Dr. Rao & Partners

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected Dr Rao and Partners (Belgrave Medical Centre) on 21 November 2014 as part of our new comprehensive inspection programme.

We looked at the how well the practice provided care for specific groups of patients. These included older people, people with long term conditions, families children and young people, people of working age (including those recently retired and students, patients living in vulnerable circumstances and people experiencing poor mental health (including dementia).

Our method of inspection focuses on the care patients receive under five domains of Safe, Effective, Caring, Responsive and Well led. The rating in all domains and overall rating for this service is good.

Our key finding were as follows:

- Patients were highly positive about telephone access to the practice and the availability of both urgent and routine GP appointments.
- The practice had robust, effective systems in place to protect the safety of patients and to learn by reflection.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- There was a clear culture of openness. Staff used every opportunity to learn from internal and external incidents which improved patient outcomes.
- The practice took opportunities to secure locally available funding to provide extra services for their patients. This gave patients access to a greater range of services at the practice.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for safe. Staff understood and fulfilled their responsibilities to raise concerns, and 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 effective. Data showed patient outcomes were at or above average for the locality. National Institute for Clinical Excellence (NICE) guidance was referenced and used routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff had received training appropriate to their roles and further training needs had been identified and planned. The practice could identify all appraisals and the personal development plans for all staff. We saw evidence of multidisciplinary working.

Are services caring?

Good

The practice is rated as good for caring. Data showed 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 care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice, a named GP and continuity of care. Urgent appointments were available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence the practice responded quickly to issues raised. We saw examples of shared learning from complaints with staff and other stakeholders.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) and social media 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 the practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example in dementia and end of life care. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs. Annual health assessments were offered to all patients aged over 75, including those with no pre-existing medical conditions.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. The practice employed a pharmacist with additional specialist training. The pharmacist reviewed patients with long term conditions, such as diabetes and those who took anti-coagulation (blood thinning) medication. We saw that patients with long term conditions had received thorough structured medication reviews at regular intervals. Audit of HbA1c blood tests (which indicated patients' longer term diabetic blood sugar control), had showed improved results since introduction of the pharmacist. The improvement was the reduction in this blood marker, which may help reduce the complications associated with diabetes. The practice's own patient survey reported that all patients felt the pharmacist involved them in decisions about their care. Patients with other long-term conditions had also been reviewed by either a GP or nurse as appropriate.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. For example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us and we saw evidence that showed children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We were

provided with good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group 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 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 which reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice held a registers of patients living in vulnerable circumstances including asylum seekers and those with learning disabilities. The practice had carried out annual health checks for patients with learning disabilities and 90% of these patients had received a follow-up. The practice offered longer appointments for patients with learning disabilities.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector 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 and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). 81% of patients experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health including those with dementia. The practice had in place advance care planning for patients with dementia.

The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations

Summary of findings

including Healthy Minds. The practice had a system in place to follow up on patients who had attended accident and emergency where there may have been mental health needs. Staff had signed up to receive additional training on how to promote care for people with dementia.	

Summary of findings

What people who use the service say

We spoke with five patients during our inspection. They all described practice staff as caring, helpful and approachable. Patients also told us they were treated with dignity, compassion and involved in decisions about their care and treatment.

We collected 48 comment cards from a box left in the practice waiting room for two weeks before our visit. The overwhelmingly majority of the comments recorded were highly positive about the experience of being a patient or carer of a patient registered at the practice.

We reviewed the results of the practice's own most recent survey undertaken in June 2014. A total of 225 responses were returned. The results of the survey were highly positive. 95% of patients reported that clinical staff treated them with care and concern.

Data from the latest GP national survey published in July 2014 showed 94% of patient's surveyed would recommend the practice. Also 97% of patients had trust in the last GP they saw or spoke to.

Dr. Rao & Partners

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector. The team included a Specialist GP Advisor and a Specialist Practice Nurse Advisor.

Background to Dr. Rao & Partners

Dr Rao and Partners, also known as Belgrave Medical Centre, provides primary medical services to just over 11,200 patients from purpose built premises at 116 Belgrave Road, Dresden, Stoke on Trent.

The practice has five GPs (whole time equivalent 4.8). Three are partners and two are salaried doctors. Three of the GPs are female and two male. The practice also employs a pharmacist, nurse practitioner, two practice nurses, two part time physiotherapists and a health care assistant. The practice manager oversees the day to day running of the practice and is assisted by a support manager, assistant practice manager and team of 13 administrative and reception staff.

The practice had opted out of providing out-of-hours services to their patients. These services were provided by another organisation.

Why we carried out this inspection

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

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations such as the local Clinical Commissioning Group and NHS England to share what they knew. We carried out an announced visit on 21 November 2014. During our visit we spoke with a range of staff and spoke with patients who used the service. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

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

Detailed findings

- The working-age population and those recently retired (including students)
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Good

Are services safe?

Our findings

Safe track record

The practice was able to demonstrate that it used a range of information to identify risk and improve patient safety. The staff we spoke to were clear about their responsibilities for raising concerns. We saw an example of when a request for a repeat x-ray was not followed up in a timely way. The GP who discovered this recorded it as a significant event, which led to an investigation, discussion and a change in the procedures of actioning requests. The practice manager showed us the pathway in which alerts from outside partners, serious events and comments/ complaints from patients were managed. The practice had changed from a paper based tracking system to computerised system during the previous 16 months. The examples we saw showed the practice had evidence of a safe track record over time.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. There were computerised records of events that had occurred over the last year and we were able to review these. Significant events were discussed on a weekly basis as an agenda item at the clinical meeting. These events were discussed and action plans set. We saw that significant events were revisited to minimise further risk. There was evidence that the practice had learned following such events and that findings were shared with staff. We saw the practice held three staff meetings each week. The practice manager told us this was to make sure as many staff as possible could attend, without affecting operation of the practice.

Staff including GPs, pharmacist, practice nurses, receptionist and administrators demonstrated the system for reporting incidents and near misses. The practice manager showed us their system for monitoring and managing incidents. We tracked five incidents and saw records were completed and processed in a prompt way. We saw the practice had taken action taken as a result of a patient expressing concern at the method their request for prescription medication was handled, whilst the patient was away on holiday. The practice investigated the concerns and changed its policy for dealing with prescription requests when patient's medication had run out. Where patients had been affected by something that had gone wrong, we saw examples of them being given an apology and the actions taken were shared.

National patient safety alerts were disseminated to staff at the weekly meetings and displayed on staff notice boards. Staff we spoke with told us that they received information about alerts at the weekly staff meeting or could view them on staff notice boards.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. We saw that contact details for local safeguarding teams were easily accessible.

The practice had appointed a dedicated GP and nurse as leads in safeguarding vulnerable adults and children. Both safeguarding lead staff had received safeguarding training to level three. We reviewed the training of all staff and saw they had training appropriate to their role. All staff we spoke to were aware of who the nominated safeguarding leads were and how to raise a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments. For example children classified by social services as at risk.

Child protection issues were discussed at the weekly clinical meeting when required.

The practice had a chaperone policy. A chaperone is an impartial observer usually a health professional to safeguard the interaction between both patient and clinician during consultations. The policy and signage stating the availability of chaperones was visible on the waiting room notice board, consulting rooms and detailed on the practice website. All nursing staff had been trained

to be a chaperone. If nursing staff were not available to act as a chaperone, 10 receptionists had also undertaken training and understood their responsibilities. This included where to stand to be able to observe the examination.

The practice had a policy for following up patients who did not attend appointments. This policy made reference to the non-attendance of vulnerable patients and detailed the actions to take if a vulnerable patient did not attend an appointment. We saw examples of when patients who did not attend appointments had been followed up. One example was when a child did not attend an appointment to receive immunisations. The practice manager was unable to contact the child's parents so visited the home address to ensure there were no issues or concerns in relation to non-attendance of the appointment.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found that they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept within the required temperatures which described the action to take in the event of a potential failure. The practice staff followed the policy. We saw records to confirm staff members undertook daily checks of the 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 these directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines. The practice pharmacist and one member of nursing staff were qualified as independent prescribers. Both these members of staff confirmed that they received regular supervision and support in their prescribing roles. The practice nurse and pharmacist also confirmed that they had received further training to enable them to prescribe in clinical situations.

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

Cleanliness and infection control

We observed the premises to be clean and tidy. We reviewed cleaning schedules and records detailing the frequency and areas of cleaning undertaken. The practice manager showed us minutes of monthly audits undertaken which highlighted any areas that needed improvement. We saw that practice staff fed back daily to the cleaning staff in a communication book. All of the patients we spoke to said they always found the practice to be clean and tidy and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff had received induction training about infection control specific to their role and received annual updates. We saw evidence the lead had carried out audits for the last year and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

The practice had a number of policies to promote cleanliness and control infection. These included infection control and specimen handling. There were procedure documents and flowcharts to support these policies to enable staff to plan and implement measures to control infection. For example we saw that clinical waste was separated from domestic waste. Staff were able to describe items that would be classified as clinical waste and how to dispose of them in a correct manner. There was a policy and procedure in case a member of staff suffered a needle stick injury.

The practice had hand gel dispensers and hand decontamination notices at regular points throughout the premises. All treatment rooms had hand washing sinks with soap dispensers, paper towels and hand gel dispensers available.

There was a good supply of personal protective equipment in the form of disposable gloves, aprons, eye protection and covers in clinical areas for staff to use to minimise the risk of the spread of infection.

Good

Are services safe?

The practice had a policy for the management, testing and investigation of legionella (a germ in the environment which can contaminate water systems in buildings). We saw records that confirmed the contractor employed by the practice to carry out regular checks in line with this policy had not carried out regular water testing checks as required. The practice manager told us she had identified this and showed us the steps she had taken to assess the risk to staff and patients. We saw the written communications from the practice manager with the contractor to ensure they fulfilled their requirements to test the water supply. The steps taken were reasonable. The practice manager told us she would continue to monitor the performance of the contractor to ensure water testing was carried out at the required intervals.

Equipment

Staff we spoke with told us they had suitable equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the date of last test. We saw evidence of calibration of clinical equipment. One example was a non-invasive blood pressure machine (an automated machine to take a blood pressure reading).

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to a staff member commencing employment. For example proof of identification, references, qualifications, professional registrations with the appropriate body and criminal records checks through the Disclosure and Barring Service (DBS).

The practice manager told us about arrangements for planning and monitoring the number and skill mix of staff needed to meet patients' needs. We saw that the practice had identified peak times of demand and had a rota system in place to ensure enough staff were on duty. Some practice staff were trained to perform additional job roles. For example, the practice administrative staff could handle telephone calls from patients and perform reception duties. The practice manager told us that this helped to maintain the day to day staffing requirements and provided additional support in times of high demand on services. Administrative staff also covered reception duties to enable receptionists to attend staff meetings. There was an arrangement in place for members of staff including nursing and administrative staff to cover each other's annual leave.

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

Monitoring safety and responding to risk

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

Identified risks were included on a risk log. This was displayed on the staff noticeboard. Each risk was assessed and rated with mitigating actions recorded to reduce and manage risk. We saw any risks were discussed at the weekly clinical and practice meetings. For example, the practice manager had reinforced the importance to GPs of following up on patient queries by checking the communication book on a daily basis.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed all staff had received training in basic life support. Emergency equipment was available at a secure central point. Equipment included oxygen therapy and nebulisation (to assist someone with difficulty in breathing) and an automated external defibrillator (which provides an electric shock to stabilise a life threatening heart rhythm). There was also a pulse oximeter (to measure the level of oxygen in a patients' bloodstream All the staff knew the location of this equipment and records confirmed it was checked regularly.

All of the staff we spoke to could describe the action to take if a patient presented with an urgent health need to ensure prompt treatment would commence if required.

Emergency medicines were available in a lockable carry box within a secure central area of the practice. These were comprehensive and could be used to treat a wide range of medical emergencies. Examples were medicines for

Good

Are services safe?

anaphylaxis (allergic reaction), convulsions (when a patient suffers a seizure/fit) and hypoglycaemia (a very low blood sugar levels). We saw some emergency medicines were contained in preloaded syringes and in smaller doses for children. This would reduce the time taken to draw up and administer the medication in an emergency. Processes were also in place 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 a business continuity plan in plan to deal with unplanned events that may occur and would hinder operation of the practice. Each risk had been rated and mitigating actions recorded to reduce and manage the risk. The plan included details of alternative accommodation to operate the practice from in the event of a major issue with the existing premises. The document also contained details of who to contact in the event of specific issues, for example contact details for computer system failure.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff had received training in fire safety and fire drills were practised.

The practice manager told us about the arrangements at the practice for changes in staffing. Staff had received training and supervision to perform different job roles. For example the administrative staff who dealt with backroom functions could also work on reception and answer telephone calls to deal with patient enquiries. The practice had the capability to facilitate 10 phone calls being received or made at one time. She told us this was to ensure the practice was resilient in times of high patient activity, also to facilitate unplanned changes in staff due to sickness or other problems.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs, pharmacist and nursing staff we spoke with could clearly outline their approaches to treatment. All were familiar with the current best practice guidance and accessed guidelines from the National Institute for Clinical Effectiveness (NICE) and local commissioners. We saw that the clinical staff met on a weekly basis. New guidelines were discussed with the implications for patients and performance considered and actions agreed. Clinical staff had undertaken development training to equip them with greater knowledge in relation to certain health conditions. For example the practice pharmacist had completed additional training in both independent prescribing and diabetic care. This ensured that patients had access to the most relevant medicines for their condition. One practice nurses had also completed an approved independent prescribing course to enable her to prescribe medicines independently to patients when indicated. We found from our discussions with the clinical staff that they completed thorough assessments in line with NICE guidelines and reviewed them when appropriate.

Staff told us they had leads in specific clinical areas, for example the practice pharmacist was the lead professional for diabetic care. The pharmacist told us this meant she would pay particular focus to published literature and guidelines in that area. Our review of the clinical meeting minutes confirmed such changes to best practice were discussed regularly.

We reviewed nationally published data on the practice's performance in a number of clinical areas. The Quality and Outcomes Framework (QOF) is a national performance measurement tool. Data from QOF showed that the practice performed on a comparable basis with similar practices and had met all QOF standards.

Data for referral to secondary and community case services was in line with national averages. All GPs we spoke with used national standards for referral of patients with suspected cancers to be seen in a secondary care setting within two weeks. All patient referrals from the practice to secondary care were discussed at the weekly clinical meeting. The senior GP told us this was to ensure the referral was peer reviewed by other GPs and helped to ensure the referral was appropriate. He also commented this had encouraged discussion on any alternative pathways that were available.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that there was a positive culture in the practice and that patients were referred on a need basis with age, sex and race not taken into account in decision making.

Management, monitoring and improving outcomes for people

The practice had well established links with a local university and was designated as a research practice. This meant clinicians and research students had worked together in a joined up approach to look at patient outcomes.

The practice showed us 14 clinical audits that had been undertaken in the last two years. All of these were completed audits where the practice was able to demonstrate the changes resulted since the initial audit. One example was an audit into the outcome for patients referred to specialist doctors in orthopaedics. Orthopaedics is the area of medicine concerned with bones, muscles and supporting structures of the body. The audit results showed the majority of patients had been discharged from the orthopaedic specialists with only advice or referral to physiotherapists. Following this audit changes were made to practice by GPs receiving refreshment on referral guidelines. The practice also secured additional funding from the local health economy for the employment of two part time physiotherapists. The senior GP told us this had reduced the number of patients being referred to specialist doctors and had also reduced the time patients waited to access treatment. The waiting times for appointments for physiotherapists at the practice, were lower than hospital doctor waiting times, so patients had received quicker assessment.

We saw GPs who undertook minor surgical procedures were doing so in line with their registration and NICE guidance.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the QOF tool. For example, we saw an audit of outcomes for diabetic patients who had displayed higher term high blood sugar levels. The practice

had introduced a procedure of flagging these patients on their computer system. These patients were recalled at regular intervals to see the practice pharmacist, who reviewed their medication and offered advice on how to best manage their condition. We saw records showing services to patients had been evaluated and the success of changes was documented.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example 84% of patients diagnosed with dementia had been reviewed in person in the last year. We saw that the practice had met or exceeded all the minimum standards for QOF.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they could enhance on the outcomes being achieved also reflected on areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

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

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and held multidisciplinary meetings every six weeks to discuss the care and support needs of patients and their families.

The practice also participated in local benchmarking run by the local Clinical Commissioning Group (CCG). CCGs are responsible for deciding on and commissioning NHS services in the area they operate. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area

Effective staffing

Practice staffing included medical, a pharmacist, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. A practice nurse told us the practice had funded an independent prescribing course. The nurse also told us the senior GP had acted as a mentor for her throughout the period of learning.

The practice was a teaching practice for medical students who were training to become qualified doctors. Students in years one and five of doctor training were placed with clinical staff and always had access to a senior GP for support. We spoke to a medical student who confirmed that they had been well supported and encouraged whilst at the practice.

The practice had employed a pharmacist to enhance the care provided to patients. The pharmacist had undertaken additional training in independent prescribing, diabetes care and management of anticoagulation (blood thinning) therapy. We spoke to the pharmacist and she demonstrated a solid understanding of the areas she specialised in. The practice manager told us the practice had been visited by several other practices interested in the use of a pharmacist in reviewing patients on complex medications or with long term health conditions.

One practice nurse was an independent prescriber which enabled her to independently prescribe medicines

Good

Are services effective?

(for example, treatment is effective)

within her competence and administer vaccines as appropriate. A health care assistant had received additional training to take venous blood samples and administer vaccines. This ensured there was a good skill mix available across the levels of clinical staff and demonstrated staff had received appropriate training to fulfil their roles.

Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. Blood test results, x-ray results, and letters were processed from the local hospital, out-of-hours providers and the 111 service. These were received both electronically on a computerised system called Docman and by post. The practice had a policy outlining the responsibilities of all relevant staff in reading, passing on and acting on any issues that arose from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for organising the required action. All staff we spoke with understood their roles. There had been three instances of requests to repeat a test not being carried out correctly or results not being actioned in the last year. The practice had recorded these occurrences as significant events and had changed the policy in way it handles results, requests and letters as a result. There had been no further instances of tests which not been carried out since the policy had changed.

The practice was commissioned for an enhanced service which required processes in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect. The practice undertook a yearly audit of follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed.

The practice held multidisciplinary team meetings every six weeks to discuss the needs of complex patients, for example those with end of life care needs. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made all referrals possible last year through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. One GP showed us how straightforward this task was using the electronic patient record system, and highlighted the importance of this communication with A&E. The practice had also signed up to the electronic Summary Care Record and this was fully operational. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record called EMIS Web to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. Staff demonstrated that they knew how to operate this system and highlighted safety features such as warnings to patients' allergies for example. Software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

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

Good

Are services effective?

(for example, treatment is effective)

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. The records we reviewed highlighted that 84% of patients on the register had been reviewed in the last year. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

The practice placed an alert on the computer system to record patients' who had made an advanced directive. An advanced directive is a decision by a patient on the treatment they choose or refuse to receive in the future. This alerted the team member reviewing the record to the patient's decision and consent.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. We were shown an audit that confirmed the consent process for minor surgery had being followed in all cases.

The practice manager told us all patients who have a diagnosis of dementia were recorded on an admissions avoidance register. The needs of these patients were discussed at regular multidisciplinary team meetings to ensure their current health needs were being met.

Health promotion and prevention

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

The practice also offered NHS Health Checks to all its patients aged 40-75. Practice data showed that 51% of the patients in this age group took up the offer of the health check. The practice had invited 90% of eligible patients for a health check. These rates were significantly higher than the local and national average. A GP told us patients were followed up if they had risk factors for disease identified at the health check and how they scheduled further investigations.

Practice staff told us 95% of patients aged 45 and over had a recorded blood pressure reading taken within the last 12 months and saw this as a way of spotting and tackling potential medical problems associated with high blood pressure.

The practice invited any patient aged 75 or over to attend an annual health check as a proactive way of identifying emerging health problems. Practice staff told us this was an opportunistic way of screening for emerging health problems.

Practice staff offered weekly circular walks for patients. The practice manager told us this was a way of encouraging patients to engage in physical activity and offered a platform for patients to ask for advice regarding their health.

The practice displayed posters and leaflets on a wide range of health promotion issues in the waiting room.

The practice had numerous ways of identifying patients who needed additional support, and were proactive in offering additional help. For example, the practice kept a register of all patients with learning disabilities and 27 out of 30 were offered an annual physical health check. Practice records showed 90% had received a check up in the last 12 months.

A counsellor attended the practice on a weekly basis to offer support to patients experiencing poor mental health.

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

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the latest national patient survey published in July 2014, a survey of 225 patients undertaken by the practice's Patient Participation Group and patient satisfaction questionnaires undertaken by each of the practice's partners. The evidence from all these sources showed patients were highly satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients rating the practice as good or very good. The practice was also well above average for its satisfaction scores on consultations with doctors and nurses with 96% of practice respondents saying the GP was good at listening to them and 97% saying the GP gave them enough time.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 48 completed cards and the overwhelming majority were very positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Two comments were less positive but there were no common themes to those. We also spoke with five 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.

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

We observed that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice switchboard was located away from the reception desk in another office which helped keep patient information private. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff. We were shown an example of a report on a recent incident that showed the actions taken had been robust. There was also evidence of learning taking place as staff meeting minutes showed this has been discussed.

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

All reception staff at the practice had undertaken customer services training to assist in providing a positive experience for patients, carers and relatives attending for appointments.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice highly in these areas. For example, data from the national patient survey showed 78% of practice respondents said the GP involved them in care decisions and 89% felt the GP was good at explaining treatment and results. Both these results were above the local and national average. The results from the practice's own satisfaction survey showed that 95% of patients said they were sufficiently involved in making decisions about their care.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during

consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also very positive and aligned with these views.

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

We saw examples of when people had been supported in making decisions about the care they receive in the future, in the form of advanced directives. An advanced directive is a decision made by a person detailing the level of care they wish to receive or not receive in the event of their health deteriorating. Staff logged these decisions on the practice computer system. The information appeared as an alert, to inform the GP or nurse viewing the record that the patient had an advanced directive in place.

Patient/carer support to cope emotionally with care and treatment

All of the survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 95% of respondents to the patient participant group survey said they felt the healthcare professional who treated them, did so with care and concern. The patients we spoke to on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, on the TV screen and patient website also signposted patients to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us families who had suffered bereavement were discussed at the weekly clinical meeting. A GP told us based on the individual circumstances a GP would call the families if appropriate. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or signposting to a support service. Patients we spoke to who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The NHS Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements which needed to be prioritised. The senior GP at the practice also held the role of chairperson on the executive board at the CCG. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. The practice had agreed to extend opening times on a Saturday to provide a GP led walk in service. This was part of a local seasonal measure to reduce unnecessary patient attendance at the Accident and Emergency department of the local hospital.

There had been very little turnover of staff during the last three years which enabled good continuity of care and accessibility to appointments with a GP of choice. Longer appointments were available for people who needed them and for those with long term conditions. This also included appointments with a named GP or nurse. We reviewed data from the national patient survey which revealed that 87% of patients expressed, they normally get access to their preferred GP. This was higher than both the local and national average.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG). An example of this was the practice increasing the number of receptionists available to receive telephone calls. This followed comments from the PPG on time periods when patients had expressed difficulty in making telephone calls to the practice.

The practice had achieved and implemented the gold standards framework for end of life care. They had a palliative care register and held weekly internal meetings as well as multidisciplinary meetings every six weeks to discuss patient and their families care and support needs.

Tackle inequality and promote equality

The practice had recognised the needs of different groups in the planning of its services. For example leaflets containing helpline numbers and information on domestic abuse had been placed in a private area by the toilets. The practice manager told us this was to enable patients to select them without the fear of being overseen if collecting one.

The practice displayed posters advertising access to telephone translation services if required.

The premises and services had been adapted to meet the needs of patients with disabilities. The external door automatically opened, access was all at one level with wide doorways to enable wheelchair access and the receptionist desk had a lowered section to enable a wheelchair user to see the person they were talking to directly. There was an automated booking in system which had been placed at a height that was accessible to a person who used a wheelchair,

Access to the service

Appointments were available from 7:30am to 6:30pm Monday to Friday. The practice offered extended availability of appointments until 7:30pm on a Tuesday and 9am to 12pm on a Saturday. As part of a local initiative to reduce A&E attendances, the practice was providing a GP led walk in service each Saturday from 8:30am to 5pm until 14th February 2015.

We looked at the availability of appointments and saw that all GPs at the practice had appointments available within two working days. The practice had same day appointments available for patients in urgent need.

Appointments were booked by telephone, in person or online. The practice also offered bookable telephone appointments to enable consultation by telephone.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice.

We looked at information from the national GP survey. Results showed 92% of patients stated they found it easy to contact the practice and 87% of patients with a preferred GP stated they normally get to see that GP. These results were well above the local average.

Three of the patients we spoke with commented that they been able to get a same day appointment that day. These comments were reinforced by the comment cards we received.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. The practice displayed posters and documentation detailing the complaints procedure. The practice website had a section explaining how to make a complaint and the assurance that making a complaint would be non-discriminatory. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

We looked at twenty six complaints received in the last twelve months. The practice had followed its policies and procedure in handling complaints and had dealt them in a timely way. None of the previous years complaints had been referred to the Parliamentary and Health Service Ombudsman (PHSO). The PHSO is an independent government service, to investigate complaints that have not been resolved at a local level.

The practice discussed complaints at weekly clinical and staff meetings. We saw evidence of complaints being discussed, learning shared and if appropriate issues recorded as serious events. Practice staff told us about the open approach to complaints they have. We saw an example of a negative comment concerning the practice on a social media site page. The practice had responded to the comment inviting further discussion with the individual and had not removed the comment from the site.

The practice reviewed complaints on an annual basis to detect themes or trends. We looked at the report for the last review and no themes had been identified, however lessons learnt from individual complaints had been acted upon

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's business plan. These values were clearly displayed in the waiting areas and in the staff room. The practice mission statement was "working together as a team to provide quality healthcare services for the health improvement and continuing welfare of patients registered with the practice".

All of the practice staff we spoke to knew the essence of the mission statement and their role in relation to it.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at eight of these policies and procedures and most staff had completed a cover sheet to confirm they had read the policy and when. All eight policies and procedures we looked at had been reviewed annually and were up to date.

The practice held three meetings each week and governance was discussed at each. We looked at minutes from the last ten meetings and found that performance, quality and risks had been discussed.

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

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us their risk log which addressed a wide range of potential issues, such as loss of the entire computer system. We saw that the risk log was regularly discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example, the practice had arrangements with neighbouring GP practices to provide telephone cover if the event of a loss of the telephone system.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example there was a lead nurse for safeguarding and the senior partner was the lead for minor surgery audit. We spoke with 11 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

We saw from minutes that clinical meetings were held weekly. Administrative staff meetings were held twice a week. The practice manager told us holding two meetings helped all staff to attend at least one meeting, without impacting on the operation of the practice. Staff told us there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example the staffing policy. This policy was in place to support staff, by ensuring the correct number and skill mix of staff was available to provide an appropriate level of service.

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

The practice had gathered feedback from patients through patient surveys, comments cards and on a public page of a social media website. We looked at the results of the practice's own patient survey and noted the satisfaction scores of patients were high. 84% of patients had rated the ease of getting through on the telephone as at least good. The practice had acted on feedback made on telephone access, by ensuring that more receptionists were available at times stated to be most difficult to get through.

The practice had an active patient participation group (PPG). The PPG was underrepresented in the under 50 age range and in terms of ethnic minority groups. The practice manager told us they had taken action to ensure that the PPG represented the age and ethnic demographic of patients registered at the practice. An example of this was establishing a social media PPG group which had increased the under 50 age demographic due to more patients of that age using social media. The PPG met every month, a common theme at each meeting was to meet a different member of practice staff and for them to explain their job role.

Are services well-led?

Good

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

The practice had performed yearly in house patient surveys. The surveys' looked at aspects of patient care on an individual clinician basis. The results showed that all clinicians scored high feedback scores from patients. Results of the survey were shared with the clinician at the time of appraisal. This gave the clinician the opportunity to reflect on the results and their performance. We saw this had led to improved satisfaction scores on previous years for some clinicians.

The practice held one clinical and two administrative staff meetings each week. The minutes taken at these meetings demonstrated that information sharing was a two way process between the staff and management. The staff notice boards displayed information on patient satisfaction and practice performance. There was a staff feedback box in a private area of the practice. This was to enable staff to make suggestions in which the practice could improve their services or performance. Staff confirmed they could leave feedback in the suggestion box for discussion.

An example of acting on staff feedback was to invite all patients aged over 75 to a yearly health check. This was a staff member's suggestion as they felt it would be a way of spotting emerging health problems. This was implemented and was seen as a way to improve the care offered to older patients.

We found the practice leadership sought opportunities to extend services for patients. An example of this was the securement of additional funding to provide rapid access to physiotherapists at the practice. Another example was the seasonal provision of a GP led walk in appointment service designed to ease the pressure on local accident and emergency services.

The practice had a whistle blowing policy which was available to all staff on the staff notice board and electronically on any computer within the practice.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at six staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and they had staff away days where guest speakers and trainers attended.

The practice was a training practice supporting doctors in years one and five of their training to become qualified doctors. The practice was also a research practice, which worked in conjunction with a local university looking at clinical outcomes. In the previous year there had been fourteen audits undertaken. All of these audits were analysed, discussed and led to change.

The practice had completed reviews of all significant events and other incidents and shared these with staff via meetings and to ensure the practice improved outcomes for patients.