidance.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning was checked regularly by the practice manager. 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. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in consultation and treatment rooms. Personal protective equipment such as disposable gloves, aprons and coverings were also available for staff. Staff we spoke with were knowledgeable about infection control procedures.

An infection control policy was available but this document did not specify measures to control infection and lead roles to plan and implement these measures. The practice manager told us that all staff had received induction training about infection control specific to their role. We however did not see records of this training or that of periodic update training. We did not see evidence of a recent infection control audit. There was a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

There had been a recent risk assessment for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).The practice manager told us that they would act on any recommendations when the report was received from the external contractor.

Equipment

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

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 used the NHS care records service (CRS) smart card as proof of identity. The CRS smart card is used by some practice staff to access NHS care records. The CRS smart card has the name, photograph and the unique user identity number of the staff concerned. The practice had recruitment procedures that set out the standards it followed when recruiting clinical and non-clinical staff. However these procedures were not explicit on how the practice checked the identity of other staff who did not access the NHS Care Records Service (CRS). Schedule 3 of Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 requires such checks for all staff.

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

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative. Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that risks were discussed at relevant practice meetings.

Are services safe?

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example the practice had a metabolic screening clinic for monitoring patients at high risk of developing diabetes, which aimed to prevent deteriorating health, and had an emergency medication care plan for patients with chronic obstructive pulmonary disease (COPD) which aimed to anticipate and prevent exacerbations of this condition.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records which showed all staff had received training in basic life support. Emergency equipment was available including access to oxygen. Staff knew the location of the equipment and records showed it was checked regularly. A hazardous substance warning notice was not displayed on the door of the room where oxygen was stored.

Emergency medicines were available in a secure area of the practice and staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were in place to check the emergency medicines were within their expiry date and suitable for use. The emergency medicines we checked were clearly labelled, in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, loss of heating, and loss of the telephone or computer system. All staff had access to the plan. Key contact names and telephone numbers were recorded in it. For example, contact details of a heating company to contact if the heating system failed.

Records showed that staff was up to date with fire training which was updated every 18 months.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and other clinical staff we spoke with were able to describe how they accessed guidelines from both the National Institute for Health and Care Excellence (NICE) and from NHS Milton Keynes CCG. GPs told us new guidelines were discussed and disseminated through practice meetings and we saw evidence of this.

The practice had systems for assessing and reviewing patient care needs which was planned in accordance to best practice. For example the screening of patients aged over 75 offered proactive and comprehensive health checks and care plans for this population group. The practice had systems in place to ensure the GPs reviewed the diagnostic and blood tests of their patients.

The practice ran various specialised clinics to meet the needs of their patients. These clinics included for conditions such as asthma, chronic obstructive pulmonary disease, diabetes, heart disease and also for family planning. The practice had a system in place to ensure patients at risk of developing diabetes were tested routinely for early indications of diabetes. These were led by clinical staff with advanced training in diabetic care.

The GPs told us they lead in specialist clinical areas such as management of chronic conditions like diabetes, heart disease and asthma and skilled practice nurses supported this work. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us they supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders and encouraged them to better their skills by attending relevant courses and training. Our review of the clinical meeting minutes confirmed that this happened.

We reviewed the data from the local clinical commissioning group (CCG) of the practice's performance for antibiotic prescribing, which was comparable to similar practices. We saw evidence of regular review and assessment of patients with chronic conditions and referrals to specialist services as appropriate.

Interviews with GPs indicated that the culture in the practice was that patients were referred on need and that age, sex and race were taken into account as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. Information about the outcomes of patients care and treatment was collected and recorded electronically in individual patient records. This included information about their assessment, diagnosis, treatment and referral to other services. Information from the quality and outcomes framework (QOF) which is a national performance measurement tool showed the intended outcomes were being achieved for patients. For example the percentage of patients new patients diagnosed with dementia was better than average compared with the diagnosis rate with other local practices and nationally. This ensured appropriate care was planned and delivered in a timely way. The practice was not an outlier for any QOF clinical indicator.

The practice had a system for completing clinical audit cycles. These were quality improvement processes that aimed to improve patient care and outcomes through the systematic review of patient care and the implementation of change. Clinical audits were instigated from within the practice or as part of the practice's engagement with local CCG initiated audits. We saw four recent examples of these at the practice two of which related to antibiotic prescribing, and the use of opiates in patients with chronic pain. Both had been completed.

The GPs told us clinical audits and monitoring were often linked to medicines management information, safety alerts or as a result of information from the QOF. For example, we saw that the practice had audited how well patients on blood thinning medication was managed by regularly checking patients' international normalisation ratio (INR) which ensured the patient received the correct dose. This audit had shown that no significant or adverse incident had occurred in the past 12 months.

The practice had a palliative care register and had regular internal as well as multidisciplinary case review meetings where the care and support needs of patients and their families were discussed

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed the training that had taken place over the last three years and saw that all staff were up to date with attending mandatory courses such as annual basic life support.

Are services effective?

(for example, treatment is effective)

Staff we spoke with confirmed that appraisals had taken place and included a process for further review of identified learning needs and targets made during appraisals. The manager told us that appraisal records were kept in individual staff files and showed us one example. Our review showed that staff had been trained in core subjects such as safeguarding children and vulnerable adults, health and safety and manual handling and specialised subjects such as asthma and diabetes.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, practice nurses and healthcare assistants seeing patients with long-term conditions such as asthma, chronic obstructive pulmonary disease (COPD), and diabetes were also able to demonstrate that they had appropriate training to fulfil these roles and had attended protected learning time sessions or dedicated training.

GPs were supported to obtain the evidence and information required for their professional revalidation. This was when doctors demonstrated to their regulatory body, the GMC, that they were up to date and fit to practice. Two GPs had been recently revalidated and the remaining GPs had a scheduled programme for revalidation. The practice nurses were supported to attend updates to training that enabled them to maintain and enhance their professional skills.

The practice had a process to manage poor performance both for clinical and non clinical staff.

Working with colleagues and other services

Systems were in place to ensure patients were able to access treatment and care from other health and social care providers where necessary. We saw examples of personalised care plans which contributed to this process including for those patients who had complex needs or suffered from a long term condition. There were clear mechanisms to make referrals in a timely way which ensured patients received effective, co-ordinated and integrated care. We saw that referrals were assessed as being urgent or routine.

A system was in place for hospital discharge letters blood test results and X ray results to be reviewed by the responsible GP who would initiate the appropriate action in response. Responsible GPs who saw these documents and results took appropriate action as required. All staff we spoke with understood their roles and felt the system in place worked well.

We saw that clinicians at the practice followed a multidisciplinary approach in the care and treatment of their patients. This included regular meetings with professionals such as health visitors to discuss child health and safeguarding issues, and with MacMillan nurses to plan and co-ordinate the care of patients coming to the end of their life. They also liaised with the out of hours service and provided detailed clinical information about patients with complex healthcare needs.

Information sharing

There was effective communication, information sharing and decision making about a patient's care across all of the services involved both internal and external to the organisation, in particular when a patient had complex health needs. Care was delivered in a co-ordinated and integrated manner with appropriate sharing of patient sensitive data. There were arrangements to receive hospital summaries of recently discharged patients. These were scanned and directed to the relevant GP for their review and any follow up action.

The practice used electronic systems to communicate with other providers. Electronic systems were also in place for making referrals, and the practice made use of the Choose and Book system for making referrals. (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). Staff reported that this system was easy to use.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record called SystmOne to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use.

The practice had a system to communicate with other providers. We saw evidence of information sharing, for example with the out of hours service, palliative care team and the Macmillan service.

The practice supported the electronic NHS summary care record scheme for emergency patients. Under the scheme, with a patient's consent, a summary of their care record is

Are services effective?

(for example, treatment is effective)

provided to healthcare staff that treat patients in an emergency or out of hours situation which enabled them to have faster access to essential clinical information about that patient. The practice planned to have this scheme fully operational during 2015.

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. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. GPs and practice nurses we spoke with told us that they referred to Gillick competency when assessing young people's ability to understand or consent to treatment.

The practice administered joint injections (as a minor surgical procedure) which helped to reduce inflammation and pain within a joint, and had a process to obtain written consent before this procedure was performed. A GP told us that a record of the relevant risks, benefits and complications of the procedure would also be made in the patient's records at the same time.

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. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision.

The practice provided care for patients in a nursing home that cared for people with dementia and provided support as needed to use restraint. Staff we spoke with were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

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

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. 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 smoking cessation advice to smokers the practice had achieved the highest 12 months 'quit rate' across the CCG area.

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 and of all patients in need of palliative care and support irrespective of age. The practice had also identified the smoking status of 97% of patients over the age of 16 and actively offered smoking cessation advice to relevant patients.

The practice offered proactive diabetic care. For example 86% patients with diabetes had received a foot examination and risk classification within the preceding 15 months.

The practice's performance for cervical smear uptake was 80%

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice nurses had specialised skills and had received specific training to deliver a range of services for example treatment of diabetes, asthma, travel vaccines and chronic obstructive pulmonary disease related care

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients completed CQC comment cards to tell us what they thought about the practice. We received twenty completed cards and all but one were positive about the service experienced. Patients commented that the practice offered an excellent service and found staff accommodating efficient and helpful and treated them with dignity and respect.

We spoke with eight patients on the day of our inspection. They were all happy with the care they received. People told us they were treated with respect and were positive about the staff. They spoke highly about the practice and the care and treatment they had received. They felt well looked after and staff listened and attentive to their needs.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey. This survey showed that 72% reported that their GP was good at treating them with care and concern. This result is similar to other GP practices in the local CCG area and confirmed what patients told us on the day of the inspection. The practice manager told us that they were taking action to improve patient experience.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. We noted all treatment and consulting rooms had privacy curtains installed to ensure the patients dignity and privacy 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.

There was a clearly visible notice in the patient reception area and on the practice website stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

Patients told us practice staff took the time to understand their needs. Staff had listened to their opinion and considered these when agreeing treatment options and medication. Patients told us that they were never rushed during appointments and were given opportunity to ask questions to help them understand their condition or ailment.

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. The national patient survey showed that 71% of practice respondents said the GP involved them in care decisions and 79% felt the GP was good at explaining treatment and results. Both these results were similar to other GP practices in the local CCG area.

Patients we spoke with on the day of our inspection told us that health issues were fully discussed with them and they felt involved in decision making about the care and treatment they received. They told us they felt listened to and supported by staff and had sufficient time during their consultations to understand what they were being told and to make an informed decision about their choice of treatment. The patient comment cards we reviewed were very positive about involvement and confirmed the views of the patients we spoke with.

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

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection and the comment cards highlighted that staff responded compassionately when they needed help and provided support when required. We observed patients in the reception area being treated with kindness and compassion by staff.

The practice made referrals to emotional support services such as Improving Access to Psychological Therapies (IAPT), and signposted patients to support services such as bereavement counselling and MIND the mental health charity.

Notices in the patient waiting room, and on the practice website also told people how to access a number of support groups and organisations. The practice' computer

Are services caring?

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.

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

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

The practice used a system whereby every patient had an allocated GP responsible for their care to ensure continuity of care. Patients however could choose which GP they wished to see. Patients told us they could request a specific GP and understood they may have a slight delay if this particular GP was busy, which they did not mind.

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

The practice delivered a number of specific enhanced services to support the needs of the local population. This included supporting patients with smoking cessation, health checks, keeping people on anticoagulants healthy and risk free and joint injections. Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract.

The practice through the Parkside Medical Centre Marketing and Health Promotion group had made changes to the way it delivered services in response to feedback from patient surveys and the patient participation group (PPG). For example improvements were made to practice website with more patient centred information made available, such as with self-care, care planning, health promotion and signposting to relevant help and support.

The practice had responded to the needs of the practice population and operated extended hours to ensure they were available for students, commuters and working people.

Older people who lived in care/nursing homes benefited from bi-annual medication reviews. They also had direct access to the community nurse led high impact team who reviewed any immediate care needs at an early stage to help avoid unnecessary hospital admissions.

For families, children and young people, appointments were available outside of school hours and family planning clinics were held during extended hours. In addition the practice offered telephone consultations, on-line booking and Facebook for non-confidential advice.

People whose circumstances may make them vulnerable could see a GP of their choice. A designated area by the reception desk was available should they wish to discuss their needs in private.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services.

Staff we spoke with had a good understanding of equality and diversity. Any specific issues were discussed at practice meetings and staff were actively asked for their opinions and views.

Staff told us they felt their views were listened to and felt comfortable raising concerns or queries about inequity and or promoting equality either on a one to one basis, in appraisals or in a larger staff meeting.

There were facilities for the patient who used a wheelchair such as fully automated doors at the main entrance to the practice, same level flooring throughout, clinical and consultation rooms available on the ground floor and a toilet for patients with disabilities including grab rails and alarm. Consultation rooms upstairs were accessed by a lift. The practice had access to translation services. The practice had disabled parking available.

Practice staff told us they knew the patient list well and flexible appointments in terms of time and length of appointment times could be accommodated based on their specific needs.

The practice operated a policy to care for patients without stigma or prejudice. Homeless patients for example were able to register the same way as other eligible patients and the practice a flexible approach when providing to the needs of the individual.

Access to the service

Appointments were available from 8.00 am to 6.30 pm on weekdays. Extended opening hours were available on Mondays, Tuesdays and Wednesdays till 8 pm. The practice's extended opening hours was particularly useful to patients with work commitments. Patients could book

Are services responsive to people's needs?

(for example, to feedback?)

appointments in person or by telephone. When appointments were full or where appropriate, patients were also offered a telephone consultation with a GP, or a practice nurse.

Comprehensive information was available to patients about appointments on the practice website and on the practice information leaflet. Information provided included how to arrange urgent appointments and home visits. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, a recorded message gave the telephone number they should ring for the out-of-hours service.

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. Home visits were available to housebound patients and to patients who lived in care homes.

Patients were generally satisfied with the appointments system. Information from the national patient survey showed that 89% of those who responded were able to get an appointment to see or speak to someone. Patients we spoke with confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice.

Listening and learning from concerns and complaints

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

Information on how to make a complaint was available in the practice leaflet and on the website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice. However we did not see information in the patient waiting area that gave patients information on how to complain.

A complaints log was kept and we reviewed the complaints received in the past year and found that these had been investigated and responded to in a timely manner. Staff told us that complaints received were discussed during practice meetings so they were able to learn and contribute to determining any improvements that may be required. We reviewed the minutes from practice meetings which showed evidence of discussion shared learning. Staff we spoke with were aware of the system in place to deal with complaints.

We looked at the report for the last review and no themes had been identified, however lessons learnt from individual complaints had been acted upon.

Are services well-led?

(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. This was documented within the practice's statement of purpose. Staff we spoke with shared this vision and showed enthusiasm to provide a wide range of clinical services that benefited their patients.

We spoke with a number of GPs nurses and other staff and they all knew the provision of high quality care for patients was their main priority and knew their responsibilities in making this vision a reality.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff through the shared drive on any computer within the practice. We randomly looked at five of these documents and found that these had recent review date. The recruitment policy, though it was designated as current did not explicitly reflect the requirements of legislation and directives such as the need for identity checks. The infection control policy did not specify measures to control infection and lead roles to plan and implement these measures.

The practice was currently assessing different options for improving staff access to the intranet so internal policies, guidelines and information sharing was more effective.

The practice used the quality and outcomes framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice was part of the south neighbourhood group of seven practices for commissioning purposes, and took part in local external peer review facilitated by the clinical commissioning group (CCG) which included sharing good practice and learning.

Clinical audits were regularly undertaken by the practice GPs. We were shown records of completed audits the practice had undertaken during the past twelve months. These included audits on deferred antibiotic prescriptions, effectiveness of the metabolic clinic for diabetic patients and the use of opiates to manage chronic pain. As a result of these audits, further training and other changes had been identified and implemented.

The practice had a system for capturing any significant events that had occurred. The information from the significant events was analysed, reviewed and a clear action plan with learning points completed. The practice used this information to minimise the risk by identifying any trends or themes that may have affected patient care and or quality of service.

The practice held regular staff, clinical and performance meetings where performance and related governance issues were discussed. We looked at minutes of these meetings and found that performance, quality and risks had been discussed. Examples of items discussed included compliance with the QOF requirements, applicability and implementation of NICE guidance, and issues with prescribing, administration, access and appointments.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example there were named leads for safeguarding, infection control, GP training and information governance (known as the Caldicott Guardian). Staff we spoke with were clear about their roles and responsibilities and were clear as to who their line manager was and who to go to for support. They told us they felt valued, well supported and knew who to go to if they had any concerns.

We saw completed minutes from various team meetings that were held on a regular basis, some weekly and others monthly. Staff told us the practice had an open and honest culture and they felt comfortable to raise any issues at team meetings.

Appraisals were carried out annually and staff told us any training needs identified were supported by the practice.

Staff we spoke with described a happy and supportive practice team, and told us the training they had received was role specific and facilitated an effective work environment. Staff told us meetings had been less frequent recently but were confident to raise concerns as they arose.

Are services well-led?

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

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through annual patient surveys, their website, comments left on NHS Choices website and complaints process. We saw that the practice acted on comments received and had improved their website by making available more patient centred information such as with self-care, care planning, health promotion and signposting to relevant help and support.

The practice gathered feedback from staff through a variety of methods such as, general meetings, appraisals, one to one supervisory meetings and practice strategy days. Staff told us they were content to give feedback and discuss any concerns or issues with colleagues and management.

Staff told us they were aware of the whistle blowing procedure and would feel comfortable to implement it.

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. Staff were given annual appraisals and agreed objectives with their line manager to ensure their continued development. We saw examples of completed appraisals for GPs and one other staff.

The practice was a GP training practice. We spoke with a trainee GP and they told us that the practice offered them appropriate clinical support in this learning role.

The practice had completed reviews of significant events and other incidents and had shared learning from these with staff during clinical and practice meetings to ensure the practice improved outcomes for patients. Issues shared included patient safety, clinical care and information security.