The Willows 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?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We inspected this service on 6 January 2015 as part of our new comprehensive inspection programme.

The overall rating for this practice is good. We found the practice to be good in all areas. We found the practice provided good care to all of their population groups including older people, patients with long term conditions, families, children and young people, working age people (including those recently retired and students), people whose circumstances may make them vulnerable and people experiencing poor mental health, including dementia.

Our key findings were as follows:

- Patients were kept safe because there were arrangements in place for staff to report and learn from key safety risks. The practice had a system in place for reporting, recording and monitoring significant events over time.
- There were robust recruitment systems in place to ensure the safety of patients.
- Patients' needs were assessed and care was planned and delivered in line with current legislation.
- Patients were extremely satisfied with how they were treated and felt that staff treated them with kindness, dignity and respect.
- There was a transparent and inclusive culture at the practice which encouraged contributions from staff and patients in the development of the service.

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 people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were mostly in line for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and planned. The practice could identify all appraisals and the personal development plans for all staff. Staff worked well within multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. Staff treated patients with kindness and maintained confidentiality. Patients who had experienced bereavement were supported to access other support services. The practice was committed to supporting and being involved in the local community and participated in local fundraising initiatives such as raising money for testicular cancer or Macmillan cancer care. The practice co-ordinated patients' reviews with their carer and telephoned them rather than send a letter to arrange a mutually convenient time for the review. This demonstrated a caring approach and recognition of the pressures that carers may have particularly when having to deliver full time care.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure

Summary of findings

improvements to services where these were identified. Patients said that overall, they found it easy to make an appointment with a named GP, and that there was continuity of care, with most urgent appointments available the same day.

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 with staff and other stakeholders took place.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff understood 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 upon. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were satisfactory for conditions commonly found in older people such as diabetes. 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. Home visits were offered for older people who were house bound and rapid access appointments for those with enhanced needs.

The practice had signed up to be part of the Dementia Friends initiative and staff had attended additional training to become Dementia Champions and to promote dementia awareness within the local community

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. All patients with a high level of need had a named GP and a structured annual review to check that their health and medicine 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. All patients with a long term condition had a care plan and there was a robust recall system in place.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. 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. We saw that the practice proactively worked with midwives, health visitors and district nurses to provide joined up services for patients.

The practice had plans in place to promote the services at the practice through social media websites in order to reach the younger element of the population.

Summary of findings

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 adjusted the services it offered to ensure that they were accessible, flexible and offered continuity of care for this population group. The practice was proactive in offering online appointments, extended hours and repeat prescription services as well as a full range of health promotion and screening that reflected the needs of 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 those with a learning disability. Annual health checks had been completed for patients with a learning disability and most of these patients had received a follow-up. The practice offered longer appointments for these patients.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health and carried out advance care planning for patients with dementia. Patients were referred for counselling, cognitive behavioural therapy and support in times of mental health crisis.

Summary of findings

What people who use the service say

We reviewed 27 patient comments cards from our Care Quality Commission (CQC) comments box that had been placed in the practice prior to our inspection. We saw that all comments were extremely positive. Patients told us that all of the staff, including the receptionists were always helpful, respectful and treated them in a dignified and caring manner. They said the nurse and doctors listened to them and they did not feel rushed. They confirmed that they were involved in decisions about their care. Patients told us that the practice was always clean and tidy. Two patients told us that they sometimes had problems getting an appointment.

The results from the National Patient Survey 2014 showed that 91% of patients (above local average) felt that their overall experience of the practice was good. The practice, in conjunction with the patient participation group had carried out annual surveys to assess patient satisfaction. PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care for patients. We saw that action plans, a newsletter and a PPG noticeboard were developed as a result of patient feedback.

The Willows Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to The Willows Medical Centre

The Willows Medical Centre is located in a purpose built primary care medical centre. It is situated in Carlton, Nottingham and serves the local population by providing general practitioner services.

The practice has one permanent male GP and two locum GPs, (one male and one female), a practice manager, a practice nurse, a senior receptionist, a health care assistant and administration and reception staff. There are 3700 patients registered with the practice. The practice is open from 8am to 6.30pm Monday and Friday, Tuesday 7.30am - 6.30pm, Wednesday 8am - 7.30pm and Thursday 8am - 1pm.

The practice treats patients of all ages and provides a range of medical services. This includes a number of services such as reviews for asthma, diabetes and chronic obstructive pulmonary disease (COPD). It also offers child immunisations, contraception advice and travel health vaccines. The majority of patients who use the practice are aged between 19 and 65 years of age.

The Willows Medical Centre 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.

Why we carried out this inspection

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

This provider had been inspected in June 2014 and August 2014. We found that there was a minor non-compliance in relation to recruitment of staff which had been addressed.

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

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?

Detailed findings

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

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

Before carrying out our inspection, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 6 January 2015. During our visit we spoke with a range of staff, the lead GP, one practice nurse, the practice manager, the senior receptionist, the healthcare assistant and a receptionist. We reviewed 27 comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, 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. One member of staff gave us an example of a recent incident in relation to cervical screening and test results. We saw that this had been escalated as a significant event and managed appropriately.

We reviewed safety records, incident reports and minutes of meetings over a 12 month period which showed that safety incidents were discussed and monitored regularly. This showed that the practice had managed these consistently over time and could show evidence of a safe track record over the year.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last 12 months and we were able to review these. We saw that significant events were discussed at weekly practice meetings and effective action plans were put in place when required. There was evidence that the practice had learned from these events and that the findings were shared with relevant staff. We also saw evidence that the actions identified for learning or improvement, as a result of individual significant events, were completed. Staff, including receptionists knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. The lead GP confirmed that the significant events were also reviewed annually.

National patient safety alerts were disseminated by the practice nurse 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 told us alerts were discussed at practice meetings and recorded to ensure that all staff were aware of those 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 vulnerable children, young people and adults. We saw that a significant amount of information had been sourced by the practice to support the GPs and staff within the practice. This included details about the Mental Capacity Act 2004, the Deprivation of Liberty Safeguards (DoLS) guidance and safeguarding vulnerable children and adults. We looked at training records which showed that all staff had received specific training in safeguarding children and vulnerable adults. For example we saw that the lead practice nurse had received level three (advanced) training in safeguarding vulnerable children. Staff we spoke with confirmed they knew how to recognise signs of abuse in older people, vulnerable adults and children.

We saw that the practice had completed a safeguarding audit in September 2014 to establish the effectiveness of the safeguarding processes within the practice. This included checking staff knowledge and awareness of safeguarding issues and the referral process. We saw that regular newsletters were sent to the practice from the Nottingham Safeguarding Board and were shared with staff. We also saw information provided by the Clinical Commissioning Group (CCG) for GP practices in relation to safeguarding children. This information dated July 2014 identified a trilogy of risk for GPs and staff to be aware of and the action to take to reduce the risk.

The practice had a lead GP for safeguarding vulnerable adults and children. We saw that the lead GP had received advanced level three training in safeguarding children and training in safeguarding vulnerable adults. We found that they could demonstrate how this training had supported them to fulfil this role. All staff we spoke with were aware of who the lead was and who to speak with in the practice if they had a safeguarding concern. We saw that the practice had a safeguarding policy which included details of how the practice should refer any suspicion, concern or allegation of abuse without delay.

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 and carers. We also saw records which showed that the practice held monthly safeguarding meetings with a health visitor and local school nurse to discuss children and families at risk.

There was a chaperone policy, which was visible in the waiting room and in consulting rooms. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during an intimate or personal medical examination or procedure. We found that staff we spoke with had not received the relevant training to be a chaperone and did not clearly understand their responsibilities when acting as a chaperone. This included where to stand to be able to observe the examination. Within a day of the inspection, the practice manager had redesigned the chaperone policy, sent a staff memo informing them of the changes in the policy and arranged training for the staff. This information was sent to us. The policy was seen to include visual aids to enable staff to be clear about their responsibilities as a chaperone. It also included the names of the staff that had been designated as chaperones at the practice.

We saw that GPs were appropriately using 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 GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures which described the action to take in the event of a potential failure. The practice staff followed the policy and could explain the process for maintaining medicines at the required temperatures.

Processes were in place to check medicines were within their expiry date and suitable for use. We looked at three medicines and found that they were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. We checked to see if any medicine management audits had been carried out and discussed this with the practice nurse. They confirmed and records showed that audits were carried out regularly. For example in October 2014 an audit on vaccine storage had been carried out including checking staff knowledge. We found that all areas were satisfactory.

The practice nurse administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up to date copies of both sets of directions and evidence that nurses had received appropriate training to administer vaccines. They told us that they received regular supervision and support in their role from the GP, practice manager and other staff.

All prescriptions were reviewed and signed by a GP before they were given to the patient. We found that blank prescription forms were kept securely at all times. We found that the system for managing, storing and issuing of prescriptions was robust and in line with national best practice guidelines.

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 and written patient feedback in comment cards told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice's infection control policy. We saw that the induction programme for all new staff included training on infection prevention and control. All staff had received infection control training and had annual training updates. We saw an infection control audit had been carried out by the Clinical Commissioning Group (CCG) in January 2014 at the practice and a re-audit to establish progress made in July 2014. We saw that an action plan had been developed to address any areas for improvement and the practice was in process of completing this.

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 was available for staff to use, including disposable gloves, aprons and coverings for couches. Staff were able to describe how they would use these to comply with the practice's infection control policy, for example when dealing with the disposal of sharps (needles) safely.

Good

Are services safe?

Notices about hand hygiene techniques were displayed in various locations around the practice. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. We saw that there was a need to improve infection control procedures in non-patient areas such as staff toilets, for example notices about hand hygiene techniques.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

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. A schedule of testing was in place. We saw evidence that calibration of relevant equipment; for example, weighing scales had been completed in 2014.

Staffing and recruitment

Staff records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment for all new employees including GP locums. For example proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. At previous inspections in August and September 2014 we found that the practice did not always follow this process and appropriate checks had not been carried out for all staff. At this inspection we found that there were improvements in this area and all relevant employment checks had been carried out for all staff, including locums to maintain the protection and safety of the patients.

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 that there was a rota system in place for all the different staffing groups to ensure that there was enough staff 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. We saw records which demonstrated that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice, such as medicines management and staffing. We saw records of reviews of staffing levels and the skill mix of staff to ensure that patients received safe care and treatment at all times, particularly in times of higher demand such as winter periods. Identified risks were included on a risk assessment file. We saw that each risk was assessed and rated and control measures identified, for example building checks and control of substances hazardous to health (COSHH). We saw that risks were discussed at practice and team meetings. For example, the findings from the infection control audit carried out by the Clinical Commissioning Group (CCG) were shared with staff.

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 we saw evidence of how staff had recently responded to a medical emergency for a person who was a refugee. Staff were also able to give examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment.

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 to attempt to restart a person's heart in an emergency). Staff we spoke with knew where to access the emergency equipment if required and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of an anaphylactic shock (allergic

Good

Are services safe?

reaction) and hypoglycaemia (low blood sugar). Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that could impact on the daily operation of the practice. Risks identified included a loss of the computer or telephone systems, loss of electricity or gas.

We saw that the document identified the steps that must be taken to reduce or manage each risk. The document also contained relevant contact details for staff to refer to, for example suppliers of essential supplies.

We saw that the practice had carried out a fire risk assessment which included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP 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 told us that they received up to date guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of clinical team meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. We found from our discussions with the GP and the practice nurse that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

We looked at data produced by the Clinical Commissioning Group (CCG) of the practice's performance for antibiotic prescribing, which was lower than the CCG average. This demonstrated that the practice was proactive in monitoring the prescribing of antibiotics.

The GP we spoke with used national standards for the referral of patients with suspected cancers to be referred and seen within two weeks. The two week cancer referral process was seen to be managed by one member of staff who monitored the process of referral until a definite appointment had been arranged for the patient. This showed that the process was actively managed. The staff member responsible for this confirmed that all requests for patients to have an appointment in two weeks had been met.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with the lead GP and other staff showed that the culture in the practice was that patients were referred on need and that age, sex and ethnicity was not taken into account in this decision-making process.

Management, monitoring and improving outcomes for people

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 and discussed at practice meetings to support the practice to carry out clinical audits.

The GP told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes 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. Following the audits, the findings were shared with relevant staff and actions taken to address any identified improvements.

The practice showed us a number of clinical audits that had been undertaken since January 2014. We looked at two of these in detail and found that the practice was able to demonstrate the positive changes and outcomes resulting since the initial audit. For example one audit was carried out to review the prescription of anti-depressant medicines within the practice. This was done specifically to establish if the practice was compliant with local and national guidelines on prescribing these medicines and to determine if all patients diagnosed with depression had access to talking therapies/cognitive behavioural therapies at the time of presentation. The completed audit demonstrated that the practice had almost met its set criteria for prescribing a first line anti-depressant to all patients who presented with depression at first presentation. It also concluded that the GPs in the practice should continue to offer psychological therapies to enable patients with depression to benefit from this form of treatment. A follow up audit had been planned for the following year to assess the improvements made for this group of patients.

Another audit had been completed in relation to improving outcomes for patients with chronic obstructive pulmonary disease (lung disease) and to check if medicines for these patients were in line with the local Clinical Commissioning Group's (CCG) guidelines. We saw that one of the changes proposed as a result of this audit was for all new guidelines received by the practice to be discussed at weekly clinical meetings. This was to ensure that all clinicians were aware of the new changes and to identify any potential medicine changes which may affect the patients.

Good

Are services effective?

(for example, treatment is effective)

We saw that the practice used the information collected for the quality and outcomes framework (QOF) and performance against national screening programmes to monitor outcomes for patients. 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, we saw that 100% of patients with dementia registered at the practice had received an annual medicine review which was significantly higher than the national average of 84%.

The team was making use of clinical audit tools, clinical supervision and mentoring, 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 and the associated learning from these.

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

The practice had a palliative care register and had monthly meetings with multidisciplinary teams to discuss the care and support needs of those patients at end of life and their families.

The practice also 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 generally delivered outcomes that were comparable to other services in the area.

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 had 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).

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 one member of staff was in the process of completing a course to carry out phlebotomy services (collection of blood samples) for patients at the practice.

The practice nurse was expected to perform defined duties and was able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology (examination of tissue cells from the body). We were also shown evidence of other appropriate training that had been completed by the practice nurse, for example diabetes to support patients with this long term condition.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. 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 GP checked all of the test results and x rays, discharge summaries and allocated them to the relevant staff member to deal with. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs. These meetings were attended by a variety of professionals including palliative care nurses and district nurses. Decisions about care

Good

Are services effective?

(for example, treatment is effective)

planning were documented in a shared care record. Staff told us that these were useful as a means of sharing important information and to ensure that complex patients received joined up care and treatment.

Information sharing

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

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system and we saw that it scanned paper communications, such as those from hospital which were saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. We saw that all staff had access to a range of information in relation to mental capacity. Mental capacity is the ability to make an informed decision based on understanding a given situation, the options available and the consequences of the decision. People may lose the capacity to make some decisions through illness or disability.

We found that there were mechanisms to seek, record and review consent decisions. We saw evidence that patients had given written consent for minor surgery procedures.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions.

Health promotion and prevention

The practice had met with the CCG to discuss the implications and share information about the needs of the practice population. This information was used to help focus health promotion activity at the practice.

The practice was currently looking to develop their out of hour's services within the CCG area. The CCG group had signed up for the prime minister's challenge fund for out of hours services across the CCG. This involved a number of trial projects testing ideas for improving patient access to general practice services and to reduce the number of patients attending the accident and emergency department.

It was practice policy to offer a health check with the practice nurse or the healthcare assistant 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 clinicians to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering weight management advice where relevant.

The practice also offered NHS Health Checks to all its patients aged 40-75 years of age. The NHS Health Check programme was designed to identify patients at risk of developing diseases including heart and kidney disease, stroke and diabetes over the next 10 years. GPs and clinical staff showed us how patients were proactively followed up if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability who were offered more time for their annual physical health check both with the nurse and with the GP if required. The practice was also registered as a Safe Haven Centre for any people with a learning disability, not just patients, so that they could access the practice if they felt confused or stressed at any time.

Up to date care plans were in place that were shared with other providers such as the out-of-hours provider and with multidisciplinary case management teams. Patients aged 75 or over and patients with long term conditions were provided with a named GP.

Good

Are services effective?

(for example, treatment is effective)

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

We saw that a range of health promotion leaflets were available in the waiting room, treatment rooms and on the practice's website. Clinical staff we spoke with confirmed that health promotion information was available for all patients. They told us that they discussed health issues such as smoking and weight management with patients when they carried out routine checks with patients. Staff confirmed that patients were given information to access other services as was needed, such as Cruse, the national bereavement service.

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 and a survey of patients undertaken by the practice in conjunction with the patient participation group (PPG) in 2013. PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care for patients. The evidence from these sources showed patients were satisfied with how they were treated and that they were treated with compassion, dignity and respect.

Feedback from patients in the national patient survey carried out in 2014 showed that the practice was above average in some areas and needed to make some improvements in others. For example 91% of practice respondents said that the last GP they saw or spoke with was good at treating them with care and concern (above the local Clinical Commissioning Group (CCG) average), 87% said the GP was good at listening to them (slightly below CCG average of 88%), 86% said the nurse gave them enough time (above CCG average) and 74% would recommend the surgery to someone new to the area (below CCG average of 79%). We saw that the practice was aware of the areas for improvement and had already taken action to address these which had begun to have a positive impact.

Patients were invited to complete CQC comment cards to tell us what they thought about the practice. We received 27 completed cards and all the feedback from patients was positive about the service that they experienced. Patients said that staff were helpful, kind and compassionate. One patient said that the practice provided an excellent, all round service. Four patients said that they felt staff took time to listen to them and all patients said that staff treated them with dignity and respect. Two patients commented that it was sometimes difficult to get an appointment. Five patients that we spoke with on the day of the inspection were extremely positive about the staff and the service they experienced at the practice.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. We saw this system in operation during our inspection. Staff told us that they informed patients that a 'confidentiality' room was available for them if they needed to speak to a member of staff privately.

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 told us they would investigate all instances of this type and any learning identified would be shared with staff.

The practice was extremely committed to supporting and being involved in the local community such as raising money for testicular cancer or Macmillan cancer care for example by holding a cake sale or other initiatives. It was also able to demonstrate a number of examples of being compassionate and empathetic towards vulnerable members of the community and patients. One example of this was that the practice had registered as a Safe Haven Centre for people with a learning disability as this had been identified as a need locally. The practice had a yellow sign on the outside of the main door to the practice which identified it as a place where people with a learning disability, not just registered patients, could go if they felt agitated, anxious or confused and they would receive the support they needed. Staff had received specific training on how to support people with a learning disability in this situation. Each person with a learning disability had a 'passport' which provided contact details of their carers for staff to call. Staff knew how to calm the person in these situations rather than escalate it, which was a more positive outcome for them and their carer.

The practice also held a 'Winter Watch Register'. This included details of older patients who were vulnerable, lived alone and had been identified as being particularly at risk in cold weather. The practice proactively contacted these patients by telephone to check on their health and

well-being and worked with the pharmacy on their behalf to enable them to access their medicines. The practice had a winter leaflet which included advice for these patients on how to keep well and warm during the winter season.

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

Care planning and involvement in decisions about care and treatment

We checked to see how patients felt about their involvement in planning and making decisions about their care and treatment. For example, data from the 2014 national patient survey showed 76% of practice respondents said that the GP involved them in care decisions and 86% felt the GP was good at explaining treatment and results.

All of the patients we spoke with on the day of our inspection told us that the GPs and nurses discussed their health issues with them and they felt involved in decision making about the care and treatment they received. They 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.

We found that the GP and staff we spoke with demonstrated their knowledge about best interest decisions for patients who lacked capacity. They told us that patients were always encouraged to be involved in the decision making process and obtained their agreement for any treatment or intervention even if the patient attended with a carer or relative. We saw that older patients who had been identified as at risk of hospital admission and patients with a long term condition were also involved in the development of their own care plan and invited for regular health reviews.

Staff told us that translation and interpreting services were available for patients who did not have English as a first language. This ensured that all patients could understand and be involved in decisions about their care and treatment. We also found that four staff at the practice spoke a number of different languages including Shona (an African language), Urdu and Punjabi.

Patient/carer support to cope emotionally with care and treatment

Four of the patients we spoke with on the day of our inspection and comments seen in the CQC comment cards we received confirmed that patients felt staff responded compassionately when they needed help and provided support when required. Notices in the patient waiting room and patient website also told patients how to access a number of support groups and organisations.

We saw that the practice was proactive in the support of carers and had begun to develop strong links with the local carer's organisation to improve support and services for carers, particularly young carers. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. The practice's computer system alerted GPs if a patient was a carer. The practice co-ordinated patient's reviews with their carer and telephoned them rather than send a letter to arrange a mutually convenient time for the review. This demonstrated a caring approach and recognition of the pressures that carers may have particularly when having to deliver full time care.

The practice manager told us about an initiative they were involved in to support their patients with dementia and their carers. The Alzheimer's Society had set up the Dementia Friends initiative to help people with dementia to feel understood and included in their community. The practice had signed up to be part of this initiative and staff had become Dementia Friends in their community after attending a training course and receiving on-going support. Staff who had registered for this told us that they were promoting dementia awareness within the local community and were going to hold a weight loss challenge later in the year to raise funds for people with dementia.

We spoke with a patient who told us that the GP and other staff at the practice had been extremely supportive following a family bereavement. Other patients confirmed that they had received this type of support and said they had found it helpful. Staff at the practice confirmed that referrals were made for relevant patients to receive for bereavement support at the local hospital where appropriate.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The NHS Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. For example in relation to reducing the number of referrals made and to improve the cost of the service.

We saw there was a system in place that ensured patients with long term conditions such as asthma and diabetes received regular health reviews. Clinical staff told us they carried out regular and routine blood tests for patients with diabetes. They explained they also used these sessions to give advice and support for patients on how to manage their conditions. Longer appointments were available for patients who needed them such as patients with mental health concerns, learning disabilities and long-term conditions.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care for patients. For example the PPG had highlighted the need for the practice to be available for patients on five days per week and to have a late evening clinic. The practice had taken on board these comments and had put these improvements into place.

Tackling inequality and promoting equality

The practice proactively removed any barriers that some people faced in accessing or using the service. Staff we spoke with told us they would arrange for an interpreter if required and that information could also be translated by GPs at the practice. There was a female GP who worked at the practice and was able to support patients who preferred to have a female doctor. This also reduced any barriers to care and supported the equality and diversity needs of the patients.

The practice had recognised the needs of different groups in the planning of its services. For example, staff told us about services they provided for patients with a learning disability and refugees. We saw that the practice supported patients who may be living in vulnerable circumstances, such as those who were homeless. Staff confirmed that people with "no fixed abode" were allowed to use the practice's address in order to register for NHS services with them.

The practice website offered a facility for patients who first language was not English to translate information into different languages. The practice also provided an interpreter service and four languages were spoken by staff at the practice.

The practice was situated on the first and second floors of the building with all services for patients on the ground floor. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. There was a hearing loop facility in the waiting area for those with hearing difficulties. We saw that there were ample car parking spaces adjacent to the practice including one for those with mobility problems. We saw that there were also accessible toilet facilities for all patients attending the practice.

Access to the service

Appointments were available from 8am to 6.30pm Monday and Friday, Tuesday 7.30am - 6.30pm, Wednesday 8am - 7.30pm and Thursday 8am - 1pm. We saw that there had been a number of audits in relation to the appointment and telephone systems to test their effectiveness and we were told that there was on-going monitoring in place.

Information was available to patients about appointments in the practice leaflet and on the practice website. This included how to arrange urgent appointments, home visits and how to book appointments on line through the practice website. The practice had also introduced a new phone triage service where patients with particular health issues could speak to a nurse or GP rather than access an urgent appointment. There were also arrangements to

Good

Are services responsive to people's needs?

(for example, to feedback?)

ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, they were connected to the out-of-hours service.

Longer appointments were also available for people who needed them and those with long-term conditions. Home visits were available for patients who were too ill to attend the practice for appointments. Home visits were made routinely to the local care home by one of the practice nurses who also carried out home visits to support patients to have routine blood tests if needed. The practice was in the process of working with the care home staff to develop a more formal arrangement for the GPs to review the patients at the home each week.

Patients were generally satisfied with the appointments system. Patient feedback in the annual survey and patients we spoke with on the day of the inspection said that they could see a doctor on the same day if they needed to. They could see another doctor if there was a wait to see the doctor of their choice. Two patients told us that they had a problem getting a same day appointment.

The practice's extended opening hours was particularly useful to patients with work commitments. This was confirmed by patients we spoke with from the working age population. The practice had an online booking system which was easy to use and they provided text message reminders to patients for their appointments. Staff told us that there were future plans to promote the services at the practice through social media websites in order to reach the younger element of the population.

We saw that the practice had introduced an online prescription request service for patients and an electronic prescription service which allowed prescriptions to be sent electronically to the pharmacy making it easier for patients to have their medicines dispensed.

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. The practice manager was the designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. For example, detail about how to make a complaint was on the practice website. We did not see any information on how to make a complaint in the waiting area of the practice for patients or complaint forms readily available for patients. Patients were provided with a complaints leaflet from reception on request. The practice manager took action to address this the day after the inspection and sent a completed action plan to us in relation to this. Patients we spoke with were aware of the process to follow if they wished to make a complaint although none of them had felt it was necessary to ever make a complaint.

We looked at four complaints received in the last 12 months and found that these were satisfactorily handled and dealt with in a timely way. The practice reviewed complaints annually to detect themes or trends. We looked at the summary report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on. We found evidence of shared learning from complaints with staff. Minutes seen of team meetings showed that complaints were discussed to ensure all staff were able to learn and contribute to determining any improvement action that might be 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 'work in partnership with our patients and staff to provide the best possible Primary Care services working within local and national governance structures'. We found details of the vision, mission statement and practice core values were part of the practice's business strategy for the future. The practice mission statement was 'to improve the health, wellbeing and lives of our patients' and the practice had identified that this would be underpinned by core values of fairness, openness, respect and accountability. Key aims and objectives included working in partnership with patients, their families and carers to provide a positive experience and understanding; to involve them in decision making about their treatment and care; focussing on the prevention of disease by promoting health and wellbeing by offering care and advice to patients and to ensure all staff have the competency and motivation to deliver the required standards of care, ensuring that all members of the team have the required skills and training to carry out their duties competently.

We spoke with six members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. They told us there was an open culture within the practice and that their views were listened to, respected and acted on.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff in individual information files for them and on the computer within the practice. We looked at six of these policies and procedures and saw that they were regularly reviewed and updated. Staff told us that they had read those that were appropriate for them and understood them.

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 one of the GPs was the lead for prescribing. All staff we spoke with were clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF is a scheme which rewards practices for providing quality care and helps to fund further improvements. The QOF data for this practice showed it was performing above national standards by obtaining 97.8 QOF points out a possible 100. We saw that QOF data was regularly discussed at monthly practice meetings and action plans were produced to maintain or improve outcomes. For example the practice had been working with the community pharmacist to improve the cost effectiveness of their prescribing activity. Staff confirmed that this had been highly successful and the practice had remained within its prescribing budget for the last eight years.

We saw that performance data was regularly discussed at weekly practice meetings and action plans were produced to maintain or improve outcomes. We found there was a culture of transparency at the practice and a constant review and audit of working processes and change being undertaken to ensure the most effective and efficient working.

Leadership, openness and transparency

There was a clear and visible leadership and management structure in place. Staff told us that there was a positive culture and focus on quality at the practice. We saw examples where staff had been supported and encouraged to develop their skills through discussions at team meetings and through individual appraisals. All staff we spoke with confirmed that there was an open and transparent culture of leadership which encouraged team working. The lead GP confirmed that there was a 'no blame' culture in the practice and staff were encouraged to work to their strengths and support each other.

Staff told us that the practice was well led. We saw that there was strong leadership within the practice and the senior management team was visible and accessible. Records showed that regular staff and clinical meetings took place at the practice. The practice manager told us that they met weekly with the lead GP and other senior management. They confirmed that information from those meetings was shared with staff. Staff told us that the GP, practice manager and other senior staff were very supportive.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example a recruitment policy and an induction policy which were in place to support staff. Staff we spoke with knew where to find these policies if required.

Are services well-led?

Good

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

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. We saw a number of examples which demonstrated that the practice listened to the views of patient feedback and took action to make any required improvements. The practice had an active patient participation group (PPG) which met every quarter and carried out annual patient satisfaction surveys in conjunction with the practice. PPGs are an effective way for patients and GP practices to work together to promote and improve the quality of care patients receive. We spoke with the chair of the group on the day of our inspection who told us that the group was listened to and worked well with the practice. The PPG contained eight representatives who supported the group in areas such as designing patient satisfaction surveys and providing patient feedback on individual issues. The practice was proactive in working effectively with the PPG and had invited them to one of their team away days.

The practice gathered feedback from staff through staff meetings, appraisals, surveys and discussions. Staff told us that the atmosphere at the practice was very good and they worked well together as a team. Staff confirmed that they supported each other and were able to speak with their line manager, practice manager and GPs at any time. They said that they felt involved and engaged in the practice to continue to improve outcomes for both staff and patients. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Management lead through learning and improvement

The practice held regular meetings that ensured continued learning and improvements for all staff. We saw minutes of staff meetings and management team meetings that showed discussions had taken place on a range of topics. This included significant events, complaints and palliative care for patients, with actions to be completed where appropriate.

The practice was able to evidence through discussion with the staff and via documentation that there was a clear understanding among staff of safety and learning from incidents. Concerns, near misses, significant events (SEs) and complaints were appropriately logged, investigated and actioned. For example, we saw that significant event reporting had been discussed at the practice meetings held throughout 2014. We saw that the details of the incidents, who was involved and that action taken had been discussed.

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 appraisals had been completed with detailed objectives and identified training needs for each member of staff. Staff told us that the practice was very supportive of training appropriate to their roles. We saw that there was a culture of learning, planning and change within the practice. Positive patient outcomes were the driver for change and staff worked hard to embrace the changes needed and implemented them.

The practice had plans to become a training practice in August 2015 for qualified doctors to become GPs. We saw that one of the GPs at the practice had completed a post graduate certificate in Medical Education to support this.