# Dr Marianne Ford

## Quality Report

38 Manor Road
Deal
Kent. CT14 9BX
Tel: 01304 367495
Website: www.doctor-surgery-deal-kent.co.uk

Date of inspection visit: 3 June 2015
Date of publication: 27/08/2015

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 Marianne Ford on 3 June 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for older people, people with long-term conditions, families, children and young people, working age people (including those recently retired and students), people living in vulnerable circumstances, and people experiencing poor mental health (including people with dementia).

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, with the exception of enhanced training for the infection control lead. Further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that 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.
- 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 some areas of practice where the provider needs to make improvements.

# Summary of findings

Importantly the provider should:

- Review the training arrangements for infection control, including the lead within the practice, to ensure their responsibilities in relation to the role are clearly understood.
- Review the process for monitoring professional registration checks for GPs and nursing 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?**

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 that most patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' 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 staff. Staff worked with multi-disciplinary teams.

**Are services caring?**

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. 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 clinical commissioning group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that 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 was shared 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 set of aims and objectives and a long-term strategy. Staff were clear about 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 patient population. For example, promoting a multi-disciplinary approach to the care of older patients living in local care homes. It was responsive to the needs of older patients, 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 patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multi-disciplinary 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 to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, attendance at accident and emergency (A&E) departments were followed up by the GPs. Immunisation rates were above average for the locality for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice had systems to communicate and share information with the health visitor and midwifery team.

**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, those recently retired and students had been identified and the practice had adjusted the services it offered

# Summary of findings

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 reflected the needs for this age group.

**People whose circumstances may make them vulnerable**

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances, such as those with a learning disability. The practice had carried out annual health checks for people with a learning disability and where patients found it difficult to attend the practice, the GP visited them at home to carry out health assessments.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. There was information available in the practice 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 (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. Care plans were in place for patients with dementia.

There was information available in the practice about how to access various support groups and voluntary organisations. The practice had a system to follow-up patients who had attended accident and emergency (A&E) departments, where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

# Summary of findings

## What people who use the service say

We spoke with six patients on the day of our inspection. All the patients we spoke with were positive about the services they received from the practice and said they felt the care and treatment was good. Patients told us they had no concerns about the cleanliness of the practice and that they always felt safe. They said referrals to other services for consultations and tests had always been efficient and prompt.

Patients were particularly complimentary about the staff, and said they were always caring, helpful and efficient, and that they were treated with respect and dignity.

Patients told us the appointments system worked well and they were able to get same day appointments if urgent. All patients told us they always had enough time with the GPs and nurses to discuss their care and treatment thoroughly, they never felt rushed and that they felt involved in decisions about their care.

We reviewed 36 comment cards completed by patients prior to our inspection. All of the comments were positive and expressed satisfaction about appointments, the staff and being treated with care and consideration. They included comments in relation to having enough time with the GPs and nurses, as well as being involved in discussions and decisions regarding their care and treatment.

Information from the 2014 national patient survey showed that the practice had been rated well in many areas, compared to other practices. For example, 98% of respondents described their overall experience of the practice as good, compared to the local average of 86% and the national average of 85%. Similarly, 96% of respondents described their experience of making an appointment as good, compared to 75% locally and 74% nationally.

## Areas for improvement

**Action the service SHOULD take to improve**

- Review the training arrangements for infection control, including the lead within the practice, to ensure their responsibilities in relation to the role are clearly understood.
- Review the process for monitoring professional registration checks for GPs and nursing staff.

# Dr Marianne Ford

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor, a practice manager advisor and a practice nurse advisor.

## Background to Dr Marianne Ford

The practice is open between 8am and 6.30pm Monday to Friday and extended opening hours are offered until 7.30pm on Tuesday evenings. Patients have access to the reception staff throughout the day during opening hours. The practice is situated in the coastal town of Deal near Dover in Kent and provides a service to approximately 2,148 patients in the locality.

Routine health care and clinical services are offered at the practice, led and provided by the GPs and nursing team. The practice has more patients registered over the age of 65 than both the local and national averages. There are fewer patients under the age of 18 registered at the practice than both the local and national averages. The practice population recognised as suffering deprivation, including income deprivation, is lower than the local and national averages.

The practice has one single-handed female GP, who employs two part-time female practice nurses. Locum GPs work in the practice on regular days each week and cover when the GP is on holiday, both of which are female. There is no regular provision of a male GP. There are a number of administration staff, and a practice manager.

The practice does not provide out of hours services to its patients and there are arrangements with another provider (NHS 111/IC24) to deliver services to patients when the practice is closed. The practice has a general medical services (GMS) contract with NHS England for delivering primary care services to local communities.

Services are delivered from:

Dr Marianne Ford

38 Manor Road

Deal

Kent. CT14 9BX.

## 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 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 received a comprehensive inspection before and that was why we included them.

# Detailed findings

## How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 3 June 2015. During our visit we spoke with a range of staff, including the principal GP, two practice nurses, two administration staff and the practice manager. We spoke with patients who used the services, as well as a representative from the patient participation group (PPG). We reviewed comment cards that patients and some health care professionals had completed to share their views about the practice.

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

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

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

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

Good

# Are services safe?

## Our findings

**Safe track record**

The practice used a range of information to identify risks and improve patient safety. For example, reporting incidents and responding to national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and adverse events.

We reviewed safety records, incident reports and minutes of meetings that demonstrated the practice had managed these consistently over time and could therefore show evidence of a safe track record over the long term.

**Learning and improvement from safety incidents**

The practice had a system for reporting, recording and monitoring significant events and we reviewed records of significant events that had occurred during the last year. Significant events were discussed at weekly practice meetings and there was evidence that the practice had learned from these and that the findings were shared with relevant staff. All staff, including reception and administrative staff, knew how to raise an issue for consideration at the meetings and said they felt encouraged to do so.

The practice manager was responsible for managing all significant events and we saw the system used to monitor these. We tracked two incidents and saw records were completed in a comprehensive and timely manner and that actions were taken as a result. For example, a root cause analysis had been undertaken to determine the cause of a health care acquired infection and potential links to antibiotic prescribing. The findings had been reviewed and discussed in a practice meeting and shared with relevant staff. Records showed that where patients had been affected by something that had gone wrong, they were given an apology and informed of the actions taken.

National patient safety alerts were received and disseminated by the GP and there was a system to help ensure that follow-up actions had been taken by staff to address safety issues relevant to the practice.

**Reliable safety systems and processes including safeguarding**

The practice had systems to manage and review risks to vulnerable children, young people and adults. The practice had safeguarding policies, which clearly set out the procedures for staff guidance. The policies reflected the requirements of the NHS and social services safeguarding protocols and contained the contact details for referring concerns to external authorities, and these were easily accessible to staff.

The practice had a GP who was the designated lead in overseeing safeguarding matters and all the staff we spoke with told us they were aware of who the lead was and who to speak with in the practice if they had a safeguarding concern. GPs, nurses and administrative staff we spoke with were knowledgeable in how to recognise signs of abuse in vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record safeguarding concerns and how to contact the relevant agencies in working hours and out of hours. Training records demonstrated that staff had undertaken safeguarding training relevant to their roles. The GPs had the necessary training (level three) to fulfil their role in managing safeguarding issues and concerns within the practice.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so that staff were aware of any relevant issues when patients attended appointments, for example, children subject to child protection plans. GPs liaised with social services to share information in relation to concerns that were identified within the practice and we saw meeting minutes where safeguarding issues had been discussed.

The practice had a chaperone policy. A chaperone is a person who accompanies a patient when they have an examination and we saw that the practice policy set out the arrangements, roles and responsibilities of staff who undertook chaperone duties. Administration staff did sometimes undertake chaperone duties, to provide flexibility in having staff available for patients who wished to have a chaperone. Patients were made aware that they could request a chaperone, and details were displayed in the practice waiting area. Staff who undertook chaperone duties had been trained to do so, although criminal record checks with the Disclosure and Barring Service (DBS) had not been undertaken for administration staff. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where

they may have contact with children or adults who may be vulnerable). However, records confirmed that the practice had completed and submitted applications for these staff and had undertaken a risk assessment to mitigate any known risks in the meantime.

**Medicines management**

We checked medicines kept at the practice 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, and staff described the action to take in the event of a potential failure. The practice staff followed the policy and we saw records of temperature checks for refrigerators used to store medicines.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of authorised directions and evidence that nurses had received appropriate training to administer vaccines.

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

We saw records that noted the actions taken in response to prescribing data for the practice over the last year. The practice had liaised and met regularly with the area medicines management team in relation to some aspects of medicines prescribing. Where possible, changes had been made to prescribing practice, for example, an amendment to the protocol for prescribing antibiotics and there was evidence that a reduction had been achieved in the level of prescribing for these medicines.

**Cleanliness and infection control**

The practice was clean and tidy and patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. The practice had an infection control policy, which included a range of procedures and protocols for staff to follow. For example, hand hygiene and the management of clinical and hazardous waste.

Personal protective equipment including disposable gloves, aprons and coverings were available and staff were able to describe how they would use these to comply with the practice's infection control policy.

Staff we spoke with were knowledgeable about their roles and responsibilities in relation to cleanliness and infection control. However, the designated lead for infection control had not received further updated training to help ensure they were clear about their responsibilities. The training records we looked at showed that staff had undertaken infection control training, including the majority of administration staff.

Following the inspection, we received evidence to confirm that an infection control audit had been undertaken, with follow-up actions identified, as well as details about how the issues would be monitored and discussed at practice meetings.

Treatment and consultation rooms contained sufficient supplies of liquid soap, sanitiser gels, anti-microbial scrubs and disposable paper towels for hand washing purposes. Domestic and clinical waste products were segregated and clinical waste was stored appropriately and collected by a registered waste disposal company. Cleaning schedules were kept that identified the cleaning activity undertaken on a daily, weekly and monthly basis and a system was used to manage the cleaning products and equipment.

The practice had considered the risks associated with Legionella (a germ found in the environment which can contaminate water systems in buildings) and had undertaken a risk assessment and checks of the water systems.

**Equipment**

Clinical equipment was appropriately checked to help promote the safety of staff, patients and visitors. Staff told us that equipment used in the practice was routinely checked and said they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Equipment was tested and maintained regularly and records confirmed this, for example, records

to demonstrate that portable electrical equipment had been tested. We saw evidence of calibration of relevant equipment, for example, weighing scales and blood pressure measuring devices.

**Staffing and recruitment**

The practice had a recruitment policy that set out the standards it followed when recruiting staff, including protocols for checking qualifications, professional registration and obtaining references. Records showed that recruitment checks had been undertaken when employing staff. For example, proof of identification, qualifications and registration checks with the appropriate professional body. Criminal record checks through the Disclosure and Barring Service (DBS) had been undertaken for GPs and nursing staff, and a risk assessment had been undertaken for administrative roles, where the practice had not considered DBS checks necessary.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to help ensure that enough staff were on duty and arrangements for members of staff, including nursing and administrative staff, to cover each other's annual leave. Staff we spoke with said that there were usually enough staff to maintain the smooth running of the practice, and that there were always enough staff to keep patients safe. Patients we spoke with told us they felt there were enough staff in the practice to support their care and treatment needs.

The practice used regular locum GPs who were sourced directly by the practice. We received information following the inspection that showed appropriate checks had been undertaken by the practice. For example, proof of identification and professional registration checks with the General Medical Council (GMC). However, the practice did not have a system to routinely monitor the information they held in relation to professional registration checks for locum GPs and nursing staff, to check that they were kept up-to-date.

**Monitoring safety and responding to risk**

The practice had systems, processes and polices to manage and monitor risks to patients, staff and visitors to the practice. For example, a health and safety policy that included a range of procedures and protocols, including accident reporting and emergency procedures. Information was displayed for staff guidance, such as fire procedures, and security of the premises. Routine annual and monthly checks of the building were undertaken, to identify and monitor risks, including fire safety checks and legionella tests.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being. For example, repeat prescriptions were monitored for patients experiencing mental health problems and urgent appointments were arranged for young children.

**Arrangements to deal with emergencies and major incidents**

The practice had arrangements to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to medical oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Staff we spoke with knew the location of this equipment and told us it was checked regularly. Although records showed that regular checks were undertaken, we found that the medical oxygen cylinder was overdue for replacement. This was immediately addressed and following the inspection, we received evidence to confirm that a contract had been renewed with an oxygen supplier to provide a new cylinder. The details were also entered into the practice's schedule of maintenance checks for the premises.

Emergency medicines were available in a secure area of the practice and all staff knew where they were kept. There were processes to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

The practice had carried out a fire risk assessment that had been reviewed in the last year and included actions required to maintain fire safety and regular checks of the premises had been undertaken. The staff files we looked at confirmed that staff had received fire safety training and a recent fire drill had been undertaken.

The practice had an emergency and business continuity / recovery plan that included arrangements relating to how patients would continue to be supported during periods of unexpected and / or prolonged disruption to services. For example, interruption to utilities and unavailability of staff.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment**

The GPs we spoke with were familiar with current best practice guidance and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. They used guidance and diagnostic tools available on the computer to access the most up-to-date documents.

The practice engaged with the clinical commissioning group (CCG) and the GP from the practice attended regular meetings with the CCG. Information and guidance was disseminated to relevant staff within the practice and we saw minutes of meetings which showed this was discussed. We found from our discussions with the GP and the nursing staff that thorough assessments of patients' needs were undertaken in line with NICE guidelines, and these were reviewed when appropriate. The GP led in specialist clinical areas, such as asthma, diabetes and heart disease and the practice nurses supported them in this work. Feedback from patients confirmed they were referred to other services or hospital when required.

Prescribing data for the practice showed that the practice had performed less well in relation to antibiotic prescribing. However, the practice had taken action to address this and had met regularly with a prescribing advisor from the CCG in the last year, which had resulted in changes to prescribing practice and a reduction in the level of antibiotics prescribed.

Discrimination was avoided when making care and treatment decisions. Interviews with the GP and other staff showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patients' age, gender, race and culture as appropriate.

**Management, monitoring and improving outcomes for people**

Staff across the practice had key roles in monitoring and improving outcomes for patients, including data input, and contacting patients to attend clinical reviews. The practice kept registers to identify patients with specific conditions / diagnosis, for example, patients with long-term conditions including dementia, asthma, heart disease and diabetes. Registers were kept under review and we saw meeting minutes where information was shared and discussed regarding the health care needs of patients and any additional risk factors that might need to be identified on the system. The electronic records system contained indicators to alert GPs and nursing staff to specific patient needs and any follow-up actions required, for example, medicine and treatment reviews.

Patients had care plans that were regularly reviewed. The practice also had processes to follow-up those patients discharged from hospital. They were contacted within three days by the GP, who carried out a review of their medicines and health care needs, as well as updating the patient records system.

Structured annual reviews were also undertaken for people with long term and chronic conditions. For example, recent data showed that 94% of patients with a diagnosis of dementia had received a face-to-face review in the last year, compared to the national average of 84%.

The practice had a palliative care register and held internal as well as multi-disciplinary meetings to discuss the care and support needs of patients and their families. We saw Quality and Outcomes Framework (QOF) data that indicated multi-disciplinary review meetings were held at least every three months to discuss all patients on the register. (QOF is a national performance measurement tool used by GP practices to measure and compare their performance to other practices on a local and national basis).

Data collected for the QOF was reviewed at clinical meetings where information was shared and discussed amongst relevant staff to monitor performance. The available QOF data showed that the practice had some areas that were higher than the national averages. For example, 100% of patients with atrial fibrillation were receiving blood therapy treatments, compared to the national average of 81%. Data also showed that 75% of older patients had received an influenza vaccination, compared to 73% nationally. The practice had achieved 97% of the total QOF target in 2014, which was above the national average of 94%. The practice was aware of all the areas where performance was not in line with national or CCG indicators and had plans setting out how these were being addressed. For example, some areas of medicines prescribing had been reviewed and actions taken in the last year to improve prescribing regimes.

Good

# Are services effective?

## (for example, treatment is effective)

The practice had a system for completing clinical audits. We saw that clinical audits were often linked to medicines management information, safety alerts or as a result of information from the QOF. We looked at an audit that had been initiated to review whether patients on certain types of medicine had undergone blood tests in accordance with clinical guidance to make sure they were on the correct dosage. The results showed that in the majority of cases, appropriate blood tests had been undertaken and where they were required, patients were contacted and blood tests arranged. The audit had been repeated six months later to check that blood tests had been completed and to monitor whether adjustments to the dosage were required according to the results. Repeat auditing was planned twice yearly to monitor compliance to the guidelines.

Other audits had been undertaken, including a dementia audit to look at whether patients had been correctly diagnosed and identified on the practice dementia register. This helped to ensure that patients were appropriately supported and had care and treatment plans. This included referral to other services, for example, memory clinics and for some patients, a recall to the practice for further assessment. The practice planned to repeat the audit periodically, to monitor that patients with dementia were correctly diagnosed and appropriately supported. The practice had also initiated an asthma audit in response to concerns that had been raised by the CCG in relation to the support provided to patients diagnosed with asthma. We saw that detailed information had been collated and patient reviews undertaken to monitor the care they received, including plans to update the audit and continued monitoring of these patients.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP and the computer system provided an alert for those patients who required a medicines review.

**Effective staffing**

Practice staff included a GP with locum support, nurses, managerial and administrative staff. Records showed that staff attended a range of training to help ensure their skills were kept up-to-date, including mandatory courses such as annual basic life support, safeguarding training and equality and diversity training. GPs and nurses had also completed specialist clinical training appropriate to their roles. For example, diabetes, asthma, family planning and cervical cytology.

The practice nurses had also undertaken additional clinical training in relation to supporting patients with asthma and the type of inhalers and techniques used to control their condition. Records showed that the nurses followed up-to-date NHS guidelines in their clinical practice and following feedback from the CCG, had worked on improving the information recorded on patient records when treating and supporting asthma patients.

Records confirmed that staff received annual appraisals. All the staff we spoke with felt they received the on-going support, training and development they required to enable them to perform their roles effectively. The practice was proactive in providing training for relevant courses, for example, management courses for practice management staff. Induction plans were used for new staff, who were appraised after one month, and received three and six monthly reviews to monitor their progress.

GPs were up to date with their annual continuing professional development requirements and had either been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

**Working with colleagues and other services**

The practice had established processes for multi-disciplinary working with other health care professionals and partner agencies. The GP and nurses told us these processes helped to ensure that links remained effective with community and specialist nurses, to promote patient care, welfare and safety. For example, the practice worked with other practices to deliver a local project and initiative for patients over the age of 75, particularly for those living in local care homes. Specialist teams comprising the GPs, community matron, district nurses and a local dementia care co-ordinator worked together to provide additional support for this age group. The GP from

Good

# Are services effective?

## (for example, treatment is effective)

the practice led monthly multi-disciplinary meetings at a local care home, to promote the project and direct the partnership working arrangements with the community specialist teams.

There were also quarterly multi-disciplinary meetings held at the practice, which included the palliative care team, to discuss other patients and review their care plans. The practice had systems to help ensure information was shared with appropriate staff so that patient's records were kept up-to-date. The practice also worked closely with the community mental health team for older patients, who were able to provide additional help and support for patients who required on-going assessment and follow-up in relation to dementia care and support.

The practice received blood test results, x-ray results and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had procedures that set out the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system worked well.

### Information sharing

Staff told us that there were effective systems to ensure that patient information was shared with other service providers and that recognised protocols were followed. For example, a referral system was used to liaise with the community nurses and other health care professionals, including the 'out of hours' service. The practice used the 'Choose and Book' referral 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).

An electronic patient record system was used by staff to co-ordinate, document and manage patients' care. Staff were fully trained in how to use the system and told us that it worked well. The system enabled scanned paper communications, for example, those from hospital, to be saved in the patients' record for future use or reference.

### Consent to care and treatment

The practice had a consent policy that governed the process of patient consent and provided guidance for staff. The policy described the various ways patients were able to give their consent to examination, care and treatment as well as how that consent was recorded.

Mental capacity assessments were carried out by the GPs and recorded on individual patient records. The records indicated whether a carer or advocate was available to attend appointments with patients who required additional support. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Records showed that staff had undertaken training in the Mental Capacity Act 2005. Staff were aware of the need to identify patients who might not be able to make decisions for themselves and to bring this to the attention of GPs and nursing staff.

### Health promotion and prevention

Staff told us about the process for informing patients who needed to come back to the practice for further care or treatment or to check why they had missed an appointment. For example, the computer system was set up to alert staff when patients needed to be called in for routine health checks or screening programmes. Patients we spoke with told us they were contacted by the practice to attend routine checks and follow-up appointments.

We saw a range of information leaflets and posters in the waiting area for patients, informing them about the practice and promoting healthy lifestyles, for example, smoking cessation and weight loss programmes. Information about how to access other health care services was also displayed to help patients access the services they needed, for example, sexual health, including chlamydia testing.

The practice offered and promoted a range of health monitoring checks for patients to attend on a regular basis. For example, cervical smear screening and general health checks including weight and blood pressure monitoring. The most recent data for the practice showed that 86% of women eligible for cervical screening had undergone a test within the last five years, compared to 81% nationally.

Good

# Are services effective?

## (for example, treatment is effective)

We spoke with nursing staff who conducted various clinics for long-term conditions and they described how they explained the benefits of healthy lifestyle choices to patients with long-term conditions such as diabetes, asthma, epilepsy and coronary heart disease. All new patients who registered with the practice were offered a consultation with one of the nurses to assess their health care needs and identify any concerns or risk factors that were then referred to the GPs.

The practice had systems to identify patients who required additional support and were pro-active in offering additional services for specific patient groups. For example, vaccination clinics were promoted and held at the practice, including a seasonal influenza vaccination for older patients. The most recent data for the practice showed that 75% of patients over the age of 65 had received a vaccination, compared to the national average of 73%. Also, 61% of other patients in 'at risk' groups with long-term or chronic conditions had received the vaccination, compared to 52% nationally. NHS health checks were offered to patients aged between 40 and 75 using national guidance, to identify health issues that required follow-up or further investigation.

The practice kept a register of patients who had a learning disability and promoted / encouraged annual health checks for these patients. For those patients unable to attend the practice, the GP visited them at home to help ensure they received regular health assessments.

The practice offered a full range of immunisations for children and travel vaccines. Last year's performance for childhood immunisations was above average for the CCG area and showed that the practice had achieved the maximum target (100%) in all areas of child immunisation. For example, data showed that 100% of 5 year olds had received the meningitis booster vaccination, compared to the CCG local average of 93%. The practice had a system to follow-up non-attenders to help maintain a full programme of childhood immunisations.

Good

# Are services caring?

## Our findings

**Respect, dignity, compassion and empathy**

We reviewed the most recent data available for the practice in relation to patient satisfaction. Information from the 2014 national patient survey and a practice survey of 51 patients showed that patients rated the practice highly in many areas. For example, 93% of respondents from the national patient survey said the last GP they saw or spoke with was good at giving them enough time, compared to 85% nationally and 86% locally. Results also showed that 92% of respondents said that GPs were good at listening to them, compared to the national average of 87% and the local average of 86%.

The practice survey results also showed that of those patients surveyed, all expressed positive comments in relation to their care and treatment received from the practice. For example, all respondents felt the GP explained things adequately and that they had received enough information about their treatment options. Patients also felt that the nurses listened well to their concerns.

Patients completed comment cards to provide us with feedback on the practice. We received 36 completed cards and they were all positive about the service experienced. Patients commented that the practice offered an excellent service, that all staff were helpful, caring and respectful. We also received four comment cards from other health care professionals who worked on a multi-disciplinary basis with the practice. Comments were very positive regarding the GPs, nurses and other staff and in relation to the proactive support and care that patients received from the practice.

We spoke with six patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Patients said that reception staff were welcoming, were respectful in their manner and showed a willingness to help and support them with their requests. Additionally, 99% of respondents from the national patient survey said that they found the receptionists at the practice helpful, compared to the local average of 88% and the national average of 87%.

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

The practice had a confidentiality policy, which detailed how staff protected patients' confidentiality and personal information. Staff we spoke with described how they followed the practice's confidentiality policy when discussing patients' details in order that confidential information was kept private. Staff were aware of their responsibilities in maintaining patient confidentiality and the policy had been shared with them. The waiting area was arranged to provide as much privacy as possible when patients were talking to staff at the reception desk and we observed that staff were careful in keeping conversations private when speaking on the telephone.

**Care planning and involvement in decisions about care and treatment**

The patient survey information we reviewed showed there had been a positive response from patients to questions about their involvement in planning and making decisions in relation to their care. For example, data from the national patient survey showed that 82% of respondents said that GPs were good at involving them in decisions about their care, compared to the national average of 75% and the local average of 74%. Similarly, 72% of respondents said that the nurses were good at involving them in these decisions, compared to 66% nationally, and the local average of 67%.

The results from the practice's own patient survey showed a positive response in relation to general questions about involvement in care and treatment and both GPs and nurses were rated well in this respect.

When we spoke with patients, they told us they felt involved in decision making and were given the time and information by the practice to make informed decisions about their care and treatment. They said GPs and nurses took the time to listen and explained all the treatment options and that they felt included in their consultations. They felt able to ask questions and never felt rushed. Patient feedback from the comment cards we received was also very positive and was consistent with these views.

Good

# Are services caring?

Staff told us that translation services were available for patients who did not have English as a first language and that this could be arranged for patients when required.

**Patient/carer support to cope emotionally with care and treatment**

The patient survey information we reviewed showed that patients were positive about the emotional support provided by the practice. For example, 90% of respondents to the national patient survey rated the GPs as good at treating them with care and concern, compared with the national average of 83% and the local average of 81%. The patients we spoke with and the comment cards we received were also consistent with this survey information.

We observed that staff were supportive in their manner and approach towards patients. Patients told us that staff gave them the help they needed and that they felt able to discuss any concerns or worries they had.

Patient information leaflets, posters and notices were displayed that provided contact details for specialist groups offering emotional and confidential support to patients and carers. For example, details about counselling sessions that were held at the practice by an external health care professional. The practice's patient records system alerted GPs if a patient was also a carer. There was a range of information available for carers to help ensure they understood the various avenues of support available to them. Staff told us that if a patient had suffered bereavement, the GP would contact them to arrange a consultation or to offer support, advice or information.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting people's needs**

The practice was responsive to patients' needs. The staff we spoke with explained that a range of services were available to support and meet the needs of different patient population groups and there were systems to identify patients' needs and refer them to other services and support if required. The practice had a larger population of patients in the over 65 age group than the national average and there were systems to address identified needs in the way services were delivered. For example, the practice had worked collaboratively with other local practices to implement a project for older patients, to help prevent and reduce unplanned hospital admissions and deliver care in patients' homes led and provided by the GPs and specialist community nursing teams.

The practice engaged with the area clinical commissioning group (CCG). A GP was the practice lead and attended regular meetings to review and discuss local pathways of care. The practice was therefore kept aware of service requirements and was able to plan and develop services that reflected the needs of the local patient population.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). The practice had agreed to review the information available for patients in the reception area, to include additional advice and support for younger patients, specifically relating to sexual health awareness and screening. For example, the availability of chlamydia testing had been displayed in the patient waiting area and on the practice website.

**Tackling inequity and promoting equality**

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with long-term or more complex needs, including patients with learning disabilities.

The practice was located in purpose-built premises that met the needs of patients with disabilities. Services were provided on the ground floor and accessible to all patients. The waiting area was large enough to accommodate patients with wheelchairs and prams and the reception desk had a lowered area to accommodate patients using wheelchairs. Accessible toilet facilities were available for all patients attending the practice and included baby changing facilities. There was a hearing loop system for patients who had hearing difficulties and interpretation services were available by arrangement for patients who did not speak English. There were car parking facilities with disabled parking areas close to the building.

The practice took account of the needs of different patients in promoting equality. Records confirmed that staff had received equality and diversity training and were able to demonstrate an awareness and understanding of the needs of different patient groups. The patient records system alerted staff to vulnerable patients, including those who required support from carers when attending appointments.

**Access to the service**

Appointments were available with either the GPs or nurses from 8.40am to 11.30am on Tuesday, Wednesday and Friday and until12 noon on Monday and Thursday. Afternoon appointments were available from 3.10pm to 5.30pm on Monday, Tuesday, Thursday and Friday and from 2.20pm to 5.20pm on Wednesdays. The practice operated extended opening hours until 7.30pm on Tuesday evenings, which provided flexibility for working patients outside of core working hours and school hours for children. Outside of these times, the 'out of hours' service was available, although practice staff were available from 8am until 6.30pm each week day to take telephone calls.

Patients could book an appointment by telephone, online or in person. Appointments were bookable for the same day and pre-bookable appointments were also available. Home visits were arranged for those who found it difficult to attend the practice, for example older patients who were housebound. The practice supported two local care homes for older people and the GP visited residents on a regular basis, and if required urgently. Longer appointments were available for patients who needed them, for example, if they had long-term conditions or complex health care needs. Patients we spoke with said that they could have telephone consultations and that the GPs were very good at calling them back if requested. GPs we spoke with

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

confirmed that same day telephone consultations were offered to patients and that they were available to take telephone calls before surgery started in the mornings and after surgery each day.

Patients were generally satisfied with the appointments system and those we spoke with all expressed confidence that urgent problems or medical emergencies would be dealt with promptly, that staff knew how to prioritise appointments for them and that they would be seen the same day. The staff we spoke with had a clear understanding of the triage system to prioritise how patients received treatment. For example, the practice had a system to identify and prioritise patients at risk of unplanned hospital admissions to help ensure they had urgent access to a GP appointment.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and rated the practice well in these areas. For example, 98% of respondents said they found it easy to get through to the practice on the telephone, compared to both the local and national averages of 72%. The results also showed that 91% of respondents were satisfied with the practice opening hours, compared to both the local and national averages of 76%.

Information was available to patients about appointment times on the practice website, in the patient information booklet and also in the practice reception area. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. Information about the 'out of hours' service was provided to patients in the practice reception area, in the patient information booklet and on the practice website and was displayed outside the practice. A telephone message informed patients how to access services if they telephoned the practice when it was closed. Patients we spoke with told us that they knew how to obtain urgent treatment when the practice was closed.

**Listening and learning from concerns and complaints**

The practice had a system for handling complaints and concerns. There was a complaints policy and a procedure that was in line with NHS guidance for GPs and there was a designated responsible person who handled all complaints in the practice.

Information was available to help patients understand the complaints system. The complaints procedure was included in the practice information booklet, on the practice website, and was displayed in the patient waiting / reception area. There were also questionnaires for patients to complete to provide comments and feedback to the practice. We looked at two complaints that had been received in the last year and found that these had been satisfactorily handled and dealt with in a timely way and in accordance with the practice policy.

The practice had produced a summary report of the complaints received for the previous year and identified where changes had been made as a result of some of the complaints received. For example, the procedure used by GPs for dictating letters and forwarding information had been reviewed following an error in the information sent to a patient. The complaints summary report had been discussed and reviewed at a practice meeting and shared with staff.

Patients we spoke with told us that they had never had cause to complain but knew there was information available about how and who to complain to, should they wish to do so.

# 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' and a business plan that set out the aims and objectives of the practice, to provide an excellent service and to encourage patients to become involved in decisions about their care. These objectives were used to inform individual learning objectives and when speaking with staff, it was clear that the leadership / management team promoted a collaborative and inclusive approach to achieve its purpose.

**Governance arrangements**

The practice had a clear leadership structure with named members of staff in lead roles. For example, there was a lead GP for safeguarding and a lead nurse for infection control. We spoke with staff who were clear about their own roles and responsibilities. They told us they felt valued, well supported and knew who to go to in the practice with any concerns or issues.

The practice had regular meetings, and these included discussions about significant events, medicines management, safeguarding concerns, as well as discussions in relation to updated clinical guidance that was shared with relevant staff. The GP and the practice manager also met regularly to review and discuss general governance of the practice, including business objectives, improving services and the business plan in taking the practice forward. For example, a succession plan had been developed for the retirement of the practice manager. All other staff, including administration staff, attended team meetings on a regular basis.

The GP and practice manager took an active leadership role in overseeing the systems and processes to monitor the quality and safety of the practice. This included collating information from the Quality and Outcomes Framework (QOF) and this was reviewed to enable the practice to monitor on-going performance. QOF data indicated that the practice was performing either in line or above national standards in most areas and where improvements were required, follow-up actions were agreed in practice meetings.

The practice had undertaken clinical audits to monitor quality and to identify where action should be taken to improve outcomes for patients. For example, audits to review medicine prescribing, dementia diagnosis and monitoring asthma care. Repeat audits had been completed to monitor on-going outcomes for patients and were planned for those audits recently undertaken.

The practice had a number of policies and procedures to govern activity and these were available on the computer and in hard copy files for staff guidance and reference. We looked at nine of these and saw that they had been reviewed annually and were up to date.

The practice had arrangements for identifying, recording and managing risks in relation to the premises and its staff. Routine checks were undertaken and any risks were identified and recorded. Risk assessments had been undertaken, for example, a fire risk assessment. The practice had also undertaken an overall premises risk audit, which included processes / procedures in relation to patient safety, and general management of the practice.

**Leadership, openness and transparency**

We spoke with the practice GP who told us they advocated and encouraged an open and transparent approach in managing the practice and leading the staff team. Staff we spoke with told us they felt there was an 'open door' culture, the GPs were approachable, they felt supported and were able to approach the senior staff about any concerns they had. They said there was a good sense of team work within the practice and communication worked well.

All staff said they felt their views and opinions were valued. They told us they were positively encouraged to speak openly to all staff members about issues or ways that they could improve the services provided to patients and in the running of the practice. Minutes from practice meetings showed that staff participated and contributed their views.

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

The practice had gathered feedback from patients through patient surveys, as well as comments and complaints received by the practice. It had an active patient participation group (PPG), which included members from various population groups, including younger adults, working age patients as well as older patients. The practice had undertaken its own patient survey and had reviewed the results and developed an action plan in conjunction

# Are services well-led?

Good

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

with the PPG, to consider any areas of improvement that could be made. This included some changes in the patient waiting area, for example, additional information displayed for younger patients and parents of children at school, as well as the purchase of new chairs.

We spoke with a representative from the PPG, who told us that they aimed to increase their membership to include a wider representation from all patient population groups. The PPG met on a six monthly basis and the GP and practice manager attended. They felt the practice supported the work of the PPG and was proactive in listening and seeking patient's views, comments and suggestions and taking action wherever possible to improve the service.

We also saw evidence that the practice had reviewed the results from the national patient survey to see if there were any areas that needed addressing. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. A staff survey had also been carried out and questionnaires used to seek the views of staff. Feedback from the survey had been very positive about the practice and how it was managed. Staff we spoke with told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. They said they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff in the policy folder and on the practice computer. Staff told us they were aware of the policy and knew where to find it if needed.

**Management lead through learning and improvement**

The practice GP and nursing staff accessed on-going learning to improve their clinical skills and competencies. For example, attending specialist training for diabetes, childhood immunisation and opportunities to attend external forums and events to help ensure their continued professional development. Staff said they had protected learning time set aside for learning and development, for example, monthly half-day closure of the practice to undertake training and development. We saw that formal appraisals were undertaken to monitor and review performance, and to identify training requirements and learning objectives. For example, a training plan had been developed for a member of staff to support them in undertaking management courses and qualifications, to develop into the role of practice manager.

The practice had completed reviews of significant events and other incidents and shared them with staff at meetings. This helped to ensure learning was achieved and improved outcomes for patients who used the services.