Grimethorpe Surgery

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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced inspection visit on 10th December 2014. The overall rating for the practice is good. We found the practice was good in providing: safe, responsive and effective care for all of the population groups it serves.

Our key findings were as follows:

- Where incidents had been identified relating to safety, staff had been made aware of the outcome and action was taken where appropriate, to keep people safe.
- All areas of the practice were visibly clean and where issues had been identified relating to infection control, action had been taken.
- Patients received care according to professional best practice clinical guidelines. The practice had regular information updates, which informed staff about new guidance to ensure they were up to date with best practice.
- The service ensured patients received accessible, individual care, whilst respecting their needs and wishes.
- We found there were positive working relationships between staff and other healthcare professionals involved in the delivery of service.

We saw several areas of outstanding practice including:

All patients, but particularly those who work, could access appointments during early mornings in the week and Saturday morning openings throughout the year. Patients could also access the GP for telephone advice if attending the practice was difficult.

- Appointment length was need-specific so GPs arranged longer appointments when they thought this was necessary. Longer appointments were routinely offered to some patients, for example for those patients who have a learning disability.
- The practice actively supported patients who may be vulnerable, including patients with alcohol or substance misuse and those with chronic neurological problems based in a local care home.

Summary of findings

- The practice used the 'choose and book' system effectively by ensuring all patients had a referral made before they left the surgery on the day of their appointment.

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

- Events and Incidents were reviewed by the GPs and discussed at their meetings. However,the systems in place did not apply what was learnt from the event to other aspects of the practice to ensure that risks were minimised and incidents did not happen again.
- The practice did not have team meetings. This limited the opportunities for staff to contribute to the development of the practice and ensure that lessons from incidents are effectively communicated.
- The practice did not have a Pateint Participation Group which limited the opportunities for patients involvement in decision making for the practice.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated to improve the quality of the service. Information about safety was recorded, monitored, appropriately reviewed and addressed.

The practice was clean throughout and we confirmed infection control was well managed. We saw there were safe systems in place to manage and monitor medicines and medical equipment.

It was evident good staffing levels were in place and there was an appropriate mix of skills within the team. We found that staff recruitment was managed well with all the required checks in place and there were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Patients' needs were consistently met and referrals to secondary care were made in a timely manner. We saw patients' consent to treatment was consistently obtained.

The practice had carried out supervision and appraisals for staff. We saw staff had received training appropriate to their roles.

There were regular GP clinical meetings and evidence of positive working relationships with multidisciplinary teams. National Institute of Health and Care Excellence (NICE) guidance was referenced and used routinely. It was evident in practice and clinical meetings NICE guidelines were discussed and plans made for their implementation.

The practice raised awareness of health promotion in consultations, the practice waiting areas and their web site. There were screening programmes in place to ensure patients were supported with their health needs in a timely and safe way.

Are services caring?

Good

The practice is rated as good for providing caring services. Patient surveys showed that patients rated the practice higher than other practices, regarding several aspects of care. All the patients who responded to CQC comment cards, and those we spoke with during our inspection, were very positive about the service. They all confirmed staff were caring and compassionate and felt the practice provided a good service.

Summary of findings

Are services responsive to people's needs?

Good 

The practice is rated as good for providing responsive services. The GP and staff understood the diverse needs of the different population groups they supported and made arrangements for these to be met. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.

Are services well-led?

Good 

The practice is rated as good for being well-led. There was a long standing visible management team, with a clear leadership structure. Staff felt supported by the management team. There were good governance arrangements and systems in place to monitor quality and identify risk. However whilst regular GP meetings were held we saw that team meetings were not held and this did not give staff the opportunities to be involved in development plans and decision making within the practice.

Although we found that the practice had no active Patient Participation Group (PPG) we did find systems were in place to obtain feedback from patients about the service they received. The practice proactively sought feedback from staff and patients, which it acted on. The results of this informed planning and helped to develop the service further for patients.

Summary of findings

What people who use the service say

In the most recent information from Public Health England 2013 showed that 93% of people would recommend this practice to others and 87% were happy with the opening hours.

We received 39 completed patient CQC comment cards and spoke with two patients on the day of our visit. All these patients were positive about the care provided by the GPs the nurses and reception staff with many comments conveying the excellent service they received by the practice overall. They all felt the doctors and nurses were competent and knowledgeable about their health needs.

The practice did not have an active Patient Participation Group (PPG) but they had conducted their own patient's survey in 2013 and had a suggestion box in the practice waiting room. The practice had responded to the patient's survey and to individual suggestions by changing their appointment system to provide early morning and Saturday appointments to better accommodate the 'working population'.

Areas for improvement

Action the service SHOULD take to improve

- Events and Incidents were reviewed by the GPs and discussed at their meetings but the systems in place did not look at the effects of the event on the wider practice to ensure that further risks were minimised and incidents did not happen again.
- The practice did not have team meetings. Staff were not therefore able to jointly reflect with the team and be part of the planning and shaping of the future of the practice.
- The practice did not have a Patient Participation Group which limited the opportunities for patients involvement in decision making for the practice.

Outstanding practice

- All patients, but particularly those who work, could access early morning through the week and Saturday morning openings throughout the year. Patients could also access the GP for telephone advice if attending the practice was difficult.
- Appointment length is need-specific so GPs arrange longer appointments when they think this is necessary. Longer appointments are routinely offered to some patients, for example patients who have a learning disability.
- The practice actively supported patients who may be vulnerable, including patients with alcohol or substance misuse and those with chronic neurological problems based in a local care home.
- The practice used the 'choose and book' system effectively by ensuring all patients had a referral made before they left the surgery on the day of their appointment.

Grimethorpe Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead inspector and included a SPA Specialist advisor GP and a CQC inspector.

Background to Grimethorpe Surgery

Grimethorpe Surgery is located within Grimethorpe Centre sharing the facilities with other health care providers. The building is a modern purpose built health centre with good parking facilities and disabled access. The practice also has a satellite branch based in Cudworth at The Cudworth Centre Carlton Street Cudworth S72 8SU. This was not visited as part of this inspection.

The practice is registered with the CQC to provide primary care services. It provides General Medical Services (GMS) for 6,368 patients under a GMS contract with NHS England in the Barnsley Clinical Commissioning Group (CCG) area.

The practice has four GP partners (three male and one female), two practice nurses, two healthcare assistants and an experienced administration and reception team. The reception team consists of one practice manager and nine reception and administrative staff.

The Grimethorpe practice is open Monday and Wednesday from 6:50am to 5:30pm Tuesday Thursday and Friday 8:30am to 6:00pm with extended opening hours on a Saturday morning 8.30am to 11.30am. The Cudworth site is also open from 6:50am to 6:00pm on a Friday with normal opening hours throughout Monday to Friday 8:30 am to 5:30pm.

The practice treats patients of all ages and provides a range of medical services. Patients also have access to primary care services such as health visitors and midwives, district nurses and there is an independent pharmacy next door to the practice.

When the practice is closed patients can access the out of hour's provider service.

The practice population is made up of a predominately younger and working age population between the ages of 0- 60 years. Twenty-five per cent of the patients on the practice's list have a caring responsibility. Fifty-six per cent of the population have a long-standing health condition.

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 practice was part of a random selection of practices in the Barnsley CCG area. This provider had not been inspected before and that was why we included them.

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.

Detailed findings

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?

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)

Before visiting, 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 10th December 2014. During our visit we spoke with a range of staff including the practice manager, two GP partners, one practice nurse and four reception staff. We also spoke with two patients on the day.

We observed communication and interactions between staff and patients both face to face and on the telephone within the reception area. We reviewed 39 CQC comment cards where patients and members of the public had shared their views and experiences of the service. We also reviewed records relating to the management of the service.

Are services safe?

Our findings

The practice had systems in place to monitor all aspects of patient safety. Information from the Clinical Commissioning Group (CCG) and NHS England indicated the practice had a good track record for maintaining patient safety. Staff we spoke with understood their responsibilities to raise significant events. This included the process to report them internally and externally where appropriate.

Information from the Quality and Outcomes Framework (QOF), a national incentive and reward scheme that helps practices to focus better outcomes for patients, showed that in 2012-2013 the practice was appropriately identifying and reporting incidents.

There were policies and protocols for safeguarding vulnerable adults and children. Any concerns regarding the safeguarding of patients were passed onto the relevant authority. The GPs were able to give us an example of how they managed the safeguarding process and ensured the safety of adults as well as children who use the practice.

Learning and improvement from safety incidents

There were effective protocols used to scrutinise practice. The practice had systems in place for reporting, recording and monitoring significant events, incidents and accidents. We looked at records of significant events that had occurred during the last 12 months. We saw that incidents were discussed at weekly GP and monthly practice meetings and any important information disseminated to staff. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

Staff told us they felt confident in raising issues with the GPs and felt action would be taken. A culture of openness operated throughout the practice, which encouraged errors and 'near misses' to be reported.

We saw whilst GPs discussed the incident that occurred, the outcomes were not always recorded and the analysis at times was limited and did not look at the wider implications. For instance where a prescribing error had occurred the practice did not then review all prescribing to see if further incidents could be identified. Systems did not always ensure effective learning took place to minimise the likelihood of such events recurring.

Reliable safety systems and processes including safeguarding

The practice had systems in place to protect and safeguard children and vulnerable adults. The practice had a named lead GP for safeguarding. They had completed training to enable them to fulfil this role. GPs used appropriate codes on their electronic case management system. This ensured risks to children and young people who were looked after, or on child protection plans were known and reviewed appropriately.

All other staff received appropriate training for safeguarding adults and children and were aware of relevant procedures. We asked members of clinical and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children.

The computer software used by the practice meant staff entered codes which then flagged up where a patient (child or adult) was vulnerable or required additional support, for instance if they were a carer. The practice also had systems to monitor babies and children; for instance, where patients failed to attend for childhood immunisations, or who had high levels of attendances at A&E.

There was a chaperone policy, which was visible in the consulting rooms. There was evidence of patients being offered chaperone services during consultation and treatment and staff had appropriate guidance and training.

Medicines management

There was a clear policy for ensuring medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Staff confirmed the procedure to check the refrigerator temperature every day and ensure the vaccines were in date and stored at the correct temperature. The staff showed us their daily records of the temperature recordings and that the correct temperature for storage was maintained. The cold chain for vaccines was audited and closely monitored by staff.

The practice was not a dispensing practice. The amount of medicines stored was closely monitored and medicines were kept in a secure store with access by clinical staff only. We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff.

Are services safe?

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.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice.

There were systems in place to ensure GPs regularly monitored patients medication and re issuing of medication was closely monitored, with patients invited to book a 'medication review', where required.

There was a process to regularly review patients' repeat prescriptions to ensure they were still appropriate and necessary. Any changes in medication guidance were communicated to clinical staff, and staff were able to describe an example of a recent medical alert and what action had been taken. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The nurses and the health care assistant administered vaccines using Patient Group Directions(PGDs) produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines. The data from 2013 NHS England showed 98% of children aged 24 months at the practice had received their vaccinations.

Cleanliness and infection control

We saw all areas in the practice were clean. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with and responses from the CQC comment cards confirmed patients found the practice clean and had no concerns about cleanliness or infection control. Suitable arrangements had been made which ensured the practice was cleaned to a satisfactory standard.

We noted liquid soap and paper hand towels were available in treatment and public areas. Notices about hand hygiene techniques were displayed in staff and patient toilets.

Staff told us they accessed Personal Protective Equipment (PPE). Single use equipment was safely managed and was part of the infection control audit. We saw appropriate sharps receptacles in place in the treatment rooms. Separate containers were provided for the disposal of cytotoxic and contaminated sharps such as used needles. Staff told us they ensured spillage kits were available to clean areas contaminated with body fluids. The practice had a needle stick injury policy in place, which outlined what staff should do and who to contact if they suffered this injury.

There was an up-to-date Infection Control Policy in place. The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. We saw infection control training had been completed by all the staff and refresher training was done on an annual basis. An infection control checklist was used to help identify any shortfalls or areas of poor practice. Where concerns were identified, an action plan was put in place.

The practice had legionella assessments and audits in place. The practice had suitable and sufficient risk assessments required to identify and assess the risk of exposure to legionella bacteria from work activities. Water systems on the premises were checked to ensure continued safety.

Equipment

The practice had appropriate equipment for managing emergencies. Emergency equipment included a defibrillator and oxygen. We noted however that these were based on the first floor and not easily available for use in a medical emergency. We discussed this with the practice who told us they would relocate this to the ground floor where the practice was based.

A log of maintenance of clinical and emergency equipment was in place and staff recorded when any items identified as faulty were repaired or replaced.

We confirmed that equipment was checked regularly to ensure it was in working condition. Staff told us all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. We saw the practice had annual contracts in place for portable appliance tests (PAT) and also for the

Are services safe?

routine servicing and calibration, where needed, of medical equipment. We saw evidence of calibration of relevant equipment; for example weighing scales and the fridge thermometers.

Staffing and recruitment

The practice had a recruitment policy in place. The policy stated all clinical staff should have a Disclosure and Barring Service (DBS) check and two references from their previous employment. We looked at a sample of personnel files for nurses, health care assistants and reception staff. Most staff had worked for the provider for several years. We saw that pre-employment checks, such as obtaining a full work history, evidence of identity, references and a DBS check, had been carried out prior to staff starting work.

The provider routinely checked the professional registration status of GPs and practice nurses against the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) register each year to make sure they were still deemed fit to practice. Appropriate checks were also carried out when the practice employed locum doctors.

Safe staffing levels had been determined by the provider and rotas showed these were maintained. Procedures were in place to manage planned absences, such as to cover training and annual leave, and unexpected absences such as staff sickness.

Monitoring safety and responding to risk

The practice had arrangements for monitoring safety and responding to changes in risk to keep patients safe. For example, the practice had a health and safety policy setting out the steps to take to protect staff and patients from the risk of harm or accidents.

There were systems in place to monitor safety in the practice and report problems that occurred. There was a designated health and safety lead who carried out a monthly risk assessment covering such areas as the safety of the building and equipment.

There were arrangements in place to protect patients and staff from harm in the event of a fire. This included staff designated as leads in fire safety and carrying out appropriate fire equipment checks.

The practice management team looked at safety incidents and any concerns raised. They then looked at how this could have been managed better or avoided. They also reported to external bodies such as the Clinical Commissioning Groups (CCG), the local authority and NHS England in a timely manner.

The practice was positively managing risk for patients. Patients with a significant change in their condition or new diagnosis were discussed at GP and multi-disciplinary team (MDT) meetings, which allowed clinicians to monitor treatment and adjust support according to risk. Information regarding palliative care patients was made available to out of hours providers so they would be aware of changing risks.

Arrangements to deal with emergencies and major incidents

We saw evidence that all staff had received training in Basic Life Support. This was updated on a regular basis. There was an automatic external defibrillator (AED) in the practice. All staff knew where this was kept and how it should be used. Emergency medicines were available, such as for the treatment of cardiac arrest and anaphylaxis, and all staff knew their location. Processes were in place to check emergency medicines were within their expiry date.

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

There were disaster/ business continuity plans in place to deal with emergencies that may interrupt the smooth running of the service such as power cuts and adverse weather conditions. The plans were accessible to all staff and kept in reception. This provided information about contingency arrangements staff would follow in the event of a foreseeable emergency.

Are services effective?

(for example, treatment is effective)

Our findings

The practice aimed to deliver high quality care and participated in the Quality and Outcomes Framework (QOF). The QOF aimed to improve positive outcomes for a range of conditions such as coronary heart disease and high blood pressure. The practice achieved 96 per cent of the QOF framework points in year 2012/13, which showed their commitment to providing good quality of care.

All GPs and nurses demonstrated how they accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. For instance, they applied the NICE quality standards and best practice guidance in their management of conditions such as asthma and diabetes. We saw minutes of GP clinical meetings where new guidelines were disseminated and the implications for the practice's performance and patients were discussed. The GPs interviewed were aware of their professional responsibilities to maintain their knowledge.

We saw that patients were appropriately referred to secondary and community care services. The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring each patient was given support to achieve the best health outcome for them.

Feedback from patients confirmed they were referred to other services or hospital when required. National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for referral, for instance two week referrals for patients with suspected cancer were done there and then, and other routines via 'choose and book' were also done the same day.

We found that the practice completed full health checks on new patients and follow on support for any identified health needs. Special clinics for health needs such as, coronary heart disease, diabetes, asthma and chronic obstructive pulmonary disease (COPD) were held and systems were in place to identify patients who met the criteria to attend. Mothers and babies were supported with antenatal clinics, with health visitor support and child health and immunisation clinics.

The practice supported local care and nursing homes and in particular younger people with advanced neurological needs. They provided assessment and continued support for a wide range of complex health needs.

There were systems in place to identify and monitor the health of vulnerable groups of patients. Specific coding was used for patients on their electronic records. This coding records the everyday care of a patient, including family history, relevant tests and investigations, past symptoms and diagnoses. They improve patient care by ensuring clinicians base their judgements on the best possible information available at a given time. The GPs and nurses we spoke with were all familiar with read coding and its benefits when assessing patients' conditions.

There was a register of patients with learning disabilities and evidence of regular annual health checks. To accommodate the needs of this group, longer appointments and home visits were made available.

The practice ensured follow up consultations were in place for older patients when discharged from hospital. Patients over the age of 75 had a named GP. Annual health checks were in place for the over 75s and their medication was reviewed. Patients told us they were included in their care decisions and health promotion programmes were available.

Staff were able to demonstrate how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. The practice kept up to date disease registers, for patients with long term conditions. These included asthma and chronic heart disease and were used to arrange annual, or as required, health reviews.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included antibiotic prescribing, review of patients with hepatitis B and C and a review of indicators in patients at high risk of developing diabetes.

The practice was making use of clinical audit tools in both clinical supervision and staff meetings to assess the

performance of clinical staff. The staff we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved.

We saw the practice monitored patients with poor mental health; they had audits which ensured patients had a regular physical health check and follow ups if there was non-attendance.

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

The GPs from the practice met regularly with the CCG and other practices. These meetings shared information, good practice and national developments and guidelines for implementation and consideration.

Effective staffing

All the patients we spoke with were complimentary about the staff. We observed staff were competent and knowledgeable about the roles they undertook. The practice was organised so there were enough staff to meet the fluctuating needs of patients at all times.

We saw checks were made on qualifications and professional registration as part of the recruitment process and additional checks throughout the clinician's appointment. There was a comprehensive induction programme in place for new staff which covered generic issues such as fire safety and infection control. We saw evidence staff had completed mandatory training, for example basic life support, safeguarding and infection control. The practice manager told us the staff completed some training electronically and other training at their monthly training sessions. Staff had been trained in areas specific to their role for example, epilepsy care, wound management, heart disease, diabetes and COPD.

We saw evidence of regular in house training for all staff to attend. For instance recently they had training in cardiopulmonary resuscitation (CPR) and Fire safety. We did not see an accurate account of training completed or training requiring an update. The practice manager told us this would be put in place to better manage training at the practice.

All GPs were up to date with their continuing professional development requirements and all either have been revalidated or had a date for revalidation. The nurses in the practice were registered with the Nursing and Midwifery Council (NMC). To maintain registration they had to complete regular training and update their skills. The advanced nurse practioner we spoke with confirmed their professional development was up to date.

The clinical and non-clinical staff confirmed they had appraisals. They told us it was an opportunity to discuss their performance and any training concerns or issues they had. All the staff we spoke with said they were supported in their role and confident in raising any issues with the practice manager or the GPs.

There were Human Resources (HR) policies and procedures in place to support poor or variable performance amongst staff. We saw where poor performance had been identified appropriate action had been taken to manage this

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs. Treatment information from hospitals and OOHs services was received and reviewed as per the practice policy. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system worked well. There were no instances within the last year of any results or discharge summaries that were not followed up appropriately.

We saw evidence the practice worked closely with other professionals. For example they worked with palliative care nurses, health visitors, social services and care home staff to support elderly patients and younger patients with advanced neurological needs. Specialised training and care plans had been developed to assist staff to meet the needs of these patients effectively.

The staff attended multidisciplinary team meetings every month to discuss the needs of complex patients, for

Are services effective?

(for example, treatment is effective)

example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

GPs attended monthly sessions run by the local CCG to promote education and networking for GPs in their area. GPs told us that recent subjects had included child protection, NICE guidelines and dermatology.

Information sharing

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the local 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. Staff reported this system was easy to use and provided staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patient's care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. We saw audits in place to assess the completeness of these records and action had been taken to address any shortcomings identified.

The staff told us they liaised closely with the health and social care providers to ensure any health needs of their patients were promptly addressed, for example when someone was discharged from hospital. This was important to ensure integrated care and support was provided to the patients.

There was a practice website with information for patients including signposting services available and the latest news. Patients registered so they could access the full range of information on the website. Information leaflets and posters about local services were available in the waiting area.

Consent to care and treatment

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 in their practice. Staff told us they spent time discussing treatment options and plans with patients and were aware of consent procedures. They explained discussions were held with patients to assure their consent prior to treatment. They were aware of how to access advocacy services. Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing.

There was a practice policy on consent in place. Staff were able to provide examples of how they dealt with a situation if someone was unable to give consent, including escalating this for further advice to a senior member of staff where necessary. We found clinical staff understood how to facilitate 'best interest' decisions for people who lacked capacity and would seek appropriate approval for treatments.

We saw clinical staff were familiar with the need for capacity assessments and Gillick competency assessments of children and young people. These assessments check whether children and young people had the maturity to make decisions about their treatment.

Health promotion and prevention

The practice raised patients' awareness of health promotion. This was in consultations, via the web site and leaflets in the practice. This information covered a variety of health topics including smoking cessation, weight management, stroke and diabetes.

The practice held flu virus and shingles vaccination sessions and provided child immunisation programmes. We saw the practice website included information about how to access appropriate influenza advice and support. Patients confirmed with us they had access to the information and staff regularly discussed health promotion with them during their consultations and on home visits.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Reception staff were courteous and spoke respectfully to patients. They listened to patients and responded appropriately. Of the patients who participated in the national GP patient survey in 2013, 92 per cent said they found receptionists at the practice 'helpful'. A similar high level of satisfaction was found when respondents to the in-practice patient survey were asked about the reception team.

The practice switchboard was located in an area away from the reception so calls could not be overheard. The reception desk was adjacent to the waiting area shared with another GP practice in the same building. The staff we spoke with told us they were always careful about what questions they asked patients at the reception desk and they were aware of the need to maintain confidentiality.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting and treatment rooms so that patient's privacy and dignity was maintained during examinations, investigations and treatments. We noted doors were closed during consultations and conversations taking place in these rooms could not be overheard.

The staff were aware of the practice policy on chaperoning and familiar with arrangements to maintain the dignity and privacy of patients undergoing intimate examinations. Patients' on going emotional needs were supported. We saw leaflets were available in the waiting room which offered support to patients for areas such as; bereavement counselling, mental health support and also support with conditions such as cancer.

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

Care planning and involvement in decisions about care and treatment

Patients were supported to express their views and were involved in making decisions about their care and treatment. Of the patients who participated in the national GP patient survey in 2013, 89% of respondents said the GP they visited was 'good' at treating them with care and concern and involving them in decisions about their care. They also expressed their GP had satisfactorily explained their condition and the treatment they needed. Patients we spoke with said they had been involved in decisions about their care and treatment, and staff explained things clearly to them.

We found staff communicated with patients so they understood their care, treatment or condition. We received positive comments from patients confirming they understood their treatment and options were discussed during their consultation.

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

Patient/carer support to cope emotionally with care and treatment

The patients we spoke to on the day of our inspection told us staff were caring and understanding when they needed help and provided support where required.

Notices in the patient waiting room and patient website also signposted patients to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. There was written information available for carers to ensure they understood the support available.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice provided a service for all age groups. They covered patients with diverse cultural and ethnic needs and for those living in deprived areas. We found GPs and other staff had the overall competence to assess each patient and were familiar with individual's needs and the impact of their socio-economic environment.

Longer appointments were made available for people who needed them and those with long term conditions. This also included appointments with a named GP or nurse. There was a register of the housebound and home visits were made to local care homes and to those patients who needed one.

Hearing loops were installed for patients with hearing problems. There was a large waiting area which was easily accessible to wheelchairs.

We saw there was a process in place for 'Choose and Book' referrals to other services. We saw referrals the practice made to other services and saw these were done before the patient left the practice on the day of their visit.

We looked at how the practice met the needs of older people. We saw the practice had a named GP for over 75s and provided patients with an 'elderly health check' to support them with management of any long term conditions. This included a system that recalled patients annually for a comprehensive review.

Staff understood the lifestyle risk factors that affect some groups of patients within the practice population. We saw the practice provided a range of services and clinics where the aim was to help particular groups of patients to improve their health. For example, the practice provided patients with access to smoking cessation programmes, and advice on weight and diet.

Tackling inequity and promoting equality

We found the practice was accessible to patients with mobility difficulties; there was single level access and automatic doors to the building. Disabled parking bays were available. We saw the waiting area was large enough to accommodate patients who used wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

There was practice leaflets and health promotion information available.

The practice provided support to homeless and travelling people in the area and emergency appointments where made when required. The practice provided health promotion literature for these and other groups and advertised the service of support groups including Citizens Advice who held three sessions per week at the practice. They helped patients with any benefit, money, employment, housing, immigration and other issues.

Access to the service

Of the patients who participated in the national GP patient survey in 2013, 89 per cent of patients reported a good overall experience of making an appointment at the practice.

We saw that good systems were in place to help patients access appointments and order repeat prescriptions. Patients could use the web site, telephone or visit the surgery to make appointments or order prescriptions. Opening times and closures were stated on the practice website and in the practice leaflet with an explanation of what services were available.

The practice offered telephone and on line pre bookable appointments. Patients could also ring on the day for emergency appointments and were seen promptly. All children were seen the same day and usually within two hours of contacting the practice. Older patients were also seen the same day and home visits were available when required for housebound patients and those living in care and nursing homes.

Patients we spoke with said they had timely diagnosis and referrals and access to specialist support from other health providers including NHS hospitals.

Listening and learning from concerns and complaints

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

Are services responsive to people's needs?

(for example, to feedback?)

We saw information was available to help patients understand the complaints system. Information on how to make a complaint was available in a practice booklet in reception. There was a suggestion box in the waiting area for patients use. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

The practice manager kept a log of complaints about the practice. Whist there were only a few complaints over the past 12 months it was clear these were investigated and concluded in accordance with the practice's guidelines and procedures. We saw these investigations were thorough and impartial and learning from these was discussed at practice meetings.

Are services well-led?

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

Our findings

Vision and strategy

Staff we spoke with shared joint values about the practice and knew what their responsibilities were in relation to these.

We saw there was input from key stakeholders, patients and staff which ensured the practice regularly reviewed their aims to ensure they were being met.

Governance arrangements

There was a management structure with clear allocations of responsibilities, such as lead roles. Staff said they were all clear about their own roles and responsibilities. We spoke with staff including GPs, practice nurse, practice manager, reception and administration staff. They were all clear about their roles and responsibilities. We found effective monitoring took place, and this included audits to ensure the practice was achieving targets and delivering safe, effective, caring, responsive and well led care.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues, such as management and safety of medicines. We saw the risk log was regularly discussed at clinical meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented, for example in relation to the management of medicines and vaccines.

The practice sought feedback from patients and staff to help improve the service. All the staff we spoke with felt they had a voice and the practice was supportive and created a positive learning environment. They all told us they felt valued, supported and knew who to go to in the practice with any concerns.

Leadership, openness and transparency

GPs told us there was an open culture within the practice and they had the opportunity and were happy to raise issues at their clinical meetings. We noted however that the nursing staff and other staff at the practice did not meet regularly but staff told us that information was passed onto them from the GP meetings when required. The practice may benefit from staff involvement and engagement in the decision making within the practice. This may be by holding staff meetings and including nurses in clinical meetings to improve outcomes for both staff and patients.

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

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

The practice had gathered feedback from staff, through staff training days and generally through staff appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff confirmed they felt 'listened to' by management and opinions were respected.

The practice surveyed the patient population with a qualitative questionnaire and took action from these results. We also saw that a suggestion box was in place and any comments received were acted upon. The changes to the early morning surgeries were initiated through concerns raised about lack of access for working patients.

We noted however that the practice did not have a patient participation group (PPG). The practice manager explained that patients had been canvassed to form a group in 2011 but meetings had not begun. The patients were not actively engaged and involved in decision making for the practice. The practice manager told us that they would now look at ways they can promote and encourage an active PPG.

Management lead through learning and improvement

Staff confirmed they were supported to maintain their clinical professional development through training and mentoring. They confirmed appraisals took place which identified their learning objectives and training needs. We saw evidence the practice improved the service following learning from incidents and reflecting on their work.