Charlton Medical Centre

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

Charlton Medical Centre is located in Telford, Shropshire. We carried out an announced comprehensive inspection on 01 July 2015. Overall Charlton Medical Centre is rated as good.

Specifically, we found the practice to be good in caring, effective, safe and well-led services and outstanding in responsive. It was good for providing services for all the population groups.

Our key findings were as follows:

• Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.

• Patients' needs were assessed and care was planned and delivered after considering best practice guidance.

• The practice worked closely with other organisations and with the local community in planning how services were provided to ensure they met patients' needs.

• The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand

• The practice had a clear vision which had quality and safety as its top priority. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

• Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.

We saw several areas of outstanding practice including:

• The practice funded enhanced diagnostic services for their patients such as a heel scanner for diagnosis of osteoporosis, clinical photography, dermoscopy (acts as an aid in the diagnosis of skin lesions), sleep apnoea

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monitors (a sleep disorder characterized by pauses in breathing or instances of shallow or infrequent breathing during sleep). This had improved diagnostic access for its patients.

• The practice provided an enhanced service with a view to facilitating timely diagnosis and support for people with dementia. The practice held a license for the use of a tablet device application used to test for memory problems independent of language or educational attainment with the potential for allowing diagnosis of early dementia and therefore in the implementation of care and treat accordingly.

• The practice had purchased an ultrasound scanner and this had improved diagnostic access for its patients. The practice together with the local hospital trust now staffed and managed this diagnostic facility from the practice for its patients and for other local practices.

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

The provider should:

• Complete a formal written risk assessment on the emergency medicines not held as stock within the practice.

• Complete an Infection and Prevention Control audit.

• Consider the inclusion of practice nursing staff in clinical meetings and whole staff meetings.

• Consider an evaluation of the additional services provided by the practice to its patients, in particular any impact on the delivery of patient care.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe. Future developments at the practice included electronic prescribing. The practice operated clear coding systems for all their electronic patient records. These were discussed at regular partner, clinical and management meetings to ensure the practice staff maintained a consistent approach in diagnostic coding, to enable them to provide a service that met the needs of their registered patients.

Are services effective?

Good

The practice is rated as good for providing effective services. Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. Data showed that the practice was performing highly when compared to neighbouring practices in the Clinical Commissioning Group. The practice used innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice slightly higher than others for several aspects of care. For example, the national GP patient survey January 2015, found 98% of respondents said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and national average of 95%. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services. It reviewed the needs of its local population and engaged

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with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they could make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders. The National GP patient survey January 2015 found there were areas in which the practice could improve. The practice had reflected and responded to the findings by increasing staffing hours, promoting on-line services and increasing the numbers of telephone consultations available through both nurse and GP triage and provided a 'sit and wait' service from 4pm each weekday.

The practice had funded enhanced diagnostic services for their patients such as a heel scanner for diagnosis of osteoporosis, clinical photography, dermoscopy (acts as an aid in the diagnosis of skin lesions), sleep apnoea monitors (a sleep disorder characterized by pauses in breathing or instances of shallow or infrequent breathing during sleep). The practice held a license for the use of a tablet device application used to test for memory problems independent of language or educational attainment allowing diagnosis of early dementia. This assisted the practice in providing early dementia diagnosis and to implement care and treat accordingly. The practice also purchased an ultrasound scanner and this improved diagnostic access for its patients. With this success and demand locally, this service was expanded over the last three to four years to offer ultrasonography to many of the other practices in adjacent areas. This is staffed and maintained in partnership with the local hospital trust. The practice had determined that the use of locally available enhanced diagnostic services had enabled them to make more accurate referrals into secondary care as well as improving patient access to these diagnostic tests.

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 practice was in the early stages of developing a virtual

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patient participation group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings and events. The practice had yet to develop a business plan. However this was forecast to take place with the newly appointed GP partner.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. The practice had 845 older patients registered at the practice. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice worked with staff at the local residential and nursing care homes where they had registered patients to ensure staff managed the ongoing care needs of these patients. We received positive feedback about the service provided by the practice from the three care homes.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The practice had 8,354 patients registered with long term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

The practice took a proactive approach to long term conditions (LTCs), reaching maximum points for the last two years on the Quality and Outcomes Framework (QOF). The QOF clinical domain results for the practice (2013 to 2014) were all above the local CCG and national averages. (The QOF clinical domain indicator groups include long term conditions such as diabetes and high blood pressure). Practice statistics demonstrated a generally high prevalence of chronic diseases which they informed us was a result of proactive management and coding of chronic disease historically.

A practice nurse led in diabetes and supported patients through to insulin initiation programmes but without the nurse prescribing element and collaboratively worked with the GPs who then prescribed according to the National Institute for Health and Care

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Excellence guidelines and best practice, enhancing the care available to diabetic patients within the practice. Any bloods or investigations required were ordered in advance of the review clinics.

The practice had funded enhanced diagnostic services for their patients such as a heel scanner for diagnosis of osteoporosis, clinical photography, dermoscopy (acts as an aid in the diagnosis of skin lesions), sleep apnoea monitors (a sleep disorder characterized by pauses in breathing or instances of shallow or infrequent breathing during sleep). The practice had purchased an ultrasound scanner and this had improved diagnostic access for its patients. The practice together with the local hospital trust now staffed and managed this diagnostic facility from the practice for its patients and for other local practices.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. The practice had 2,776 families, children and young people registered. There were systems in place to identify and follow 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 that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.Staff demonstrated a good understanding and were proactive in safeguarding and protecting children from the risk of harm or abuse. The practice had a clear means of identifying in records those children (together with their parents and siblings) who were subject to a child protection plan and who were in looked after conditions. They had undertaken a review of children at risk and liaised effectively with other agencies and health and social care professionals in minimising risk for those children and ensuring updated records were always available.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The practice had 1, 828 patients of working age. 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 that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. The practice had 288 patients whose circumstances may make them vulnerable. It had carried out annual health checks for people with a learning disability and all patients had received a follow-up. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice had 148 patients experiencing poor mental health. Of these patients 93% had a care plan in place and had received an annual physical health check. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months (April 2013 to March 2014) was 92.96% which was higher than the national average of 86.04%.

The practice provided an enhanced service with a view to facilitating timely diagnosis and support for people with dementia. The practice held a license for the use of a tablet device application used to test for memory problems independent of language or educational attainment allowing diagnosis of early dementia. This assisted the patients in providing early dementia diagnosis and in the implementation of care and treat accordingly.

The QOF clinical domain for dementia showed the practice had achieved 100%, all of the 26 points available, 5.1 percentage points above the CCG average and 6.6 above the national average The QOF clinical domain for mental health demonstrated that the practice had achieved 39.21 out of 40 points, which was 8.7 percentage

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points above the CCG average and 7.6 above the national average. The practice had 56 patients registered as living with dementia and at the time of the inspection 78.5% had an agreed care plan in place. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. The practice monitored patients with poor mental health according to clinical quality indicators and in line with good practice guidelines.

The practice sign-posted patients experiencing poor mental health to various support groups, and voluntary organisations, and were proactive in helping patients address issues to improve all aspects of their health.

The practice had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for patients with mental health needs and dementia. Cognitive Behaviour Therapy (CBT) counsellors attended the practice each week in order that patients who attended for counselling could be seen in familiar surroundings. The practice visited a local care home that provided support especially for patients who were experiencing poor mental health (including people with dementia). The care home staff told us the GP and practice provided a service that more than met their expectations.

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What people who use the service say

We spoke with eight patients during the inspection and received 26 completed Care Quality Commission (CQC) comments cards in total. All of the patients we spoke with said they were happy with the service they received.

The National GP patient survey January 2015 results for this practice found that 89% of patients who responded said the last GP they saw or spoke to was good at giving them enough time which was higher than the local CCG average of 85%. This was based on findings from the 121 surveys returned out of the 330 surveys sent out, giving a 37% completion rate. The survey found that 64% of respondents found it easy to get through to the practice by phone, which was lower than both the local Clinical Commissioning Group (CCG) average of 71% and the national average of 74%. The percentage of patients that would recommend their practice was 78% which was higher than the CCG average of 75%. Sixty-nine per cent of patients in the survey described their overall experience of this practice as good which was lower than the local CCG average of 74%.

The practice did not have a Patient Participation Group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The practice was in the process of setting up a virtual PPG and had 11 patients who were interested in taking part.

The position of the open reception desk within the waiting room made it difficult for confidential conversations to take place. Patients were aware they could ask to speak to the reception staff in another room if they wanted further privacy.

Patients we spoke with told us they were aware of chaperones being available during examinations. They told us staff were helpful and treated them with dignity and respect. We were told that the GPs, nurses and reception staff explained processes and procedures and were available for follow up help and advice. They were given printed information when this was appropriate.

Areas for improvement

Action the service SHOULD take to improve

Complete a written risk assessment on the emergency medicines not held as stock within the practice.

Complete an Infection and Prevention Control audit.

Consider the inclusion of practice nursing staff in clinical meetings and whole staff meetings.

Consider an evaluation of the additional services provided by the practice to its patients, in particular any impact on the delivery of patient care.

Outstanding practice

The practice funded enhanced diagnostic services for their patients such as a heel scanner for diagnosis of osteoporosis, clinical photography, dermoscopy (acts as an aid in the diagnosis of skin lesions), sleep apnoea monitors (a sleep disorder characterized by pauses in breathing or instances of shallow or infrequent breathing during sleep).This had improved diagnostic access for its patients.

The practice provided an enhanced service with a view to facilitating timely diagnosis and support for people with dementia. The practice held a license for the use of a tablet device application used to test for memory problems independent of language or educational attainment allowing diagnosis of early dementia and therefore in the implementation of care and treat accordingly.

The practice had purchased an ultrasound scanner and this had improved diagnostic access for its patients. The practice together with the local hospital trust now staffed and managed this diagnostic facility from the practice for its patients and for other local practices.

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Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP, a specialist advisor and an Expert by Experience. Experts by Experience are members of the inspection team who have received care and experienced treatments from a similar service.

Background to Charlton Medical Centre

Charlton Medical Centre is located in Telford, Shropshire. It is part of the NHS Telford and Wrekin Clinical Commissioning Group. The total practice patient population is 11,616.

The staff team currently comprises of three full time GP partners and three salaried GPs and a long term locum GP who works one day per week. There are three female and four male GPs who provide services which equate to five whole time equivalent GPs. The practice team includes three part time practice nurses and a healthcare assistant, a management team including the practice manager, secretaries, receptionists, administrators and cleaners. In total there are 33 staff employed either full or part time hours.

Charlton Medical Centre opening times are 8am to 6.30pm Monday to Friday. The practice doors open at 8.20am ready for morning consultations and at 1.40pm ready for afternoon consultations. The practice closes for lunch with assigned staff available to answer phone calls. The practice does not provide an out-of-hours service to its own patients but has alternative arrangements for patients to be seen when the practice is closed through Shropdoc the out-of-hours service provider. The practice telephones switch to the out of hours service at 6.30pm each weekday evening and at weekends and bank holidays.

The practice provides a number of clinics for example long-term condition management including asthma, diabetes and high blood pressure. It also offers child immunisations, minor surgery and travel vaccinations and is a certified Yellow Fever vaccination centre. The practice has an ultrasound scanner and associated equipment and provides an integrated in-house diagnostic ultrasound screening service with the local hospital trust, which offers easy access to diagnostics to local people in the community (both patients of the practice and for patients of several local practices). The service was instigated by one of the partners of the practice and started in 2009. The number of scans/sessions at the practice has increased and they now offer 80 ultrasound scans per week at the practice.

The practice works with the local visiting clinicians who offer weekly, audiology, diabetic eye screening, diabetic foot screening, diabetic dietician, counselling and cognitive behaviour therapy counselling, and a weekly blood taking service. The practice accesses care co-ordinator staff that provide case management and co-ordinated integrated care support which is a local CCG initiative.

The practice has a General Medical Services (GMS) contract with NHS England. This is a contract for the practice to deliver general medical services to the local community or communities. They also provide some enhanced services, for example they offer minor surgery and have Directed Enhanced Services, such as the childhood vaccination and immunisation scheme, facilitating timely diagnosis and support for patients with dementia.

Detailed findings

Why we carried out this inspection

We carried out 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

Prior to our inspection we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. This included NHS Shropshire Clinical Commissioning Group, Healthwatch and NHS England Area Team. Clinical Commissioning Groups (CCG) are groups of General Practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services. None of the organisations we contacted raised any concerns with us prior to the inspection.

We carried out an announced inspection on 1 July 2015. During our inspection we spoke with a range of staff including GPs, practice nurses, healthcare assistant, practice manager, reception and administration staff. We observed how patients were communicated with and how the practice supported patients with health promotion literature. We reviewed 26 CQC comment cards where patients and members of the public were invited to share their views and experiences of the service. The CQC comment cards had been made available to patients at Charlton Medical Centre prior to the inspection.

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, the GPs found that when prescribing some of the default doses on their electronic systems could be inaccurate. They actioned change within the practice which included; the removal of the incorrect dosing options within the electronic software, they completed a test patient software review and put in place measures to ensure that a medicines review appointment was always made after a patient started medicines. If the practice had not had the patients' medicine review arranged the default error may have gone on undetected until their next medication review.

We reviewed safety records, incident reports and minutes of meetings where these were discussed since 2013. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of four significant events that had occurred during the last 12 months and saw this system was followed appropriately. Significant events were a standing item on the partners and clinical practice meeting agendas, the outcomes were shared on the practice electronic systems with staff and meetings were held to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. We saw that incident records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared. For example, when a patient missed a telephone consultation, this was reported, reviewed and actioned for example all staff were reminded of current best practice and guidelines. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again. The practice had reported on an adverse event when the practice lift had broken down between the two floors with a patient in the lift at the time. Staff supported the patient, maintained their hydration, and stayed with them as a support through the event with a professional and calm manner. The call for repair to lift was promptly addressed. The practice wrote and sent flowers to the patient with apologies following this unforeseen event.

National patient safety alerts were disseminated by the practice electronic systems to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts, where relevant, were scanned into their electronic systems and saved in a specific folder for staff to access. Alerts were cascaded to appropriate staff following discussions at clinical or partners meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

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

The practice operated clear coding systems for all their electronic patient records. These were discussed at regular partner, clinical and management meetings to ensure the practice staff maintained a consistent approach in diagnostic coding, to enable them to provide a service that met the needs of their registered patients. All note summarising and clinical coding was undertaken by clinicians with partners summarising all new patient notes on a weekly basis. They found there was a relationship

between good clinical care and high quality clinical coding and note summaries this enabled them to provide accurate, timely coding which offered efficient, patient safety and in the long run would reduce the GPs' workload. They also maintained an up to date coding manual, accessible to all clinicians on their electronic on line library function.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had 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 subject to child protection plans. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority.

There was a chaperone policy, which was visible in the waiting rooms on the televisual noticeboard. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Chaperones at the practice had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). Chaperone staff had also undertaken chaperone training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

GPs used the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies, such as the police and social services. Staff were proactive in monitoring if children or vulnerable adults attended accident and emergency or missed appointments frequently. These were brought to the GPs attention, who then worked with other health and social care professionals.

Medicines management

We checked the medicines at the practice and found they were stored appropriately, securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

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.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. The GPs informed us that they rarely, if ever, used hand written prescriptions. Following a home visit the GPs returned to the practice and prescribed electronically to ensure the patient's medicine history, allergies and any medicine contra-indications could be fully explored. The medicines were dispensed according to the patient's choice of pharmacy. Future developments at the practice included electronic prescribing.

We saw records of the actions taken in response to reviews of prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice. All clinicians had access to a copy of the local prescribing guidelines and evidenced change in prescribing habits in line with the guidelines.

There was a system in place for the management of high risk medicines such as disease modifying drugs, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been

produced in line with legal requirements and national guidance. The lead partner had received regular training in Yellow Fever vaccinations. We saw sets of PGDs that had been updated in 2015. We saw evidence that nurses had received appropriate training and been assessed as competent to administer the medicines referred to under a PGD from the prescriber.

We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment such as disposable gloves were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. For example when dealing with spills of blood or bodily fluids. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice had a practice nurse 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. This staff member started this lead role in March 2015. All staff received induction training about infection control specific to their role and received annual updates. We did not see evidence that the practice had carried out an infection control audit since the Infection and Prevention and Control Team audit in 2013. The practice had demonstrated that any improvements identified for action were completed. We saw that the practice had completed an infection prevention and control risk assessment in 2015. The practice assured us that they would undertake an audit and implement any improvements accordingly.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings).

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was 2015. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it should follow when recruiting clinical and non-clinical staff. The practice had systems in place to ensure staff maintained their registration with the appropriate professional body and had a system in place to verify this information. The appropriate checks through the Disclosure and Barring Service had been completed for all staff. (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also 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. The practice manager showed us records to demonstrate that actual staffing levels and skill mix met planned staffing requirements. The practice patient list had grown and the practice manager and GP partners informed us they had plans to recruit another practice nurse.

Good

Are services safe?

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

The practice had a risk assessment policy for example in its disaster recovery documentation and plan document which identified risks related to the practice. The practice had completed a risk assessment table where specific risks related to the practice were documented. We saw that each risk was reviewed and mitigating actions recorded to reduce and manage the risk. We saw that where risks were identified that action plans had been put in place to address these. Risks associated with the service and staffing changes (both planned and unplanned) were included in the risk assessment. For example these included fire risk assessments and safety of medical electrical equipment.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, there were emergency processes in place for patients with long-term conditions; referrals made for patients whose health deteriorated suddenly and the practice monitored repeat prescribing for patients receiving medication for mental ill-health. Staff we spoke with told us that children were always provided with an on the day appointment if required.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. We found that the practice did not stock medicines used to treat suspected bacterial meningitis, nausea and vomiting, and for an epileptic fit. The partner GPs found that where they had stocked these medicines they had not been used and went out of date. The GPs had informally risk assessed that the practice did not need to stock these medicines due to the close proximity of secondary care support and the prompt ambulance response times when they attended the practice. Processes were 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.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact numbers and details of where the practice could relocate to in the event of the loss of the premises. The plan was last reviewed in June 2015.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were u

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that guidance from local commissioners was readily accessible in all the clinical and consulting rooms.

We discussed with the practice manager, GPs and nurses how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff. Staff gave us examples of recent updates for example on prescribing in diabetes. A practice nurse led in diabetes and supported patients through to insulin initiation programmes but without the nurse prescribing element and collaboratively worked with the GPs who then prescribed according to the National Institute for Health and Care Excellence guidelines and best practice, enhancing the care available to diabetic patients within the practice. We saw minutes of clinical meetings which showed changes in best practice was discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required.

The GPs told us they led in specialist clinical areas such as minor surgery and diabetes and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to review and discuss new best practice guidelines, for example, for the management of respiratory disorders.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

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

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and used to support the practice to carry out clinical audits.

The practice showed us five clinical audits that had been undertaken in the last 12 months. All of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, they completed an audit on the success of using a thread retriever as an effective method for intrauterine contraceptive device (IUCD) thread retrieval. IUCD is a method of contraception which is also known as 'the coil'. It sits inside the womb (uterus). The findings from the September 2012 to November 2013 audit were that this method had proved unsuccessful. A repeat audit was completed from November 2013 to October 2014. In the repeat audit however they used a different retrieval instrument. The results of the re-audit showed a dramatic improvement and achieved 75% success rate. This benefited patients that would have otherwise had to attend a family planning clinic at a later date for an attempt at retrieval and/or removal of IUCD.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes

Good

Are services effective?

(for example, treatment is effective)

framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example an audit was completed on the use of a specific medicine used in nausea and vomiting but The Medicine and Healthcare products Regulatory Agency (MHRA) advice was that it should no longer be used to treat other conditions such as heartburn, bloating or relief of stomach discomfort. This audit was completed in 2014 and re audited in May 2015. The re audit findings were that all prescribers had adhered to current best practice related to long-term use of the specific medicine.

Other examples included a minor surgical procedures audit. The findings were that there continued to be very low levels of post-operative infection or other complications in the minor surgery clinic. In addition no complaints had been received from patients relating to minor surgery in this time period. We saw that the infection rate was 2.2% of the 89 procedures carried out in 2012/13 and had improved even further to 0.89%for the 112 procedures carried out in 2013/14.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets. The practice had achieved 99.1% of the total QOF performance points available which was 5.5 percentage points above the local CCG average and 5.6 above the national average. For example the practice QOF results were higher than the national average in five of the six diabetes indicators and at the time of the inspection 84% of patients with diabetes had received an annual review.

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 on the outcomes being achieved and 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.

The practice's prescribing rates were also similar to national figures. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. We saw that 62% of patients on four or more repeat medicines had received a medication review in the last 12 months. They also checked 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 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.

We saw there was a system in place that identified patients at the end of their life and staff at the practice told us that they had 13 patients on the palliative care register. There were alerts within the clinical computer system making clinical staff aware of their additional needs. The practice held multidisciplinary meetings every eight weeks with other professionals involved in their care.

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups such as learning disabilities. Structured annual reviews were also undertaken for people with long term conditions. There were 92 patients on the practice's mental health register. Ninety-three percent had an agreed care plan in place. The practice also held a register of patients living with dementia; we found that 78.5% had an agreed care plan in place at the time of the inspection.

The practice participated in local benchmarking run by the CCG. 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 and in the majority of cases higher than other services in the area. For example, the practice had achieved 92.96% in the proportion of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months, which was 9.2 percentage points above the local CCG average and 7.1 above the national average. Cognitive Behaviour Therapy counsellors also attended the practice each week in order that patients who attended for counselling could be seen in familiar surroundings.

Good

Are services effective?

(for example, treatment is effective)

Effective staffing

Practice staffing included medical, 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, for example the management of long term conditions.

Practice nurses had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles such as seeing patients with long-term conditions such as asthma were also able to demonstrate that they had appropriate training to fulfil these roles.

The GP partners said that the salaried GPs had fixed working patterns that were not be altered at short notice and that any additional clinical or administrative work was done by the partners to avoid creeping demands being made on the salaried GPs. The salaried GPs felt support in their work.

The practice had a history of promoting staff from within the practice by supporting staff development and progression through learning and this was evidenced during the inspection.

The practice had policies in place to ensure that should poor performance be identified that appropriate action would be taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from these communications. Out-of-hours reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up.

The number of emergency hospital admissions for 19 ambulatory care sensitive conditions per 1,000 head of population between April 2013 and March 2014 was 14.63% which was in line with the national average of 14.4%. Ambulatory care sensitive conditions (ACSCs) are conditions where effective community care and case management can help prevent the need for hospital admission.

The practice held multidisciplinary team meetings every eight weeks to discuss patients with complex needs, 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. Care plans were in place for patients with complex needs and shared with other health and social care professionals as appropriate.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system in place with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. They also had a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services. A policy was in place of providing a printed copy of the patients summary care record to take with them should a patient be referred to hospital in an emergency.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients'

Good

Are services effective?

(for example, treatment is effective)

care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff. For example, with making do not attempt resuscitation orders. The policy also highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

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 patients' preferences for treatment and decisions. The percentage of patients diagnosed with dementia whose care had been reviewed in a face-to-face review in the preceding 12 months was 80%. The practice currently had 56 patients on their dementia register and 44 (78.5%) had an active care plan.

We found for example that there was a named GP for each care home. The practice had 24 patients in three local care homes and of these 95.8% had received a flu vaccination in 2014/15. There were 231 patients eligible for a shingles vaccination (as of September 2014) and the percentage uptake of the shingles vaccines was 61%.

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 the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, the practice scanned the patients consent form with their signature record which was documented in the electronic patient notes. This record also included discussion about the relevant risks, benefits and possible complications of the procedure. All staff were clear about when to obtain consent.

The practice had not needed to use restraint, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

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

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice monitored patients aged 75 or over with a fragility fracture who were treated with an appropriate bone-sparing agent and had achieved 94.44% when compared to the national average of 81.29%. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for the cervical screening programme was 81.94%, which was slightly above the national average of 81.89%. There was a policy to offer reminders for patients who did not attend for their cervical screening test. The practice nurses had responsibility for following up patients who did not attend. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

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 was above average for the majority of immunisations where comparative data was available. For example:

• Flu vaccination rates for the over 6 months to under 65 years in at risk groups was 54.4% and higher than the national average 52.29%.

Good

Are services effective?

(for example, treatment is effective)

• Childhood immunisation rates for the vaccinations given to under twos ranged from 80.6% to 100% and five year olds from 94.4% to 100%.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey published in January 2015

The evidence from all these sources showed patients were 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 who rated the practice as good or very good. The practice was also well above average for its satisfaction scores on consultations with GPs and nurses. For example:

• 89% said the GP was good at listening to them compared to the CCG average of 87% and national average of 89%.

• 89% said the GP gave them enough time compared to the CCG average of 85% and national average of 87%.

• 98% said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and national average of 95%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 26 completed cards and all, without exception were satisfied with the service experienced. Patients said they felt the practice offered a good service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with eight patients on the day of our inspection. All said the care provided by the practice was good and that their dignity and privacy was always respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. 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 / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The position of the open reception desk within the waiting room made it difficult for confidential conversations to take place. Staff that we spoke with were aware of the difficulties. Systems were in place to maintain patient's confidentiality, calls made to the practice initially went to a room located away from the reception desk, where reception staff where available to take the calls. The national GP survey published in January 2015 found that 89% of respondents found the receptionists at the practice helpful which was higher than both the local CCG average of 86% and national average of 87%.

Staff told us that 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 would investigate these and any learning identified would be shared with staff.

Patients could access the practice without fear of stigma or prejudice. Staff received specific customer care training and told us the training included how to deal sympathetically with all groups of patients.

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 well in these areas. For example:

• 84% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 83% and national average of 86%.

• 83% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 79% and national average of 82%.

The majority of patients we spoke with 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. The majority 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 positive and aligned with these views.

Good

Are services caring?

Staff told us that translation services were available for patients who did not have English as a first language. However, there were no notices in the waiting room reception areas informing patents this service was available.

The practice nurses and GPs ensured that all care home patients registered at the practice had up to date care plans. We saw evidence that these were in place and regularly reviewed. Patients living with dementia and their carers and/or advocates were involved in the development of their planned care, involvement in agreeing these and patients where appropriate were offered information about end of life care planning. The practice ensured they held at least every eight weeks multi-disciplinary meetings with other health and social care professionals for patients with complex needs, end of life care planning and for palliative care.

Patient/carer support to cope emotionally with care and treatment

The patient 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:

• 81% said the last GP they spoke to was good at treating them with care and concern which was slightly lower than both the local CCG average of 83%, and the national average of 85%.

• 89% said the last nurse they spoke to was good at treating them with care and concern which was slightly lower than the local CCG average of 91% and the national average of 90%.

The majority of patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices the patient waiting room and patient website also told patients how to access 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 that if families had suffered bereavement, they would be contacted by their usual GP. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Outstanding ☆

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 patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The GP and nursing team fitted in urgent patient appointments during their day and took time with patients to deliver health promotion and advice. The GPs and nurses supported each other as necessary to ensure the best possible service was given to patients.

The practice told us they engaged regularly with the NHS England Area Team and Clinical Commissioning Group (CCG) and other practices to discuss local needs and service improvements that needed to be prioritised. Clinical Commissioning Groups (CCG) are groups of General Practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

The local care homes the practice visited told us staff offered a compassionate and responsive service that met patients' needs.

The practice had funded enhanced diagnostic services for their patients such as a heel scanner for diagnosis of osteoporosis, clinical photography, dermoscopy (acts as an aid in the diagnosis of skin lesions) and, sleep apnoea monitors. (Sleep apnoea is a disorder characterized by pauses in breathing or instances of shallow or infrequent breathing during sleep.) The practice held a license for the use of a tablet device application used to test for memory problems independent of language or educational attainment allowing diagnosis of early dementia. The practice also purchased an ultrasound scanner and this improved diagnostic access for its patients. With this success and demand locally, this service was expanded over the last three to four years to offer ultrasonography to many of the other practices in adjacent areas. This is staffed and maintained in partnership with the local hospital trust. The practice had determined that the use of these enhanced diagnostic services had enabled them to make more accurate referrals into secondary care as well as improving patient access to these diagnostic tests.

The practice funded ambulatory blood pressure monitors, 24 hour electrocardiogram (ECG) equipment to record electrical activity of the heart to detect abnormal rhythms and the cause of chest pain.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities. There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

The practice actively supported patients who had been on long-term sick leave to return to work by referring them to other services such as physiotherapists, counselling services and by providing 'fit notes' for a phased or adapted return to work.

The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients.

The practice recognised the needs of different groups in the planning of its services. The practice first floor consulting rooms were accessible to all patients via a lift. The waiting area was able to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients. Facilities for patients with mobility difficulties included designated car parking spaces and adapted toilet facilities, baby change facilities were also available. A hearing loop for patients with a hearing impairment was available.

Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

Access to the service

The practice was open from 8am to 6.30pm Monday to Friday. 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 to ensure patients received

Are services responsive to people's needs?

(for example, to feedback?)

urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to three local care homes by a named GP to those patients who were assessed as requiring a home visit. However, it did not offer earlier or later opening times for working patients.

The patient survey information we reviewed showed patients responded to questions about access to appointments and rated the practice well in these areas. For example:

• 75% described their experience of making an appointment as good which was higher than both the local CCG average of 71% and national average of 74%.

• 70% were satisfied with the practice's opening hours, which was lower than both the local CCG average of 76% and national average of 76%.

• 80% said they usually waited 15 minutes or less after their appointment time which was better than both the local CCG average of 66% and the national average of 65%.

The majority of patients we spoke with were satisfied with the appointments system and said it was easy to use, with the exception of three patients. The January 2015 national patient survey found that 64% of respondents said they could get through easily to the surgery by phone which was lower than both the local CCG average of 71% and the national average of 74%. The patient views in the 26 CQC comments cards we received aligned with these views with three patients noting difficulty getting through to the practice by phone at times. The practice had produced a reflection and response document to their GP national patient survey results. This noted that they were working on the issues of patients finding it difficult to get through to the surgery on the phone with increasing staffing hours and promoting on-line services. The practice had increased the number of telephone consultations with the GPs and nurses as well as offering a 'sit and wait' urgent clinic from 4pm each weekday.

The practice had varied its triage systems over time in response to patient needs and the current system had been in operation since 2006. Patients under 50 years old without complex needs requiring on the day support were called back by the triage nurse who assessed their needs. The triage nurse dependant on the assessment findings decided if the patient required advice, a nurse appointment or a same day or routine appointment with the GP. The practice found this system best utilised the staff skill mix within the practice. Patients with complex needs and those over 50 years old were referred to the GPs. The practice demonstrated that the appointment system offered patients flexibility and choice and the waiting time for a pre-bookable appointment had been reduced. The GPs and staff informed us that if the routine appointment waiting time was increasing the GPs made extra appointments available. The practice doubled the number of appointment slots available for its triage on Mondays and post bank holiday weekends to meet a predictable increase in patient demand.

Patients confirmed that they could see a GP on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another GP if there was a wait to see the GP of their choice. Routine appointments were available for booking in advance. Comments received from patients also showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. Appointments were available outside of school hours for children and young people. An online booking system was available and easy to use, telephone consultations where appropriate and the practice offered support to enable patients to return to work.

The practice took account of patients whose circumstances may make them vulnerable by offering services to support them, for example, longer appointments for those that need them, flexible appointments such as avoiding booking appointments at busy times for patients who may find this stressful.

Listening and learning from concerns and complaints

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

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

person who handled all complaints in the practice. We saw that there was information on the practice website, in the waiting rooms and in the practice brochure which informed patients how to complain.

We looked at the complaints log with 10 complaints noted from February to November 2014 and four complaints from 2015. We saw they had been responded to and dealt with in a timely manner and found the practice demonstrated openness and transparency when dealing with complaints. We saw practice partner meeting minutes that demonstrated complaints were discussed and learning from them was shared with staff. This supported staff to learn and contribute to any improvement action that might have been required. We saw that lessons learned from individual complaints had been acted on.

Information contained in the complaint summary showed that an investigation had been carried out, that response letters were sent to patients, any trends to the complaints considered and reviewed and the issues discussed with staff involved. The report contained brief details of the complaint, the action to be taken to prevent reoccurrence, which included a review of clinical practice and policies and procedures where required and the outcome. The report also detailed the learning shared with all staff. We saw practice meeting minutes that demonstrated complaints were a regular agenda item. This supported staff to learn and contribute to any improvement action that might have been required.

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. The practice vision statement noted they strive for the highest possible standards of quality personal care in which patients are treated with dignity and respect, and in strict confidence. We found details of the vision and practice values were part of the practice's strategy. The GPs informed us that they had a new GP partner and a GP partner had retired. They had delayed formulating their business plan until the new partner had settled into their role. The partners met on a weekly basis usually in the early morning, not in their clinical time, to discuss business matters.

The practice were aware of the challenges facing the practice and had invested time in considering the most appropriate future developments to improve the practice for patients and staff, for example electronic prescribing due to start in August 2015. The practice list size had been increasing and they had changed their systems to work more efficiently to meet the increase in demand without impact on the service delivered to patients. The practice thoughts included for example, closer working in large groups with other local practices to consider the workload and workforce issues locally and voiced their awareness of the likely challenges ahead.

We spoke with 10 members of staff. We found that staff knew and understood the vision and values for the development of the practice. Staff knew what their responsibilities were in relation to these and had been involved in developing them.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at eight of these policies and procedures and staff confirmed that they were asked to read any updated policies and on their training induction. The practice manager informed us that policies and procedures were reviewed annually unless otherwise stated.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a GP was the lead for safeguarding. We spoke with 10 members of staff and they were all clear about their own roles and responsibilities. They told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The GPs and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. This included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was a high performing practice. We saw that QOF data was regularly discussed at their weekly meetings and should improvements be required action plans would be produced to maintain or improve outcomes.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented, for example in respect to improvements to the premises. The practice monitored risks on a monthly basis to identify any areas that needed addressing.

We looked at minutes from the partner and clinical meetings and management meetings and found that performance, quality and risks had been discussed.

The practice manager and GP partners were responsible for human resource policies and procedures. The practice had clear awareness of workforce succession planning. We reviewed a number of policies, (for example disciplinary procedures, induction policy, and management of sickness) which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew

Are services well-led?

Good

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

where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice.

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us they were approachable and always took the time to listen to all members of staff. All staff were involved in discussions about how to run the practice and how to develop the practice: the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. Staff said they felt respected, highly valued and supported, particularly by the partners in the practice. The practice did not hold whole staff meetings or involve practice nurses in the clinical meetings. Staff however found that the information disseminated to staff groups following meetings held was sufficient and all were able to demonstrate their ability to add to the various meeting agendas and received feedback on issues raised. The practice manager said that the nurses had been invited to attend meetings and there were plans in place for a practice nurse to attend in the future.

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

The practice team encouraged and valued feedback from patients. It had gathered feedback from patients through in house and national surveys and complaints received. It was in the process of recruiting for a Patient Participation Group, but suggested that there had initially been very little interest. The practice manager said that there were now 11 patients interested in being a part of their virtual PPG.

We also saw evidence that the practice had reviewed its results from the national GP survey to see if there were any areas that needed addressing. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice. The practice had produced a reflection and response to their GP national patient survey results. The practice noted they were working on the issue of patients finding it difficult to get through to the practice on the phone by increasing staffing hours and promoting on-line services. The nurse triage was available every weekday morning and afternoon and the practice had increased the number of telephone consultations with the GPs and nurses as well as offering a 'sit and wait' urgent clinic from 4pm each weekday.

The practice had also gathered feedback from staff through staff meetings, training days, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

We found that the practice did not arrange whole staff meeting as they had found it problematic to arrange this with 33 staff working a variety of hours. All staff had the opportunity to add to meeting agendas and we saw for example that the reception manager maintained a log of these items to take to the meetings. Staff told us they received feedback in the form of emailed minutes and if they required further information they could discuss this further with the management team including the practice manager and GPs. All staff we spoke with were happy with these arrangements. We found that the clinical staff meetings had not included the practice nurses. The practice manager informed us they had recently suggested a nurse representative attends the meetings and this was verified by the nurses.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four 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 that they had staff away days where guest speakers and trainers attended. The practice had a history of promoting staff from within the practice by supporting staff development and progression through learning and this was evidenced during the inspection.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients.