Drs Cloak, Choi and Milligan

Quality Report

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

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Summary of findings

Overall summary

The information we reviewed showed the practice has a good track record for maintaining patient safety. The GPs looked at how they could continually improve the service and learn lessons from any incidents that had occurred.

The patients we spoke with as well as those who who completed the CQC comment cards were complimentary about the care and treatment being provided. We heard how the practice had responded to patients views and reviewed the appointment system. We saw that there were a wide range of ways to make appointments from in person to on line and advance appointments were available.

Staff were responsive to patients' needs and has tried to encourage them to share their views and suggestions. The practice ran a virtual patient participation group, which had 102 members and also completed annual surveys of all their patients.

The building is well-maintained and very clean. Effective systems were in place for the oversight and management of medication. Clinical decisions followed best practice recommendations.

We found that the leadership team were very visible. Governance and risk management measures are in place.

The practice safely and effectively provided services for all patient groups. The staff were caring and ensured all treatments being provided followed best practice guidance.

We found that the practice had met the regulations and provided services that were safe, caring, responsive, well-led and effective.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The service was safe. Information from NHS England and the Clinical Commissioning Group (CCG) indicated that the practice had a good track record for maintaining patient safety. Effective systems were in place to oversee the safety of the building and patients. Staff took action to learn from any incidents that occurred within the practice. Staff took action to safeguard patients and when appropriate made safeguarding and child protection referrals.

Are services effective?

The service was effective. There were systems in place which supported GPs and other clinical staff to improve clinical outcomes for patients. Care and treatment was being delivered in line with current published best practice. Patients' needs were consistently met. Consent to treatment was obtained appropriately.

Are services caring?

The service was caring. The two patients who completed CQC comment cards and 14 patients we spoke with during our inspection were complimentary about the reception staff and clinicians. They all found the staff treated them with respect and listened to their views. Staff we spoke with were aware of the importance of providing patients with privacy. Carers or an advocate were involved in helping patients who required support with making decisions.

Are services responsive to people's needs?

The service was accessible and responsive to patients' needs. The practice made adjustments to meet the needs of patients, including having access to interpreter services. The practice responded appropriately to complaints about the service. Regular patient surveys were conducted and the practice took action to make suggested improvements.

Are services well-led?

The service was well led and effectively responded to changes. Governance and risk management structures were in place. The practice had a clear set of values which were understood by staff and recorded on the practice website. The team used their clinical audit tools, clinical supervision and staff meetings to assess the quality of service being provided and how to make improvements.

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
The practice was knowledgeable about the number older people they had and their related health needs. The practice actively reviewed the care and treatment needs of older people and ensured each person who was over the age of 75 had a named GP. Medication reviews were completed with all patients over the age of 75. Up to date registers were kept of patients' health conditions, carers' information and whether patients were housebound. They staff used this information to provide services in the most appropriate way and in a timely manner.

People with long-term conditions
Staff had a good understanding of the care and treatment needs of people with long-term conditions. The practice closely monitored the needs of this patient group. We heard from patients that staff invited them for routine checks and reviews. We found staff had a programme in place to make sure no patient missed their regular reviews for conditions, such as diabetes, respiratory and cardiovascular problems. Staff taff regularly updated their skills and training iin their specialist areas which helped them ensure best practice guidance was always being followed.

Mothers, babies, children and young people
The practice provided services to meet the needs of this patient group. There were comprehensive screening and vaccination programmes which were managed effectively. The practice monitored any non-attendance of babies and children at vaccination clinics and worked with the health visiting service to follow up any concerns. All of the staff we spoke with were responsive to parents' concerns about their children and ensured parents could readily bring children who appeared unwell into the practice to be seen. Staff were knowledgeable about child protection and a GP took the lead for safeguarding.

The working-age population and those recently retired
The practice provided a range of services for patients to consult with GPs and nurses, including on-line booking and telephone consultations. The practice had developed a solid information base which covered the needs of their entire patient group. Staff had a programme in place to make sure no patient missed their regular reviews for their condition such as diabetes, respiratory and cardiovascular problems. Appointments were available prior to 9am and after 5pm.

Summary of findings

People in vulnerable circumstances who may have poor access to primary care

The practice was aware of patients in vulnerable circumstances and actively ensured these patients received regular reviews, including annual health checks. We found that all of the staff had a good understanding of what services were active within their catchment area such as supported living services, care homes and families with carer responsibilities. Staff were knowledgeable and proactive when safeguarding vulnerable adults. They had access to the practice's policy and procedures and had received safeguarding training in the last 12 months.

People experiencing poor mental health

The practice maintained a register of patients who experienced mental health problems. The register supported clinical staff to offer patients an annual appointment for a health check and a medication review. Clinicians routinely and appropriately referred patients to counselling and talking therapy services, as well as psychiatric provision.

Summary of findings

What people who use the service say

We received two completed patient CQC comment cards and spoke with 16 patients who were using the service on the day of our inspection. We spoke with people from different age groups, including parents and children, patients with different physical conditions and long-term care needs. The patients were extremely complimentary about the staff and clinicians. Patients told us they found the staff to be helpful and felt they were treated with respect.

The national GP survey results published in December 2013 stated the practice was found overall to be better than expected nationally. We noted that the practice reviewed there performance on the survey and made improved their performance. We saw that 72% of patients found it easy to make an appointment and 87% of patients found it easy to see the nurse. In the June 2014 survey these results had increased by 1%.

We heard that staff had looked at how to make it easier to obtain appointments and had introduced an on-line booking for appointments. Appointments with the nurse and GP could be made at least two weeks in advance. Three patients told us that making a telephone appointment remained difficult at times but 12 other patients we spoke with found this was not problematic. Patients told us that over the last year the practice had made significant improvements to the appointment system. All of these patients commented that they could make an appointment both for the day and at least two weeks in advance. Over the last year five comments have been made by patients on the NHS choices website and these were in respect of their very positive experience of the service.

The practice ran a virtual patient participation group (PPG), which has over a 100 members. We saw that they were regularly consulted about developments made to the practice and the practice manager used their views when planning how the practice would run in the forthcoming year. The staff at the practice felt the PPG members worked well together and were an important part of the practice system for making sure the service operated well.

Patients we spoke with told us they were very happy with the service and felt the GPs made sure they received the best course of treatment for them. We heard that the GP completed telephone consultations and, if needed, would book the patient in for a face-to-face appointment. The patients told us that the nurses were very responsive and they could readily get appointments to see them.

We were told that the staff were all committed to providing the best care possible and really cared about their wellbeing. Patients discussed how the GPs had been extremely supportive. They all told us the doctors and nurses were competent and knowledgeable about their treatment needs. They told us that the service was very good and staff were very respectful.

Areas for improvement

Outstanding practice

Our inspection team highlighted the following areas of good practice:

There was an effective appointment and clinic scheduling planning tool, which made sure that the work load for the week was evenly spread across the team and ensured fluctuations between busy/quite times were avoided as much as possible.

The GP partners and practice manager had ensured the full potential of the IT system was used, including using this to monitor staff's review of the policies and training. The practice manager actively used this information in staff appraisals and for planning learning and development.

Summary of findings

The practice recognised the financial difficulties their patients experienced when the practice had an 0844 telephone number. Costs from “Pay as you Go” mobile phones were prohibitive . The practice re-imbursed some patients for their calls.

The practice manager had developed a responsive complaints system and responded to concerns on the same day, often with face-to-face meetings. This approach had led to full information about concerns being obtained and being actively used to improve the practice.

The practice had created a virtual PPG and promoted this in such a way that over a 100 patients had joined this group.

Drs Cloak, Choi and Milligan

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC inspector and the team included a second CQC inspector, a GP, a practice manager and an expert by experience, who is someone that has used health and social care services.

Background to Drs Cloak, Choi and Milligan

Drs Cloak, Choi and Milligan is registered with CQC to provide primary care services, which includes access to GPs, minor surgery, family planning, ante and post natal care. The practice provides GP services for 9919 patients living in the Southwick area of Sunderland. The practice has three GP partners, five salaried GPs, two practice nurses and a healthcare assistant. The practice is part of NHS Sunderland CCG.

The practice is open 8am to 8pm on Monday and Wednesday, 8am to 6pm on Tuesday, Thursday and Friday; and 8am to 11.30am on a Saturday. Patients can book appointments in person, via the telephone and online. Appointments can be booked for up to a week in advance for the doctors and a month in advance for the nursing clinics. The practice treats patients of all ages and provides a range of medical services.

The practice is registered with the Care Quality Commission to deliver the regulated activities:

Diagnostic and screening procedures

Family planning

Maternity and midwifery services

Surgical procedures

Treatment of disease, disorder or injury

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward. This practice had not been inspected before and that was why we included them in this programme of inspections.

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problems

Detailed findings

Before our inspection we carried out an analysis of the data from our Intelligent Monitoring system. We also reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We reviewed the policies, procedures and other information the practice provided before the inspection. The information reviewed did not highlight any significant areas of risk across the five key question areas.

We carried out an announced inspection on 2 September 2014 and spent seven hours at the practice.

We reviewed all areas of the practice including the administrative areas. We sought views from patients both face-to-face and via comment cards. We spoke with the practice manager, registered manager, a GP, a nurse, two administrative staff, the clinical lead for infection control and the receptionists on duty.

We observed how staff treated patients visiting and ringing the practice. We reviewed how GPs made clinical decisions. We reviewed a variety of documents used by the practice to run the service. We also talked with carers and family members of patients visiting the practice at the time of our inspection.

Are services safe?

Our findings

Safe Track Record

Reports from NHS England indicated that the practice had a good track record for maintaining patient safety. Information from the General Practice Outcome Standards showed it was rated as an 'Achieving' practice. Information from the quality and outcomes framework (QOF), which is a national performance measurement tool, showed that in 2012-2013 the provider was correctly identifying and reporting significant events. GPs told us they completed incident reports and carried out significant event analysis as part of their on going professional development. We looked at the significant events from January 2014 which had been reported to NHS England using the incident reporting system. The records showed staff were appropriately reporting incidents.

The practice had systems in place to monitor patient safety. We saw that apart from reviewing incidents, individual GPs also completed evaluations of the changes their practice made to outcomes for people. For example; one GP, in line with guidance, completed condition specific audits on treatment offered to patients with long-term conditions. In addition to this, as a part of the re-validation process, GPs had completed two yearly evaluation cycles, which aimed to determine whether changes to the practice had been sustained and had improved access for patients.

Staff provided us with evidence to show they actively reported any incidents that might have the potential to adversely impact patient care. Staff told us they viewed this process as a positive process to ensure they provided excellent patient care. Staff could readily describe their roles of accountability in the practice and what actions they needed to take if an incident or concern arose. Concerns regarding the safeguarding of patients were passed on to the relevant authorities as quickly as possible.

The practice minutes of meetings we reviewed showed that new guidelines, complaints, incidents and significant events, were discussed at each meeting. The staff we spoke with discussed the use of incident analysis and how this assisted them to develop the care provided. The clinicians were confident that the treatment approaches adopted followed best practice and this was confirmed in our discussions with clinicians.

The practice manager told us they ensured reports about incidents, significant events and complaints were also taken to the partner board meetings. The board was responsible for the running of the practice. This helped ensure there was shared learning from incidents.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We saw evidence to confirm that staff had completed a significant event analysis which included identifying any learning from the incident.

We saw evidence to confirm that, as individuals and a team, staff were reflecting on their practice and critically looked at what they did to see if any improvements could be made. Significant events, incidents and complaints were investigated and reflected on by the GPs. The team recognised the benefits of identifying any patient safety incidents and near misses.

From the review of complaint investigation information we saw that the practice manager and GP partners ensured complainants were given full feedback and asked for detailed information about their concerns. We saw that the practice then checked if the complainant was satisfied with the outcome of the investigations and any actions made to improve the service.

Reliable safety systems and processes including safeguarding

The practice had up to date 'child protection' and 'vulnerable adult' policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were easily available to staff both in paper format and on their computers. Staff had access to contact details for both child protection and adult safeguarding teams. The staff routinely supplied reports for and at times attended child protection meetings. Staff were knowledgeable about the actions they needed to take and took appropriate action to discuss issues with the Safeguarding GP Lead in the area.

Staff had received training in safeguarding and child protection the last 12 months. They were knowledgeable about the types of abuse to look out for and how to raise concerns. For example, the practice manager and GPs told us about child protection and safeguarding concerns they had recently raised with the local authority and discussions

Are services safe?

they had with the GP safeguarding lead for Sunderland. Administrative staff also told us about concerns they had raised with the GPs and how these had been followed up immediately.

One of the GPs took the lead for safeguarding in the practice and had attended appropriate training to support them in carrying out their work, as recommended by professional intercollegiate safeguarding guidance. They were knowledgeable about the contribution the practice could make to multi-disciplinary child protection meetings and serious case reviews.

When safeguarding concerns were raised, staff ensured these alerts were put onto the patient's electronic record. Staff were proactive in monitoring if children or vulnerable adults attended Accident and Emergency or missed appointments frequently. These were brought to the GP's attention, who worked with other health professionals such as health visitors, midwives and district nurses.

From our discussions we found that GPs were aware of the latest best practice guidelines and incorporated this into their day-to-day practices. We saw there were effective systems in place to ensure the staff remained up to date with the latest developments. For example at each clinical meeting GPs discussed changes to guidance, clinical audits reviewed implementation of latest best practice and staff regularly attending clinical conferences.

Monitoring Safety & Responding to Risk

There were procedures in place to assess, manage and monitor risks to patient and staff safety. These included annual and monthly checks of the building, the environment and equipment. Staff were in the process of improving the risk assessments they completed. They had recently implemented an infection control audit and were working through the recommendations identified in the first run through of this audit. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager had shared the recent findings from an infection control audit with the team.

The practice manager had procedures in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness. The administration manager told us they were responsible for producing the rota, approving annual leave and for ensuring there were sufficient reception staff on duty each day.

The practice manager and lead GP oversaw the rota for clinicians. They had reviewed and developed the GP appointment system. This had led to a responsive design being in place, which allowed the practice to meet fluctuations in demand for appointments. We saw they ensured that sufficient staff were on duty to deal with expected demand; including home visits and daily telephone consultation sessions.

The PPG virtual meeting minutes highlighted that the GP partners shared the lessons they had learnt around actions that could be taken to improve the service with them.

We found checks were made to minimise risk, and best practice was followed. These included monitoring staff refresher training to ensure they had the right skills to carry out their work and monitoring stocks of consumables and vaccines to ensure they were available, in date and ready to use. The clinical staff received regular cardiopulmonary resuscitation (CPR) training and training associated with the treatment of anaphylaxis. Staff that would use the defibrillator had received regularly training to ensure they remained competent in its use, which ensured they could respond appropriately if patients experienced a cardiac arrest.

Management of medicines

There were clear systems in place for medicine management. The GPs reviewed medication for patients on an annual basis or more frequently if necessary. The practice worked with pharmacy support from the CCG to support the clinical staff in keeping up to date with medication and prescribing trends.

From our review of documents we saw that there were up to date medicines management policies in place. The staff we spoke with were familiar with them. Medicines were kept securely and could only be accessed by the clinical staff and CCG pharmacy staff. There were appropriately stocked medicine stores and equipment bags ready for doctors to take on home visits. We saw evidence that the doctor's bags were regularly checked to ensure that the contents were intact and in date.

Clear records were kept whenever any medicines were used. Arrangements for the storage and recording of controlled drugs or medicines that require extra checks were followed. All medicines we checked were in date,

stored appropriately and staff ensured stock was used in a systematic order. Any changes in medication guidance were communicated to clinical staff in person and electronically via the web form for prescriptions.

GPs reviewed their prescribing practices as and when medication alerts were received. We noted that within the practice clinical meetings, GPs and nurses were sharing latest guidance on changes to medication and prescribing practice. GPs and staff we spoke with discussed the clinical meetings and how these provided them with the opportunity to critically evaluate their practices and the service being provided.

There were standard operating procedures (SOP) in place for using certain drugs and equipment. These documents ensured all clinical staff followed the same procedures. The SOPs were reviewed, were in date and clearly marked, which ensured staff knew it was the current version.

Prescription pads and repeat prescriptions were stored securely. Reception staff we spoke with were aware of the necessary checks required when giving out prescriptions to patients who attended the practice to collect them. They were also able to describe the additional checks required when giving out prescriptions for controlled drugs.

Cleanliness & Infection Control

Patients commented that the practice was clean and appeared hygienic. The practice does not own the building and their landlord had the responsibility for managing the cleaning services and ensuring good infection control measures were in place. The practice had recently developed their own infection control audit to ensure they could check that the areas of the building they used were up to a good standard. We saw that the overall cleanliness of the building was good. The practice was cleaned in line with infection control guidelines.

We spoke with the nurse who had the lead role for infection control and found them to be knowledgeable. We found the practice had a comprehensive system in place for managing and reducing the potential for infection.

We inspected all the treatment and clinical rooms. We saw that all areas of the practice were very clean and processes were in place to manage the risk of infection.

There was an up-to-date Infection Control Policy in place. A needle stick policy was in place, which outlined what to do and in event of this happening who to contact. We saw updated protocols for the safe storage and handling of specimens and for the safe storage of vaccines. These provided staff with clear guidance and were in line with current best practice. Spillage kits were available for staff to use if bodily fluids were spilled.

Infection control training was part of induction for all staff. Clinical staff completed this training at induction and then refresher training on an annual basis. Non-clinical staff completed the training during their induction and had access to the information produced by the infection control lead.

We observed good hand washing facilities to promote high standards of hygiene. Instructions about hand hygiene were available throughout the practice with hand gels in clinical rooms. We found protective equipment such as gloves and aprons were available in the treatment/ consulting rooms and in reception. Couches were washable, curtains around them were disposable and there was easy clean flooring in treatment areas.

We were told the practice did not use any instruments which required decontamination and that all instruments were for single use only. Checks were carried out and recorded to ensure items such as instruments, gloves and hand gel were available and in date.

Staffing & Recruitment

The practice's recruitment policy was in place and up-to-date. Appropriate pre-employment checks were completed for a successful applicant before they could start work in the service. We looked at a sample of recruitment files for GPs, administrative staff and nurses. We saw that the practice independently checked the suitability of locum doctors as well as reviewing the NHS performer's lists. The practice manager also obtained health statements for all employees so they knew the person was physically and mentally able to perform their role. The recruitment procedure ensured appropriate staff were employed.

We saw that as a routine part of the quality assurance and clinical governance processes the provider checked the General Medical Council (GMC) and Nursing Midwifery Council (NMC) registration lists each year to make sure the doctors and nurses were still deemed fit to practice.

The GP partners and practice manager had agreed in conjunction with commissioners what would be safe

staffing levels and the rotas showed that these were consistently maintained. Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness.

The practice had developed clear lines of accountability for all aspects of care and treatment. The GPs and nurses had been allocated lead roles such as for infection control, respiratory disease, mental health, learning disability and the Mental Capacity Act 2005. We found that the practice manager and senior staff monitored how effectively lead staff fulfilled their role. This included routine checks to ensure that GPs and nurses were using the latest guidance and protocols. Findings were routinely analysed and any emerging risks were immediately fed back to the staff so action could be taken to improve service delivery.

Dealing with Emergencies

Comprehensive plans to deal with any emergencies that may occur and could disrupt the safe and smooth running of the practice were available. A detailed business continuity plan was in place. The plan covered business continuity, staffing, records/electronic systems, clinical and environmental events. Key contact numbers were included and paper and electronic copies of the plan were kept in the practice and by the practice manager and GPs. Reception staff we spoke with were knowledgeable about the business continuity plans and described how they had used the plan when telephone and IT systems failed.

Staff told us they had training in dealing with medical emergencies including cardiopulmonary resuscitation (CPR) and other emergencies such as fire and floods.

Equipment

The practice manager had contracts in place for annual checks of fire extinguishers, 'portable appliance testing' and calibration of equipment.

Emergency drugs were stored in a separate locked cabinet and vaccines were stored in a vaccine fridge. Temperature logs for the vaccine fridge were routinely completed. A log of maintenance of clinical and emergency equipment was in place and there was a record noted on the log when any items identified as faulty were repaired or replaced. We saw that the landlord ensured portable appliance tests (PAT) were completed on all electrical equipment on an annual basis and that the last checks were in date. The practice had made arrangements for the routine servicing and calibration, where needed, of medical equipment. The records we saw confirmed that the equipment at the practice was safe to use.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance and we confirmed this was being used. The staff we spoke with and evidence we reviewed confirmed that these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. The review of the clinical meeting minutes confirmed this happened. Staff providing gynaecology and family planning services received regular updates about this service. They, in line with the expectations of the Royal College of General Practitioners guidelines, were assessed in their delivery of these services as well as other general practice expectations. Health care assistants were qualified to monitor physical health such as blood pressure and to take blood samples.

The practice provided a service for all age groups. We heard that staff worked with patients on the poverty line and looked at ways to make accessing healthcare easier for its population. We found GP's were very familiar with the needs of each patient; the impact of the socio-economic environment and had particular interest areas. For example one of the GPs had developed additional competencies around working with patients who had respiratory conditions and another specialised in dermatology.

We saw that the GPs and clinicians ensured consent was obtained and recorded for all treatment. Where people lacked capacity they ensured the requirements of the Mental Capacity Act 2005 were adhered to and for children and young people Gillick assessments were completed.

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included a data input, clinical review scheduling, child protection alerts management and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits. Examples of clinical audits included, audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and NICE guidance. We also saw that the practice's diabetes management was in accordance national expectations. 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 reflected upon the outcomes being achieved and areas where this could be improved.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of Quality and Outcomes framework (QOF) performance. For example we saw an audit regarding the prescribing of analgesics and non steroidal anti-inflammatory drugs. Following the audit the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. QOF was used to monitor the quality of services provided**.** The QOF report from 2012-2013 showed the practice was supporting patients well with conditions such as, asthma, diabetes and heart failure. QOF information for 2013-2014 indicated the practice had maintained this level of achievement. GPs told us this reflected their commitment to maintaining and improving outcomes for patients.

Are services effective?

(for example, treatment is effective)

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 the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP went to prescribe medicines. We were shown evidence to confirm that following the receipt of an alert the GPs had clearly 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.

Effective Staffing, equipment and facilities

From our review of information about staff training we saw that, the induction programme covered a wide range of topics such as dignity and privacy, equality and diversity as well as essential training. The management team had clear expectations around refresher training and this was completed in line with national guidance as well as those of the local CCG. The management team ensured that the clinicians had access to a variety of training resources. The practice manager had purchased an e-learning training resource and this meant all staff could readily update both mandatory and non-mandatory training. We saw that the mandatory training for all staff included fire awareness, information governance, first aid, and safeguarding. Staff also had access to additional training related to their role. For example reception staff told us they had received conflict resolution and customer care training. We confirmed that staff had the knowledge and skills required to carry out their roles.

The staff files we reviewed showed that staff of all disciplines received annual appraisal and the clinicians had access to regular clinical supervision sessions. The administrative staff told us they were well-supported and regularly had conversations about their performance with their line manager. The practice had procedures in place to support staff in carrying out their work. For example, newly employed staff were supported in the first few weeks of working in the practice. An induction programme included time to read the practice's policies and procedures and meetings with the manager to help confirm they were able to carry out the role. Staff told us they had easy access to a range of policies and procedures needed to support them in their work.

The practice manager kept a record of all training carried out by clinical and administration staff to ensure staff had the right skills to carry out their work. The practice had a rolling programme of half day training for staff on one afternoon per month. GPs had protected learning time and met with their external appraisers to reflect on their practice, review training needs and identify areas for development.

The GPs received external professional appraisals. They, as well as the nursing staff also routinely accessed clinical supervision. The appraisals involved a 360 degree process; which asks staff to complete a personal reflection on their skills and behaviour. Internal colleagues were also asked to provide open and honest feedback about the appraisee's interpersonal skills and clinical competence.

Working with other services

The practice worked with other agencies and professionals to support continuity of care for patients. The GPs described how the practice provided the 'out of hours' service with information, to support, for example 'end of life care.' Information received from other agencies, such as accident and emergency or hospital outpatient departments was read and the GPs took action to deal with the matter on the same day.

The practice kept up to date registers for patients with long term conditions such as asthma and chronic heart disease which were used to arrange annual health reviews. They also provided annual reviews to check the health of patients with learning disabilities and patients on long term medication; for example for mental health conditions. We heard that the practice staff had formed strong links with the community nursing services and secondary care services. Staff then monitored the 'choose and book' system to ensure the patients were seen in a timely manner.

Health Promotion & Prevention

The practice supported patients to manage their health and well-being. The practice offered national screening programmes, vaccination programmes, long term condition reviews and provided health promotion information to patients. They provided information to patients via their website and in leaflets in the waiting area about the services available.

Are services effective?

(for example, treatment is effective)

QOF information showed the practice performed well regarding health promotion and ill health prevention initiatives. For example, in providing flu vaccinations/ smoking cessation advice, assessing for depression and providing physical health checks for patients with severe mental health conditions.

The practice also provided patients with information about other health and social care services such as carers' support. We saw a range of information posters and leaflets in the practice and on the practice website. Staff we spoke with were knowledgeable about other services and how to access them.

Staff at the practice were currently completing work to identify people on their patient list who also provided a carer's role. We saw that health promotion information was on display in the areas patients used and leaflets explaining different conditions were also freely available. Preventative work was completed with all these groups, which was aimed at assisting patients to find ways to improve their health and wellbeing.

New patients registering with the practice completed a health questionnaire and were given a new patient medical appointment. This provided the practice with important information about their medical history, current health concerns and lifestyle choices. Patients' individual needs were assessed and access to support and treatment was available as soon as possible.

The practice used the coding of health conditions in patients' electronic records and disease registers to plan and manage services. For example, patients on disease registers were offered review appointments with the nursing staff.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

The service had a patient dignity policy in place. Staff we spoke with were aware of the importance of providing patients with privacy. They told us there was a room available if patients wished to discuss something with them away from the reception area and we saw this being used. The design of the reception area ensured confidentiality was maintained when staff booked appointments for patients. We observed that the reception staff treated people with respect and ensured conversations were conducted in a confidential manner. Telephone calls in respect of discussing results and booking appointments were taken in a room at the back of the reception desk.

Consultations took place in purposely designed rooms with an appropriate couch for examinations and screens to maintain privacy and dignity. The consultation room doors were routinely locked when patients were being seen. We observed staff were discreet and respectful to patients.

The practice offered patients a chaperone prior to any examination or procedure. Information about having a chaperone was in the waiting area to help ensure patients were aware of this facility. Staff we spoke with were knowledgeable about the role of the chaperone and had received training to carry out this work. Patients we spoke with told us about the process for using chaperones and felt confident that this was effective, as it was always used with them when needed. Patients also told us that they felt the staff and doctors effectively maintained their privacy and dignity.

Patients commented that they were treated with respect and dignity. Patients we spoke with told us they had enough time to discuss things fully with the GP and most patients felt listened to and felt clinicians were empathetic and compassionate.

The most recent practice patient survey showed that 98% of patients of the 300 people who responded said reception staff were exceptional or good. The practice had a clear set of values about patients being treated courteously and the information they supplied was only shared with clinicians on a need to know basis. This was reflected in the practice charter.

Patients told us they were happy to see any GP and the nurse as they felt all were competent and knowledgeable. Most patients found that they had been able to see their preferred GP for routine appointments and saw the available GP for urgent appointments. They told us that this system worked and all of the GPs were good so it did not concern them that they could not always see their preferred GP. The national GP patient survey (December 2013) found that 80% of patients reported that they could always see their preferred GP. The rotas we reviewed showed that sufficient GPs and other clinicians were on duty to cover all the appointments including the extended hour's service.

Involvement in decisions and consent

Staff were knowledgeable about how to ensure patients were involved in making decisions and the requirements of the Mental Capacity Act 2005 and the Children's Act 1989 and 2004. GPs and nursing staff told us relatives, carers or an advocate were involved in helping patients who required support with making decisions.

We saw that healthcare professionals adhered to the requirements of the Mental Capacity Act 2005 and the Children Act 1989 and 2004. Capacity assessments and Gillick competency of children and young people, which check whether children and young people have the maturity to make decisions about their treatment, were an integral part of clinical staff practices. We found that clinical staff understood how to make 'best interest' decisions for people who lacked capacity and sought approval for treatments such as vaccinations from children's parent or legal guardian.

The practice had a consent policy which provided staff with guidance and information about when consent was required and how it should be recorded. Patients' verbal consent was recorded on their patient record for routine examinations. Written consent was obtained for joint injections and gynaecological examinations. The patients we spoke with confirmed that their consent was always sought and obtained before any examinations were conducted. The national GP patient survey (December 2013) found that 95% of patients said they were fully involved in making decisions.

The practice had an 'access to records' consent policy that informed patients how their information was used, who

Are services caring?

may have access to that information, and their own rights to see and obtain copies of their records. Information about the policy was available for patients on the practice website and in leaflets.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice held information about the prevalence of specific diseases. This information was reflected in the plan for the services provided, for example screening programmes, vaccination programmes and reviews for patients with long term conditions.

The practice was proactive in contacting patients who failed to attend vaccination and screening programmes. They worked with other health providers to support patients who were unable to attend the practice. For example patients who were housebound were identified and referred to the district nursing team to receive their vaccinations.

Staff we spoke with were knowledgeable about how to support patients who were homeless or were living on the poverty line. The practice recognised the financial difficulties their patients experienced when the practice had an 0844 telephone number. Costs from "Pay as you Go" mobile phones were prohibitive . The practice reimbursed some patients for their calls. The practice secretary was always available to chase up secondary care appointments on behalf of the patients.

We saw the level of dedication staff showed to patients. For example one patient was taken home to make their partner aware that they needed to go to the hospital. Staff discussed with us one recent occasion when one of GPs had recently used the practice's car to take a patient to hospital as they could not afford to get there independently and the patient transport had been delayed.

The practice provided good disabled access in the reception and waiting areas, as well as to the consulting and treatment rooms. Staff were aware that the front doors were heavy and difficult to open. There was a buzzer at the front door for patients to press if they needed help. The practice had a wheelchair for patients who required assistance.

There were comfortable waiting areas for patients attending an appointment and limited car parking was available nearby. There were accessible toilet facilities.

The practice made adjustments to meet the needs of patients, including having an audio loop system sign displayed on the reception counter for patients with a hearing impairment. There was guidance about using interpreter services and the contact details available for staff to use. Staff were knowledgeable about interpreter services that were available when English was a second language for patients. Patients' electronic records contained alerts for staff; for example patients requiring additional assistance in order to ensure the length of the appointment was appropriate.

Access to the service

The GPs and the clinicians had proactively managed the appointment booking system. The national GP survey results published in December 2013 showed they were performing above the national average. The patients responded positively about the contact with GPs and in most areas they scored well over 90% satisfaction rates. The patients were 100% satisfied with the GPs listening skills and ability to explain treatment decisions. Areas that indicated a poorer response rate related to contacting the surgery by telephone to make an appointment. As a result the practice had introduced a process whereby the patient could make online bookings and have telephone consultations with the GPs. The practice had then surveyed the patient group to determine if this had improved the service and the result from this as the June 2014 national survey showed satisfaction levels had improved.

The patients we spoke with thought the changes to the appointments system had been positive and improved accessibility to the GPs and clinicians.

We saw that the practice completed patient surveys annually and comments from these showed that patients were extremely pleased with the service.

Concerns & Complaints

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

We saw there was a clear complaints procedure in place and on display throughout the practice. The patients we spoke with were all aware of the process to follow should they wish to make a complaint. Patients we spoke with told

Are services responsive to people's needs?

(for example, to feedback?)

us they had never needed to complain about the service. They felt the staff were constantly looking at how to improve what they did and within this process had looked at the service from the point of view of the patient.

From a review of the complaints records, covering the last year, we saw that the practice manager contacted the complainant immediately and often at the time they were raising concerns. We heard how this proactive approach was welcomed by patients and gave them confidence that their concern would be addressed as well as emphasising the value placed upon them by the practice.

We saw that complaint investigations were thorough and impartial. We saw that a process was in place to analyse each complaint to see if themes were emerging or to look at trends in complaint rates or topics. No themes were evident but the staff proactively looked for lessons that could be learnt.

Are services well-led?

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

Our findings

Leadership & Culture

All the discussions and evidence we reviewed confirmed that the management team had a clear vision and purpose. The GPs we spoke with demonstrated an understanding of their area of responsibility and each one clearly took an active role in ensuring that a high level of service was provided on a daily basis. All the staff we spoke with told us they felt they were valued and their views about how to develop the service acted upon.

The practice had a clear vision and set of values which were understood by staff and were available on the practice website. The practice's mission statement included a commitment to involving patients in their own healthcare and the development of the service.

There was a schedule of regular weekly, monthly and quarterly meetings within the practice. Staff told us this helped them keep up to date with new developments and concerns. It also gave them an opportunity to make suggestions and provide feedback to the partners. Staff told us they were committed to providing a good service for patients and they were enthusiastic about their contribution.

The team worked collaboratively and used their understanding of the effectiveness of the service to shape and improve the practice. From our discussions and review of the evidence we confirmed that this had led to the practice being consulted by local healthcare services about developments in the delivery of care in the local area.

We saw evidence that demonstrated the practice worked with the CCG to share information, monitor performance and implement new methods of working to meet the needs of local people. GPs attended prescribing, medicines management and safeguarding meetings and shared information within the practice.

Governance Arrangements

We found that the practice had implemented systems for monitoring all aspects of the service and these were designed to be used to plan the service and to make improvements to the service. The practice managers and GPs led on the individual aspects of governance such as complaints, risk management and audits within the practice. The systems in place ensured strong governance arrangements were in place.

The GP partners took an active leadership role for overseeing that the systems in place were consistently being used and were effective. For example there were processes in place to frequently review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. At the time of the visit they were considering the integration of paper and computer systems to ensure these were effective. We noted that the process of recording home visits in a book and on the computer created duplication.

There was evidence of forward planning within the practice around the need to review and update policies and check the accuracy of current risk management tools.

The practice regularly submitted governance and performance data to the CCG.

Systems to monitor and improve quality & improvement (leadership)

The practice used information they collected for the Quality and Outcomes framework (QOF) and national programmes such as vaccination and screening to monitor patient quality outcomes. GPs told us they worked with the pharmacist from the CCG in identifying which clinical audits to carry out. Clinical audits were also carried out following significant events and complaints. These were discussed within the practice through a schedule of meetings with staff groups.

Staff told us they had annual appraisals which included looking at their performance and development needs. The practice completed clinical supervision sessions for all of the relevant staff. External appraisals of GP's was also undertaken as a way of monitoring the quality of care provided by staff.

The GPs and practice manager all contributed to risk management, clinical audits, staff training and significant event analysis. It was evident that quality monitoring was taking place and action taken to improve quality.

Patient Experience & Involvement

We received two completed patient comment cards and spoke with 16 people on the day of our visit. We spoke with

Are services well-led?

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

people from different age groups, including parents and children, patients with different physical health care needs and those who had various levels of contact with the practice. All these patients were complimentary about the clinical staff and the overall friendliness and behaviour of all staff. They all felt the doctors and nurses were competent and knowledgeable about their treatment needs. They felt that the service was exceptionally good and that their views were valued by the staff.

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

The practice had an active virtual PPG with 102 members. We saw that this group discussed how the service operated and listened to their insights into the patient experience. From a review of the minutes of their meetings we found the PPG was very effective and engaged. Their views were listened to and used to improve the service being offered at the practice. For example the introduction of online appointments system and the change from 0844 number to local number had been in response to patients' feedback.

Information about the PPG was available on the practice website and in the practice newsletter. Patients were able to sign up on line or complete a form and hand it in to reception staff. Patients were encouraged to send their comments, suggestions and questions via the practice website and in person.

Management lead through learning & improvement

The practice had a clear understanding of the need to ensure staff had access to learning and improvement opportunities. Newly employed staff had a period of induction to support them. They had the opportunity to feedback on how useful the induction period had been and to make suggestions on ways to improve it. They met with the practice manager to discuss progress and ensure they had the right skills to do their job. On going peer support and formal appraisals were evident.

Staff told us they had good access to training and arrangements were in place to monitor the completion of required training. We saw that a comprehensive training matrix for all staff employed in the organisation was in place.

The GPs and clinical staff held regular clinical meetings where they discussed changes to practice. The practice also scheduled meetings for the whole staff team, clinical, non-clinical and operations management. Staff were encouraged to attend various staff meetings and we saw from the minutes of clinicians meetings that they discussed improvements that could be made to the service. Our discussions confirmed that the whole team were highly focused and very open to exploring how they could improve. We confirmed that this had led to a constant cycle of improvement and demonstrated the practices desire to constantly strive for excellence.

Identification & Management of Risk

The practice had systems to identify, assess and manage risks related to the service. We saw the practice's health and safety policy which included clear guidance for staff. Monthly health and safety meetings had recently been introduced and we saw evidence of staff involvement and cascading information. A comprehensive business continuity plan was in place.

Procedures were in place to record incidents, accidents and significant events and to identify risks to patient and staff safety. The results were discussed at practice meetings and if necessary changes were made to the practice's procedures and staff training. All of the systems we reviewed showed that the practice was effectively monitored by the practice manager and senior staff.

The practice carried out audits and checks to monitor the quality of services provided. For example the GPs used prescribing information provided by the CCG pharmacist and national alerts to review the medication they prescribed. This helped to ensure patients were receiving the most appropriate medication in line with best practice.

Staff told us they felt confident about raising any issues and felt that if incidents did occur these would be investigated and dealt with in an proportionate manner.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Our findings

Care was tailored to individual needs and circumstances, including a person's expectations, values and choices. A named GP was accountable for the care of each patient over the age of 75 years.

Clinicians ensured patients and carers received appropriate coordinated, multi-disciplinary support (including for those people who move into a care home, or those returning home after hospital admission). Unplanned admissions and readmissions for this group were regularly reviewed and action was taken to make any necessary improvements.

Staff had the knowledge, skills and competence to respond to the needs of this patient group. Including training in appropriate communication skills.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Our findings

Care was tailored to individual needs and circumstances, including a person's expectations, values and choices. Regular 'patient care reviews', involving patients and carers were completed.

Staff had the knowledge, skills and competence to respond to the needs of this patient group.

Clinicians supported patients and carers to receive coordinated, multi-disciplinary care whilst retaining oversight of their overall care. GPs acted as a coordinator and navigator of care where this was appropriate. Clinicians made referrals to specialists in an appropriate and timely way.

The practice proactively monitored the prevalence of long-term conditions within the practice population including action to respond to a sudden deterioration of a condition; to identify patients with a long-term condition and those at risk of developing one.

A range of health promotion advice and information related to various conditions including advice on self-management were on display in the practice. Clinicians proactively case managed and completed long-term monitoring of these patients' needs.

Access to services, including flexible appointment times and same day telephone consultations where appropriate, were available.

Staff received appropriate training to ensure they have the expertise and knowledge to work with patients. People were signposted to patient groups and supported to access a support network.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

The practice proactive in seeking to safeguarded children. The practice ensured systems were in place to provide access to early identification of physical health needs and signposted all involved in the child's care to the help offered with other services.

The practice prioritised the needs of children, young people and families living in disadvantaged circumstances, looked after children, children of substance abusing parents and young carers. Extra support was offered to these families and they worked closely with other support agencies.

Staff had the knowledge, skills and competences to recognise and respond to an acutely ill child.

Clinicians completed regular assessments of children's development and early identification of problems in the physical and mental wellbeing of children and young people and when necessary followed up issues.

The practice provided primary and pre-school immunisation and health promotion advice.

Children and young people were treated in an age appropriate way and were recognised as an individual, with their preferences considered.

Communication, information sharing and decision making with other agencies, particularly midwives, health visitors and school nurses was well-established.

Clinicians provided information, including lifestyle advice on healthy living, to expectant mothers, expectant mothers and fathers to patients.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Our findings

The appointments system provided out of working hours appointments, which enabled access for this group.

Staff proactively looked at how they could learn from any incidents and they used the latest guidance to improve the service.

Care and treatment was considered in line with current published best practice for this patient group. These patients' needs were consistently met. Referrals to secondary care were made as soon as the need was identified.

The practice had a clear complaints policy and responded appropriately to complaints about the service. Regular patient surveys were conducted, which covered their satisfaction with the service and the practice took action to make suggested improvements.

Governance and risk management structures were in place. The leadership team had a clear vision about how to deliver the best care for patients.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Our findings

Open access to the service was provided, which meant all people from the catchment area could register with the practice, including those with no fixed abode. The practice provided sign-posting to specialist support groups.

The practice proactively assessed and monitored the practice population needs, including for people in vulnerable circumstances. People were encouraged to participate in health promotion activities, such as breast screening, cytology, smoking cessation. Staff took time to listen to people from this population groups.

The practice kept a comprehensive list of patient needs, which included information about people with learning disabilities, patients who were also carers and people with complex health needs.

The practice had a structured approach to addressing health needs and inequalities. Patients told us they felt able to trust the practice staff with personal information.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Our findings

The practice proactively assessed and monitored the practice population needs, including for patients with mental health needs, including within hard to reach groups.

Staff had the skills, competences and knowledge to assess and respond to risk for patients experiencing mental illness (including suicide prevention); support people to access emergency care and treatment when experiencing a mental health crisis; and recognise and manage referrals of more complex mental health problems to the appropriate specialist services.

Care was tailored to their individual needs and circumstances, including their physical health needs. Including annual health checks for people with serious mental illnesses.

The practice proactively offered access to a variety of treatments such as listening and advice, and counselling services.