Dr Winifred Helen McManus

Quality Report

Albert Road 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?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive announced inspection at Dr Winifred Helen McManus on 23 June 2015. Overall, the practice is rated as good. Specifically, we found the practice to be good for providing effective, caring, responsive and well led services. We found the practice to be requires improvement for safe. The practice was good at providing services for the six key population groups we looked at during the inspection. Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Information about safety was recorded, monitored, reviewed and addressed;
- Risks to patients were assessed and well managed;
- Overall, the practice was clean and hygienic, and there were good infection control arrangements, although infection control audits had not been carried out;
- Patients' needs were assessed and care was planned and delivered following best practice guidance;
- Data from the National GP Patient Survey showed patient satisfaction levels were either above or broadly in line with national and local Clinical Commissioning Group (CCG) comparators;
- Information about the services provided by the practice was readily available and easy to understand, as was information about how to raise a complaint;
- The practice had satisfactory facilities and was suitably equipped to treat patients and meet their needs;
- Governance arrangements had been put in place and there was a clear leadership structure.

However, there were areas of practice where the provider needs to make improvements. Importantly the provider should:

- Carry out a Legionella risk assessment;
- Carry out regular infection control audits;
- Provide the practice manager with an appraisal;
- Complete retrospective recruitment checks for recently appointed staff.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services.

The nationally reported data we looked at as part of our preparation for this inspection did not identify any concerns relating to safety. Staff understood and fulfilled their responsibilities with regard to raising concerns, recording safety incidents and reporting them both internally and externally. The GPs and practice management team took action to ensure lessons were learned from any incidents or concerns. There was evidence of good medicines management. Although infection control arrangements were good overall, and the practice was clean and hygienic, regular infection control audits had not been carried out. Also, a legionella risk assessment had not been completed. We found safe staff recruitment practices had not been followed in relation to newly appointed clinical staff. However, the practice manager had already identified this as a shortfall and was taking action to address it. Most staff had received an annual appraisal, but suitable arrangements had not been made to ensure the practice manager received one.

Are services effective?

Good

The practice is rated as good for providing effective services.

The nationally reported data we looked at, as part of our preparation for this inspection, did not identify any concerns relating to the provision of effective services. Patients' needs were assessed and care was planned and delivered in line with current legislation and best practice guidance produced by the National Institute for Health and Care Excellence (NICE), and the local Clinical Commissioning Group (CCG). Staff had received training appropriate to their roles and responsibilities. The practice had made suitable arrangements to support clinical staff with their continuing professional development. There were systems in place to support effective multi-disciplinary working with other health and social care professionals in the local area. Staff had access to the information and equipment they needed to deliver effective care and treatment.

Are services caring?

Good

The practice is rated as good for providing caring services.

Patients said they were treated well and were involved in making decisions about their care and treatment. Data from the National GP Patient Survey showed patient satisfaction levels were either above

Summary of findings

or broadly in line with national and local Clinical Commissioning Group (CCG) comparators. The practice had made arrangements to ensure patients' privacy and dignity was respected. Patients had access to information and advice on health promotion. Staff understood the help patients needed to cope with their care and treatment, and patients received support to manage their own health and wellbeing.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

Services had been planned to meet the needs of the key population groups. Patients who spoke to us, or who completed Care Quality Commission (CQC) comment cards, raised no concerns about opening hours or access to appointments. 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 there was evidence the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for providing well led services.

Overall, the practice was well managed. Although there was evidence of good governance arrangements, there were areas where these could be strengthened. Staff were clear about their roles and understood what they were accountable for. There were a range of policies and procedures covering the activities of the practice. Systems were in place to monitor and, where relevant, improve the quality of the services provided to patients. The practice actively sought feedback from patients and used this to improve the services they provided. The clinical team demonstrated good professional values and had a clear ethos which underpinned their work. They were working hard to improve the services they provided to patients by, for example, participating in a local scheme to help provide vulnerable patients with access to better co-ordinated care. However, the GP provider did not have an improvement plan with agreed priorities for action.

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 patients.

Nationally reported Quality and Outcomes Framework (QOF) data, for 2013/14, showed the practice had performed well in providing recommended care and treatment for most of the clinical conditions covered that commonly affect this population group. Achievements were either mostly above, or just slightly below, the local Clinical Commissioning Group (CCG) and England averages. The practice had obtained 100% of the points available to them for providing recommended care and treatment for patients with heart failure. This was 2% above the local CCG average and 2.9% above the England average. Staff provided proactive, personalised care to meet the needs of older people. The practice provided a range of enhanced services including, for example, a named GP who was responsible for overseeing the care and treatment received by older patients. Clinical staff had received the training they needed to provide good outcomes for older patients. Staff were responsive to the needs of older patients and offered home visits and access to same-day appointments for those with urgent needs.

People with long term conditions

Good

The practice is rated as good for the care of patients with long-term conditions.

Nationally reported Quality and Outcomes Framework (QOF) data, for 2013/14, showed the practice had performed well in providing recommended care and treatment for most of the clinical conditions covered, that commonly affect this population group. Achievements were either mostly above, or just slightly below, the local CCG and England averages. For example, the practice had obtained 100% of the points available to them for providing recommended care and treatment for patients with chronic kidney disease. This was 4.2% above the local CCG average and 5.3% above the England average. Staff had taken steps to reduce unplanned hospital admissions by improving services for patients with complex healthcare conditions. Patients on the practice's long-term conditions' registers received healthcare reviews that reflected the severity and complexity of their needs. Clinical staff had the training they needed to provide good outcomes for patients with long-term conditions.

Families, children and young people

Good

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

Summary of findings

Staff had identified the needs of families, children and young people and put plans in place to meet them. Nationally reported QOF data, for 2013/14, showed the practice had achieved 100% of the total points available to them for providing maternity services and child health surveillance. These achievements were above the England averages (i.e. 0.9 and 1.2% above respectively) and in line with the local CCG averages. Systems were in place for identifying and following-up children who were considered to be at risk of harm or neglect, where they failed to attend planned appointments. Where comparisons could be made, we found the delivery of the majority of childhood immunisations was higher when compared to the overall percentages for children receiving the same immunisations within the local CCG area. A weekly baby clinic provided patients with access to a midwife and the GP team provided ante- and post-natal care. Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of working-age patients (including those recently retired and students.)

Staff had identified the needs of the working age and recently retired population and had developed services which met their needs. Nationally reported QOF data, for 2013/14, showed the practice had performed well in providing recommended care and treatment for most of the clinical conditions covered that commonly affect this population group. Achievements were either mostly above, or just below, the local CCG and England averages. For example, the practice had obtained 100% of the points available to them for providing recommended care and treatment for patients with diabetes. This was 0.7% above the local CCG average but 3.7% below the England average. The practice was proactive in offering on-line services to patients. For example, patients could order repeat prescriptions and book appointments on-line. Health promotion information was available in the waiting area and there were links to self-help information on the practice website.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of patients whose circumstances may make them vulnerable.

Systems were in place in place to identify patients, families and children who were at risk or were vulnerable. Staff worked with relevant community healthcare professionals to help meet the needs of vulnerable patients. They sign-posted vulnerable patients to various support groups and other relevant organisations. Staff knew how to recognise signs of abuse in vulnerable adults and

children and knew when to take action to protect vulnerable patients. The practice had identified which of their patients had learning disabilities. Staff told us they worked in collaboration with the local community learning disability team to provide this group of patients with regular healthcare reviews. Nationally reported QOF data, for 2013/14, showed the practice had not performed well in providing recommended care and treatment to patients with learning disabilities. However, this was because the practice did not have patients which met the criteria for providing the recommended care and treatment.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of patients experiencing poor mental health (including people with dementia).

Nationally reported QOF data, for 2013/14, showed the practice had achieved 100% of the total points available to them for providing recommended care and treatment to patients with dementia. This achievement was 5.2% above the CCG average and 6.6% above the England average. The QOF data also showed the practice had obtained 87.7% of the total points available to them for providing patients experiencing poor mental health with the recommended care and treatment. Although high, this achievement was 2.1% below the local CCG average and 2% below the England average. The practice kept a register of patients with mental health needs which was used to help make sure they received relevant checks and tests. Where the practice had been able to, care plans had been completed for 76% of the patients who were on the register. The practice regularly worked with other community healthcare professionals to help ensure patients' needs were identified, assessed and monitored.

Summary of findings

What people who use the service say

During the inspection we spoke with two patients from the practice's patient participation group (PPG) and also reviewed 22 Care Quality Commission (CQC) comment cards completed by patients. Patients told us staff were friendly and helpful. They said they were treated with dignity and respect. Where patients commented, they also said staff listened to them, and explained things clearly in a way they could understand. The PPG members told us they could get an appointment easily, and said if you needed to see a doctor urgently you would always be seen the same day. None of the patients who completed the CQC comment cards raised any concerns about access to appointments. Many of the comments made referred to the dedication of the staff team, and the good service they had provided over many years.

Findings from the National GP Patient Survey of the practice, published in January 2015, indicated most patients had a good level of satisfaction with the care and treatment they received, and were broadly in line with national and local Clinical Commissioning Group (CCG) comparators. For example, of the patients who responded to the survey:

- 90% said the last GP they saw, or spoke to, was good at listening to them, (this was just below the local CCG of 92% but above the national average of 88%);
- 89% said the last GP they saw or spoke to was good at giving them enough time, (this was just below the local CCG average of 91% but above the national average of 86%);
- 82% said the last GP they saw or spoke to was good at treating them with care and concern, (this was below the local CCG average of 88% but in line with the national average of 82%);
- 73% said they had confidence and trust in the last GP they saw or spoke to, (this was above the local CCG average of 72% and the national average of 64%).

Good feedback was also received about the care and treatment provided by the practice nurses.

These results were based on 101 surveys that were returned out of a total of 264 sent out. The response rate was 38%.

Areas for improvement

Action the service SHOULD take to improve

The provider should:

- Carry out a Legionella risk assessment;
- Carry out regular infection control audits;
- Provide the practice manager with an appraisal.

Dr Winifred Helen McManus

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector. The team also included a GP specialist professional adviser.

Background to Dr Winifred Helen McManus

Dr Winifred Helen McManus provided care and treatment to 3100 patients of all ages, based on a General Medical Services (GMS) contract agreement for general practice. They are part of NHS South Tyneside Clinical Commissioning Group (CCG) and provide care and treatment to patients living in Jarrow and surrounding areas.

The practice is situated in a converted end terraced house with adapted disabled access at the front entrance and a platform lift to enable patients to access the first floor. Dr Winifred Helen McManus serves an area that has higher levels of deprivation for children and people in the over 65 age group, than the local CCG and England averages. The practice's population has fewer patients aged under 18 years, and more patients aged over 65, than other practices in the CCG area. The practice has more patients with a long-standing health condition and health-related problems in daily life than the England average. Life expectancy for both men and women is slightly below the England average. The practice provides services from the following address: Albert Road Surgery, 118 Albert Road, Jarrow, Tyne and Wear, NE32 5AG. We visited this site during our inspection.

Dr Winifred Helen McManus provides a range of services and clinic appointments including, for example, services and clinics for patients with asthma, diabetes and hypertension. The practice consists of a GP provider (female), a salaried GP (female), a practice manager and deputy practice manager, a practice nurse, a healthcare assistant and administrative and reception staff. Patients were not normally able to access a male GP other than when locum cover was provided by a male GP. When the practice is closed patients can access out-of-hours care via Northern Doctors Urgent Care and the NHS 111 service.

The practice opened between 8am and 6pm on a Monday, Tuesday, Wednesday and Friday, and between 8am and 1pm on a Thursday. Extended hours were provided between 6pm and 7:30pm. Core appointments were:

Monday: 9am until 12pm and 2.30pm until 5.40pm;

Tuesday: 9am until 11.30am and 2:30pm until 5:00pm;

Wednesday: 8.30am until 11.30am and 3pm until 4.30pm;

Thursday: 9.00am until 11.30am;

Friday: 9.30am until 12.00pm and 15.30pm until 17.00pm.

Why we carried out this inspection

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

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008, as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal

Detailed findings

requirements and regulations associated with the Health and Social Care Act 2008: to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

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

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

Before visiting we reviewed a range of information we held about the practice and asked other organisations to share what they knew about the services it provided. We carried out a telephone interview with the practice nurse on 17 June 2015. We also undertook an announced inspection on 23 June 2015. During this we spoke with a range of staff including: the GP provider; the salaried GP; the practice manager; a pharmacist attached to the practice; and members of the reception and administrative team. We spoke with two patients from the practice's Patient Participation Group (PPG) and reviewed 22 Care Quality Commission (CQC) comment cards completed by patients who use the practice. We observed how staff communicated with patients who visited, or telephoned the practice on the day of our inspection. We looked at records the practice maintained in relation to the provision of services.

Requires improvement

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify potential risks and to improve patient safety. This information included significant event reports, national patient safety alerts, and comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. The patients we spoke with, or who had completed comment cards, raised no concerns about safety at the practice. Staff kept records of significant events and incidents. We reviewed a sample of the records completed during the previous 12 months. The records showed the practice had treated such events seriously and appropriately during the period concerned. This provided evidence of a safe track record for the practice.

Learning and improvement from safety incidents

The practice had a system for reporting, recording and learning from significant events and complaints. The practice manager told us that discussions about significant events were held at the end of the multi-disciplinary team meetings and any necessary actions were agreed by those present. The staff we spoke with were aware of the system in place for raising issues and concerns. They told us the practice manager was responsible for notifying the local CCG of any concerning incidents, using the local safeguarding incident reporting system. The practice manager said they had made plans to train all administrative staff in the use of this system.

We spoke to staff about how the practice learned from safety incidents, and also looked at the records that had been kept. Staff had recorded two significant events during the previous 12 months. We saw evidence staff had considered events where they had not got things right or could have done something differently. It was evident staff had treated these events seriously. However, it was not clear how the practice would manage a similar incident in the future, from what was documented.

Arrangements had been made which ensured national patient safety alerts were disseminated by the practice manager to the relevant team members. The practice manager said all alerts were saved in a specific place on the practice's intranet system. The practice's approach to managing safety alerts enabled the relevant staff to take appropriate action to promote patient safety, and to mitigate any risks. (Safety alerts inform the practice of problems with equipment or medicines or give guidance on clinical practice.)

Reliable safety systems and processes including safeguarding

The practice had systems in place to manage and review risks to children, young people and vulnerable adults. Safeguarding policies and procedures were in place. Information about how to report safeguarding concerns and contact the relevant agencies was easily accessible. One of the GPs acted as the designated lead role for safeguarding children and vulnerable adults. Staff we spoke with said they knew which GP held lead safeguarding responsibilities.

Both GPs had completed child protection training to Level 3. This is the recommended level of training for GPs who may be involved in treating children or young people, where there are safeguarding concerns. The practice nurse had completed Level 2 training which is more relevant to the work they carried out. The practice manager told us administrative staff had also completed basic child protection awareness electronic-training. This was confirmed by a member of the reception team we spoke with. Staff demonstrated a good understanding of how to protect and safeguard patients. They were clear about what they would look for, and what they would do if they had any concerns about a patient's wellbeing. The GPs had completed adult safeguarding awareness training. Although none of the other staff had completed this training, the practice manager told us they had recently made arrangements for them to do so.

A chaperone policy was in place and information about this had been displayed throughout the practice. The patients we spoke with said they knew they could access a chaperone if they needed one. All the clinical and non-clinical staff who carried out chaperone duties had received chaperone training. However, some of the clinical staff who carried out this role had not undergone a Disclosure and Barring Service (DBS) check. The practice manager told us this had already been identified as an issue and steps were being taken to address this shortfall.

Regular multi-disciplinary team meetings took place. The GPs met with health visitors and other healthcare

professionals to review patients considered to be at risk and, where appropriate, to share any relevant information. A process was in place which helped to ensure the practice team followed up any at risk children who missed important appointments. Staff had placed a 'flag' on the medical records of children who had been identified as being at risk of harm to alert clinicians to their particular circumstances.

Medicines Management

Overall, the arrangements for managing medicines, including emergency drugs and vaccinations, kept patients safe. Staff carried out regular medication audits with the support of the link pharmacist, to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. Prescription pads were securely stored. Refrigerator temperatures were checked daily to help ensure medicines requiring cold storage, such as vaccines, were stored within the right temperature range. The practice nurse confirmed vaccine stocks were rotated to ensure they were used before their expiry dates. Staff had kept a log confirming this. However, we did identify some gaps in this record. For example, the person completing the checks did not always sign their name.

Patients were able to order repeat prescriptions in a variety of ways, including by telephone and on-line. The practice website provided patients with helpful advice about ordering repeat prescriptions. Reception staff handled telephone requests for repeat prescriptions competently and safely. They were clear about the processes they should follow, including checking that the number of authorised repeat prescriptions had not been exceeded. Repeat prescription requests were signed by GPs throughout the day.

Staff provided us with evidence which demonstrated they had taken steps to comply with relevant prescribing guidance by working with their link practice pharmacist. These included, for example, increasing referrals to the Talking Therapies service rather than prescribing anti-depressants as a first line treatment, and carrying out of clinical audits to ensure the GPs were following antimicrobial guidelines. We spoke with the link pharmacist as part of our inspection. They told us staff worked well with them and that they were committed to best prescribing practice for the benefit of their patients. A system was in place for responding to any medicine related safety alerts received by the practice. We were provided with evidence which confirmed that immediate responses were made to these types of alerts.

Cleanliness & Infection Control

Overall, the premises were clean and hygienic throughout. However, a carpet in one of the administrative offices was grimy, and could be seen by patients. The lead GP agreed to ensure that this matter was addressed following the inspection. The patients we spoke with, and those who commented on this in the CQC comment cards, told us the premises were always clean. The practice employed a cleaner who worked to an agreed cleaning schedule which we were able to see on the day of the inspection.

The clinical rooms we visited contained personal protective equipment such as latex gloves and paper covers for the consultation couches. Arrangements had been made for the privacy screens to be replaced every six months. Spillage kits were available to enable staff to deal safely with spills of bodily fluids. A member of the reception team we spoke with was clear about how bodily spills should be handled. Sharps bins were available in each treatment room to enable clinicians to safely dispose of needles. We noted that one of these had not been appropriately signed or dated. Clinical rooms contained hand washing sinks, antiseptic gel and hand towel dispensers to enable clinicians to follow good hand hygiene practice.

Arrangements had been made for the safe handling of specimens and clinical waste in accordance with national guidance. Reception staff were clear about how to handle specimens safely to minimise the risk of the spread of infection. Clinical waste bins were visibly clean and in good working order. However, some of the domestic waste bins were not pedal operated. The practice manager agreed to address this matter following the inspection.

Appropriate arrangements had not been made to ensure the practice's water systems were kept free of the presence of Legionella by carrying out a suitable risk assessment. (Legionella is a bacterium that can grow in contaminated water and can be potentially fatal.) There were infection control procedures which provided staff with guidance about the standards of hygiene they were expected to follow. The practice had an infection control lead who also

provided advice and training to staff when needed. However, the practice nurse confirmed that infection control audits had not been carried out. The GP provider told us this would be addressed following the inspection.

Equipment

Staff had access to the equipment they needed to carry out diagnostic examinations, assessments and treatments. The equipment was regularly inspected and serviced. For example, equipment contained in the emergency medicines kit had been checked during the previous 12 months. Other medical equipment had been calibrated to make sure they were operating effectively. Arrangements had been made to ensure fire safety equipment was appropriately maintained.

Staffing & Recruitment

All of the clinical and non-clinical staff had a NHS Smart card (containing an identity photograph). This meant their identity had been verified under the NHS Employment Check Standards process.

References and employment history information had been obtained for a recently appointed healthcare assistant. We checked the General Medical and Nursing and Midwifery Councils registers and confirmed all of the clinical staff working at the practice were appropriately registered. (It is a requirement that all clinical staff are registered with the relevant regulatory body before they can practice.) We saw evidence that the practice manager had checked to make sure the practice nurse continued to be registered with their professional body.

The practice had a staff recruitment policy which provided clear guidance about the pre-employment checks that must be carried out on new partners and staff. These included obtaining written references, a DBS check and a satisfactory medical report. However, we found that some pre-employment checks had not been carried out in line with the practice's own recruitment policy. We looked at the recruitment records of the salaried GP who had joined the practice during the previous 12 months. We found most of the employment checks that employers are required to undertake on new applicants had not been carried out in relation to this GP. For example, the following had not been obtained: evidence of satisfactory conduct in their previous role as a GP, and confirmation of why they had left their last post; details of their previous employment history; evidence of appropriate qualifications; evidence they were physically and mentally able to carry out the responsibilities of the role. Also, the practice had not sought appropriate assurances from NHS England that they had carried out a DBS check for this GP, as part of their application to join the National Medical Performers' List. In addition to this, we also found that a DBS check had not been completed for the practice nurse who had worked at the practice for many years, or for the healthcare assistant who had recently commenced employment at the practice. The practice manager told us they had recently carried out a quality assurance exercise to check how well they were complying with the new regulations and guidance produced by CQC. They said they had already identified the concerns we had found and were taking action to address them.

The majority of staff had last had an appraisal in 2013. However, the practice manager had not had an appraisal for over two years. The practice manager told us appraisals were usually carried out every 12 months but the appraisals for 2014 had been postponed until after senior staff attended a training course to help them deliver better quality appraisals.

Monitoring Safety & Responding to Risk

The practice had systems to manage and monitor risks to patients and staff. For example, there was an up-to-date fire risk assessment. This demonstrated the practice had made suitable arrangements to assess the potential risks to staff and patients. However, some of the requirements made by the local fire service had not been actioned because of advice staff subsequently received from the external contractor who completed their fire risk assessment. We shared our concern about this with the GP provider and they agreed to seek further advice from the local fire service. Risk assessments regarding the control of hazardous substances had recently been carried out to ensure staff and patient safety. Although the building was generally safe and hazard free, the inspection team noted that clinical waste awaiting collection could be stored more safely. The practice completed significant event reports where concerns about patients' safety and well-being had been identified. Arrangements were in place to learn from patient safety incidents and to cascade this learning within the team.

Arrangements to deal with emergencies and major incidents

Requires improvement

Are services safe?

The practice had arrangements in place to manage emergencies. For example, there was an up-to-date business continuity plan for dealing with a range of potential emergencies that could impact on the daily operation of the practice. The plan covered the actions to be taken to reduce and manage a range of potential risks.

The practice manager told us staff had received training in cardio-pulmonary resuscitation (CPR). There was equipment available for use in emergencies including oxygen, adrenaline and a defibrillator. (Adrenaline is used to treat life-threatening allergies).

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Care and treatment was delivered in line with recognised best practice standards and guidelines. Clinical staff had access to local guidelines, as well as guidelines from the National Institute for Health and Care Excellence (NICE). From our discussions with clinical staff we were able to confirm they completed thorough assessments of patients' needs, which were in line with NICE guidelines and local protocols. Patients' needs were reviewed as and when appropriate. The practice nurse told us they had access to a range of chronic disease management care plan templates. They said they used these to record details of their assessments and any agreements reached with patients about how they should manage their condition. Information about commonly found long-term conditions was available at the practice. We were told information could also be printed off to provide patients with further advice and guidance.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in managing, monitoring and improving outcomes for patients. For example, the lead GP acted as the lead for most key clinical areas and the practice nurse was responsible for the delivery of chronic disease management. The practice participated in the Quality and Outcomes Framework system (QOF). This is a system intended to improve the quality of general practice and reward good practice. The practice used the information collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. The practice management team monitored their QOF performance closely. The practice manager provided weekly updates to the lead GP about how well the practice was performing in relation to QOF targets.

Nationally reported QOF data, for 2013/14, showed the practice had achieved 89.8% of the total overall points available to them for providing recommended treatments to patients with common long-term health conditions. However, although high, it was 5.5% below the local Clinical Commissioning Group (CCG) average and 3.7 below the England average. The practice's clinical exception reporting rate was 5.6% for 2013/14. This was 3.5 percentage points below the CCG average and 2.3 points below the England average. (The QOF scheme includes the concept of 'exception reporting' to ensure that practices are not penalised where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side-effect). This suggests that the practice operates an effective patient recall system where staff are focussed on following patients up and chasing non-attenders. The information we looked at before the inspection did not identify the practice as an outlier for any QOF (or other national) clinical targets.

Staff had carried out clinical audits to help improve patient outcomes. These included two two-cycle audits carried out during the previous 12 months. One of the audits we looked at had been carried out because the practice had been identified as an outlier in their prescribing of co-amoxiclav (an antibiotic). After carrying out initial and follow up audits, the lead GP was able to demonstrate that there had been an improvement in clinical staff's prescribing practice. In addition, the GPs had agreed practice guidelines for prescribing co-amoxiclav which they hoped would help keep them in line with local and national prescribing targets for this type of medicine. A second clinical audit had been carried out to check whether patients with Atrial Fibrillation (an irregular heartbeat) had been prescribed recommended medicines in line with local and national guidelines. Once again, we saw evidence confirming that patient outcomes had improved as a result of this audit.

Effective systems were in place which helped to ensure patients received prompt safe care and treatment. For example, all electronic and paper information, such as discharge and other advisory letters, were scanned onto patients' medical records and given an appropriate code to enable practice staff to search more easily for information. The practice manager told us all patient information coming into the practice was dealt with on a daily basis to prevent any backlogs building up. This was confirmed by the lead GP we spoke with.

Effective staffing

At the time of the inspection the practice had sufficient numbers of skilled, competent and experienced GP staff to meet their surgery commitments. Staff turnover was low and many staff had worked at the practice for a considerable number of years. Staff who had started working at the practice had received an induction. A

member of the administrative team confirmed they had undergone a suitable induction which had met their needs. The lead GP old us that the appointment of the salaried GP in 2014 had '…made a massive difference to the practice'. They said a shared perspective and similar ways of working had promoted and enhanced the delivery of patient care. They also told us that problems recruiting an additional practice nurse during 2013/14 had affected their capacity to deliver some care and treatments and this had affected their QOF performance. We were told that a healthcare assistant with a nursing qualification had been recruited and this had enabled the practice to '…start getting back on track'.

The continuing development of staffs' skills and competence was recognised as integral to ensuring high quality care. For example, the practice nurse told us they had completed training in a range of areas relevant to their role and responsibilities. This included, for example, completing annual training updates for diabetes, asthma, chronic heart disease, chronic obstructive pulmonary disease (COPD), travel health and administering vaccines. A review of their training folder provided evidence they had also completed recent training on women's health and managing Atrial Fibrillation. The practice closed each Thursday afternoon to enable staff to attend any training considered appropriate to their roles and responsibilities.

Both the lead GP and the salaried GP were up-to-date with their annual continuing professional development requirements and had either had been revalidated or had a date for their 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 practice and remain on the performers list with NHS England.) Appropriate indemnity insurance arrangements were in place for the GPs.

Working with colleagues and other services

Staff had developed positive working relationships with other health and social care providers, to help them co-ordinate care and meet patients' needs. The practice held monthly multi-disciplinary meetings to discuss patients with complex needs, for example, those with end-of-life care needs. These meetings were attended by the GPs, practice nursing staff and local healthcare professionals, such as health visitors and the link pharmacist. The practice manager attended a local practice managers' group. They said this helped them to keep up-to-date with what was going on within the locality.

Practice staff also worked with other service providers to meet patients' needs and manage complex cases. The practice received communications from a variety of sources, such as the local hospital, electronically and by post. Staff we spoke to were clear about their responsibilities for reading and actioning any issues arising from communications with other care providers. They understood their roles and how the practice's systems worked. A member of the administrative team told us these systems usually worked well and everybody knew what they were expected to do.

Information Sharing

The practice had systems for providing staff with the information they needed to carry out their roles and responsibilities. An electronic patient record was used by all staff to coordinate, document and manage patients' care. This enabled scanned paper communications, such as those from hospital, to be saved for future reference. The practice actively used a particular system to request and obtain pathology results electronically. Although the GP provider and salaried GP worked slightly differently in terms of how they actioned tasks and kept records, we did not think this affected patient safety in any way.

The practice used several systems to communicate with other providers. For example, there was an agreed process for accessing information from the local out-of-hours provider. We were told the practice received all information from this provider electronically. This ensured the practice promptly received information about any contact this provider had had with their patients. Electronic systems were in place for making referrals using the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

Consent to care and treatment

Staff obtained patients' consent to care and treatment in line with legislation and guidance. The GPs we spoke with demonstrated a good understanding of consent and capacity issues in relation to children and young people. Staff understood the relevant consent and decision-making

Good

Are services effective?

(for example, treatment is effective)

requirements of legislation and guidance, including the Mental Capacity Act (MCA) (2005.) The GP provider told us where a patient's mental capacity to consent to care or treatment was unclear an appropriate assessment would be undertaken and recorded in their medical records. All clinical staff had completed MCA training.

Health Promotion & Prevention

The practice supported patients to live healthier lives by providing routine checks. This included offering all new patients a health check with a member of the nursing team. This was used to obtain important information, such as details of alcohol consumption and whether the patient smoked, to help them provide appropriate health advice. The practice manager told us new patients who smoked were routinely offered a spirometry test to assess their lung function. The practice also offered NHS Health Checks to all patients aged between 40 and 75 years of age, and offered patients health screening, particularly in relation to smoking, obesity and exercise. Appointments with an alcohol counsellor were available bi-weekly for patients who had been assessed as being able to benefit from this service. The practice also provided patients with access to a lifestyle counsellor who was able to see them at a variety of locations, such as local community centres. Patients receiving support to lose weight were offered regular appointments with the practice's nurse or healthcare assistant.

The QOF data for 2013/14 confirmed the practice supported patients to stop smoking using a strategy that included the provision of suitable information and appropriate therapy. The data also showed the practice had obtained 84.3% of the total points available to them for providing recommended care and treatment for patients who smoked. Although high, this was 10.4% below the local CCG average and 9.4% below the England average. The practice manager told us that, during the previous three months, 24 patients who received smoking cessation advice had given up smoking. The practice had also obtained 95.8% of the points available to them for providing cervical screening to women. This achievement was 1.7% below the local CCG and England averages.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Patients who completed Care Quality Commission (CQC) comment cards told us they received a good service from helpful, caring and professional staff. This was confirmed by the patients we spoke with on the day of the inspection. Patients told us staff treated them with dignity and respect, and 'went the extra mile' to meet their needs. The National GP Patient Survey of the practice, published in January 2015, also showed good levels of patient satisfaction with the care and treatment offered by the practice. For example, of the patients who responded to the survey:

- 90% said the last GP they saw, or spoke to, was good at listening to them, (this was just below the local Clinical Commissioning Group (CCG) of 92% but above the national average of 88%);
- 89% said the last GP they saw or spoke to was good at giving them enough time, (this was just below the local CCG average of 91% but above the national average of 86%);
- 82% said the last GP they saw or spoke to was good at treating them with care and concern, (this was below the local CCG average of 88% but in line with the national average of 82%).

During the inspection we observed that all consultations and treatments were carried out in the privacy of a consulting or treatment room. There were screens in these rooms to enable patients' privacy and dignity to be maintained during examinations and treatments. Consultation and treatment room doors were kept closed when the rooms were in use, so conversations could not be overheard. Patients were able to access a private room if they wished to talk confidentially to reception staff. The practice offered a chaperone service for patients who wanted to be accompanied during their consultation or examination.

Care planning and involvement in decisions about care and treatment

Where patients who had completed CQC feedback cards commented on their involvement in decisions about their care and treatment, they expressed satisfaction. This was confirmed by patients we spoke with on the day of the inspection. Data from the National GP Patient Survey showed patient satisfaction levels were broadly in line with national and local Clinical Commissioning Group (CCG) comparators. For example, of those patients who responded to the survey:

- 85% said the last GP they saw or spoke to was good at explaining tests and treatments, (this was just below the local CCG average of 87% but above the national average of 82%);
- 73% said the GP they visited had been 'good' at involving them in decisions about their care, (this was below the local CCG average of 80% and the national average of 74%).

Staff told us translation and interpreter services were available for patients who did not have English as a first language. Providing these services helps to promote patients' involvement in decisions about their care and treatment. The practice website also contained a facility which enabled patients whose first language was not English to translate health information into a language of their choice.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with were positive about the emotional support provided by practice staff. Where patients had made comments on the CQC comment cards they completed, they all reported they were supported to cope with the emotional impact of their illness. This was also confirmed by the Patient Participation Group (PPG) members we spoke with. We observed staff in the reception area treating patients with kindness and compassion. Notices and leaflets in the waiting room sign-posted patients to organisations offering support with coping with loss. Clinical staff also referred patients struggling with loss and bereavement to these services. Carers looking after family members were identified at the new patient health check or during subsequent clinical consultations. The practice manager told us a specific code was then added to their clinical record to alert clinicians to their particular needs. Written information was available for carers to ensure they understood the various avenues of support available to them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Staff had planned for, and made arrangements to deliver, care and treatment to meet the needs of older patients and those with long-term conditions. Staff kept a register of patients aged 75 years and over, and had written to them explaining that the lead GP would act as their named doctor. Information on the practice website also informed patients which GP would act as their named GP. Staff had identified patients considered to be vulnerable because of the risks associated with their conditions. This had enabled them to identify those at risk of, for example, an unplanned admission into hospital. Emergency care plans had been completed for approximately 50% of the patients who met the criteria for such plans, and steps were being taken to complete the remainder.

The practice nurse was mainly responsible for the delivery of chronic disease management. The practice offered patients with long-term conditions, such as asthma and Chronic Obstructive Pulmonary Disease (COPD), an annual check of their health and wellbeing, or more often where this was judged necessary. (COPD is the name for a collection of lung diseases including chronic bronchitis and emphysema.) An effective patient recall system was in place. A diary system reminded staff to contact patients two weeks before their healthcare review was due, so they could attend for any required tests. The mixed clinic system offered by the practice provided patients with a broad choice of appointment times, to help reduce barriers to attendance. The length of appointment times reflected the complexity of patients' health conditions. The practice nurse carried out home visits for housebound patients to make sure they received annual reviews and flu vaccinations.

The National GP Patient Survey of the practice, published in January 2015, showed patients were satisfied with how they were treated and the quality of the care and treatment they received from the practice nurse. For example, of the patients who responded:

- 86% said the last nurse they saw, or spoke to, was good at listening to them, (this was above the local CCG average of 82% and the national average of 79%);
- 86% said the last nurse they saw or spoke to was good at treating them with care and concern, (this was above the local CCG average of 81% and the national average of 78%).

Staff kept a register of patients who were in need of palliative care and their IT system alerted clinical staff about those who were receiving this care. Nationally reported Quality and Outcomes Framework (QOF) data, for 2013/14, showed that multi-disciplinary team (MDT) meetings took place at least every three months, to discuss and review the needs of each patient on this register. The overall QOF score for the practice in relation to the provision of palliative care was in line with the local CCG average and 3.3% above the England average.

Staff had identified the needs of families, children and young people, and put plans in place to meet them. Pregnant women were able to access a weekly midwife clinic and the GP provider offered ante-natal and post-natal care. Failures to attend planned appointments were followed up by the practice nurse. Chlamydia testing was provided to help promote the sexual health of young patients. The QOF data also showed the practice's performance for providing maternity services was in line with the local CCG average and 0.9% above the England average. The data showed that ante-natal care and screening were offered in line with current local guidelines, and child development checks were offered at intervals consistent with national guidelines. The practice's performance for carrying out child health surveillance was in line with the local CCG average and 1.2% above the England average.

Practice staff provided contraceptive advice to patients and monitored those who had had contraceptive devices fitted. We were told where women needed contraceptive advice, the GPs would refer them to an appropriate service provider. The practice offered a full range of immunisations for children, including the provision of a nurse-led baby vaccination clinic, in accordance with national guidance. On the basis of the nationally reported data available to the Care Quality Commission (CQC), we saw that, where comparisons allowed, the delivery of the majority of childhood immunisations was higher, when compared to the overall percentages for children receiving the same

Good

Are services responsive to people's needs?

(for example, to feedback?)

immunisations within the local CCG area. For example, the numbers of children who were given eight childhood immunisations that should be given to children aged five years, were above each local CCG average.

Staff had planned their services to meet the needs of the working age population, including those patients who had recently retired. Extended hours appointments were available each Wednesday evening at the surgery. The extra appointments offered were in line with the size of the practice's patient list. The practice website provided patients with information about how to book appointments and order repeat prescriptions on-line.

Staff had taken steps to identify patients with dementia and had made arrangements which helped to meet their needs. Nationally reported QOF data, for 2013/14, showed the practice had achieved 100% of the total points available to them for providing recommended care and treatment to this group of patients. This was 5.2% above the local CCG average and 6.6% above the England average. The data also showed that 93.8% of the patients diagnosed with dementia had had their care reviewed in a face-to-face meeting in the preceding 12 months. This was 7.6% above the local CCG average and 10% above the England average.

Patients with mental health needs, including those not registered with the practice, were able to access counselling and support from a visiting mental health counsellor. Nationally reported QOF data, for 2013/14, showed the practice had obtained 87.7% of the overall points available to them for providing recommended care and treatment to patients with mental health needs. Although high, the practice's achievement was 2.1% below the local CCG average and 2.7% below the England average.

The practice had identified those patients who were cared for and those who were carers. This was flagged on the practice's IT system to alert clinicians, so it could be taken into account when assessing the care and treatment needs of these patients. We saw that information for patients who were also carers was displayed in the reception area.

Tackle inequity and promote equality

The practice had made arrangements which demonstrated their commitment to tackling inequity and promoting equality. The majority of patients did not fall into any of the marginalised groups that might be expected to be at risk of experiencing poor access to health care, for example, homeless people and Gypsies and Travellers. However, staff knew there was a care home for people with learning disabilities within their practice boundary. The practice had identified which of their patients had learning disabilities, and told us they worked in conjunction with the local community learning disability team to provide this group of patients with healthcare reviews. Nationally reported QOF data, for 2013/14, showed the practice had not performed well in providing recommended care and treatment to patients with learning disabilities. However, this was because the practice did not have patients who met the criteria for providing the recommended care and treatment. Where patients had learning disabilities, a code was added to their medical record to alert staff to their special needs. An additional code was added where any of these patients might experience difficulties providing informed consent to their care and treatment.

Reasonable adjustments had been made which helped patients with disabilities and patients whose first language was not English to access the practice. Although the premises were not purpose built, they had been adapted to meet the needs of patients with disabilities. For example, there were consultation and treatment rooms, and a patient waiting area, located on the ground floor. Part of the reception desk had been lowered to make reception staff more accessible to patients using wheelchairs. A platform lift had been installed to help patients access facilities on the first floor. There was a disabled toilet which had appropriate aids and adaptations. The main doors into the practice were automatic and a ramp provided easy access for wheelchair users. Disabled parking was not available. Following attendance at a recent sight impairment course, the practice manager had increased the font size on all letters being sent out to patients with this condition. The practice had a small number of patients whose first language was not English. Staff had access to a telephone translation service and interpreters should they be needed. The practice website provided non-English speaking patients with access to fact sheets which explained the role of UK health services, including the role of the GP.

Access to the service

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice opened between 8am and 6pm on a Monday, Tuesday, Wednesday and Friday, and between 8am and 1pm on a Thursday. Extended hours were provided between 6pm and 7:30pm each Wednesday. Core appointments were:

Monday: 9am until 12pm and 2.30pm until 5.40pm;

Tuesday: 9am until 11.30am and 2:30pm until 5:00pm;

Wednesday: 8.30am until 11.30am and 3pm until 4.30pm;

Thursday: 9.00am until 11.30am;

Friday: 9.30am until 12.00pm and 15.30pm until 17.00pm.

Telephone consultations were also available on some days with the salaried GP, and telephone triage was provided daily by the practice nurse.

Patients were able to book appointments by telephone, by visiting the practice or on-line. Routine appointments were available which patients could book in advance. The practice website advised patients that staff would aim to offer them an appointment on the same day where one was available. The doctors also offered telephone advice, should patients prefer this to attending the practice for an appointment. The practice's website and leaflet provided patients with information about how to access out-of-hours care and treatment.

Patient feedback about access to appointments was generally good. Feedback from the patients we spoke with on the day of the inspection about access to appointments was positive. Most of the patients who completed CQC comment cards also reported that access to appointments was good. Of the patients who responded to the National GP Patient survey of the practice, published in January 2015:

- 89% described their overall experience of making an appointment as good, (this was above the local CCG average of 79% and the England average of 74%);
- 97% described their appointment as convenient, (this was above the local CCG average of 93% and the national average of 92%);
- 83% said they were able to get an appointment to see or speak with someone when they contacted the practice, (this was just below the local CCG average of 86% and the national average of 85%);
- 84% said they found it 'easy' to get through on the telephone to someone at the practice, (this was above the local CCG average of 80% and the national average of 71%).

However, the practice performed less well with regards to their opening hours. Of the patients who participated in the survey, 74% said they were satisfied with the practice's opening hours, this was below the local CCG average of 83% and just below the national average of 76%.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The practice's complaints policy and procedures were in line with recognised guidance and the contractual obligations for GPs in England. The practice website provided patients with clear information about how to complain. Information about how to complain was also on display within the practice reception area. The practice had received four complaints during the previous 12 months. All had received an appropriate response from the practice.

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 Statement of Purpose which clearly set out its aims and objectives as well as patient rights and responsibilities. This included, for example, a commitment to: provide a high standard of medical care; improving patient-centred care through shared decision-making and ensuring safe and effective services. The practice provided the inspection team with a clear statement about the services they delivered to the key population groups we looked at. Staff told us they knew and understood what the practice was committed to providing and what their responsibilities were in relation to these aims. However, the practice did not have an up-to-date improvement plan which set out their key priorities for 2015/16. The practice manager and lead GP told us they would address this following the inspection.

Governance Arrangements

Overall, the practice had effective governance arrangements. However, we identified that these could be strengthened in some areas. For example, having an effective system for checking that required pre-employment checks were being carried out, would have shown the practice's recruitment procedures were not always being followed.

We also identified areas where the practice performed well. We found the practice had a suitable up-to-date policy regarding their governance arrangements. The policy identified the key controls that were in place to ensure effective governance arrangements, and there were identified practice leads. For example, the policy stated the practice would promote patient involvement and seek feedback from patients on the quality of the services provided. Despite having faced difficulties trying to recruit members for their patient participation group (PPG), there was a small group of patients who met approximately quarterly. The PPG members we spoke with confirmed staff supported, encouraged and welcomed their feedback. The clinical governance policy also stated that clinical audits and significant event reporting would be undertaken to help improve patient care and minimise risks to their safety. We saw evidence that clinical audits had taken place.

Appropriate arrangements were in place for delivering evidence-based care and updating the practice's clinical guidelines to ensure they reflected national and local clinical guidelines. A system was in place for reporting and learning from significant events. Regular internal meetings, involving staff and community-based healthcare professionals, were held to enable effective decision-making and shared learning to take place. For example, regular multi-disciplinary team meetings were held to discuss at-risk patients, those requiring extra support and patients with palliative care needs. The practice manager met weekly with the lead GP to review the day-to-day business of the surgery.

Leadership, openness and transparency

There was a well-established management structure and a clear allocation of responsibilities, such as clinical lead roles. All of the staff we spoke with demonstrated a good understanding of their areas of responsibility and were able to describe how they took an active role in trying to ensure patients received good care and treatment. Staff told us they would feel comfortable raising concerns with the practice manager or the lead GP.

Practice seeks and acts on feedback from users, public and staff

The practice had made arrangements to actively seek and act on feedback from patients and staff. For example, the practice had employed an external organisation to carry out a comprehensive patient survey in 2014. The practice scored well in most areas with 96.9% of patients indicating their experience of this GP surgery was good, very good or excellent. Also, 94.5 % of patients said they would recommend this surgery to someone who has just moved to this area. Patients were also invited to complete a Friends and Family Test survey (FFT) following a visit to the practice. Comment cards were available for them to complete. However, the results of the FFT surveys had not been uploaded onto the practice website at the time of our inspection.

The practice had an active PPG comprising a small number of patients who had made a commitment to meet on a regular basis. The members of the group we spoke with told us they felt well supported by practice staff. One person told us they recognised the group did not have good representation from all patient age groups and hoped that staff could help them address this. (The main aim of

Are services well-led?

Good

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

promoting the development of a PPG is to help the practice engage with a cross section of the practice population and obtain their views.) Information about how to join the group was available in the patient reception area and on the practice website.

Management lead through learning & improvement

The practice had management systems in place which supported continued learning and performance improvement. The staff we spoke with told us they had opportunities for continuous learning to enable them to maintain and develop their skills and competencies. They said their personal development was encouraged and supported. Staff said they took part in regular 'time-out' sessions which enabled them to complete the training required for their continuing professional development. We were told the practice closed for 20 hours per month to support the practice's commitment to providing opportunities for staff training. Reviews of significant events had also taken place to promote learning and improvement.