Dr Sharma

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 carried out an announced comprehensive inspection at Dr Sharma on 23 February 2016. Overall the practice is rated as good.

Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- The practice had a programme of continuous clinical and internal audit in order to monitor quality and make improvements. All staff were encouraged to carry out individual audits.
- Feedback from patients about their care was consistently positive.
- Written information for patients on how to complain was not available at the surgery.
- 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.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by the management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the Duty of Candour.

There was one area where the provider should make improvements:

- Ensure that patients have easy access to information about how they can make a complaint.

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. There was an effective system in place for reporting and recording significant events. Lessons were shared to make sure action was taken to improve safety in the practice. When there were unintended or unexpected safety incidents, patients received reasonable support, relevant information, a verbal and written apology. They were told about any actions to improve processes to prevent the same thing happening again. The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse. Risks to patients were assessed and well managed.

Are services effective?

Good

The practice is rated as good for providing effective services. Data from the Quality and Outcomes Framework showed patient outcomes were at or above average for the locality and compared to the national average. Staff assessed needs and delivered care in line with current evidence based guidance. Staff were encouraged to monitor their own practice and clinical audits demonstrated quality improvement. Staff had the skills, knowledge and experience to deliver effective care and treatment. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams to understand and meet the range and complexity of patients' needs.

Are services caring?

Good

The practice is rated as good for providing caring services. Data from the National GP Patient Survey showed patients rated the practice higher than others for most aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. The practice's computer system alerted GPs if a patient was also a carer. There were 246 carers on the practice carer's registers, which represented 7.6% of the practice population. The practice recorded the mobile telephone number for the lead carer to be contacted if required and carers received an information pack. Information for patients about the services available was easy to understand and accessible. We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Practice staff reviewed the needs of its local population and

Summary of findings

engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. The practice provided facilities for a counselling service to offer community based appointments for patients at the practice. The practice worked with hospital consultants who specialised in the care of patients diagnosed with respiratory conditions and diabetes. This enhanced the skills available at the practice and supported the active treatment of patients. Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was not easily to patients.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by the management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk. The provider was aware of and complied with the requirements of the Duty of Candour. The GPs encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active and meetings were extended to invite other patients registered at the practice. There was a strong focus on continuous learning and improvement at all levels.

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. The practice offered proactive, personalised care to meet the needs of the older people in its population. All patients aged 75 years plus had a named GP. Older patients were offered a double appointment (20 minutes) which gave them more time to discuss health issues with a clinician. The practice offered home visits and urgent appointments for those older patients with enhanced needs. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Performance for diabetes assessment and care was higher than the national average (96% compared to the national average of 91%). Patients with complex needs and more than one health condition were offered a double appointment (20 minutes) which gave them more time to discuss health issues with a clinician. Home visits were available when needed. All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health care professionals to deliver a multidisciplinary package of care. The practice worked with hospital consultants who specialised in the treatment of patients with respiratory conditions and diabetes.

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. Immunisation rates were relatively high for all standard childhood immunisations. The practice responded promptly to child protection information. The GP who was the lead for safeguarding children had completed a diploma in child health. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and

Summary of findings

babies. We saw positive examples of joint working with midwives and health visitors. The practice's uptake for the cervical screening programme was 92%, which was higher than the national average of 82%.

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 needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice made provision to accommodate the needs of working people by offering the appointments at a time to suit their needs. This included extended appointments one evening per week. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients with a learning disability. The practice worked regularly with the local specialist learning disability nurses to ensure it carried out annual health checks for people with a learning disability. An easy read (pictorial) letter was sent to patients with a learning disability inviting them to attend the practice for their annual health check.

Staff had been trained 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. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations.

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 data showed that 93% of patients on the practice register who experienced poor mental health had a comprehensive agreed care plan in the preceding 12 months, which was higher than the national average of 88%. Appointments were available to support patients experiencing mental health problems. The practice had told patients experiencing poor mental health about how to access

Summary of findings

various support groups and voluntary organisations and a community based counselling service was available at the practice. The practice regularly worked with multi-disciplinary teams in the case management of people who experienced poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. The percentage of patients diagnosed with dementia whose care had been reviewed in a face to face review in the preceding 12 months was 84%, which was comparable to the national average of 84%. All practice staff had completed dementia friends training and one of the reception staff had completed training to be the dementia champion for the practice. The practice planned to develop this role to support meeting the needs of patients diagnosed with dementia and their carers..

Summary of findings

What people who use the service say

The national GP patient survey results published in January 2016 showed the practice was performing in line with local and national averages. A total of 289 surveys (9% of patient list) were sent out and 106 (37%) responses, which is equivalent to 3% of the patient list, were returned. Results indicated the practice performance was comparable to other practices in most aspects of care, which included for example:

- 84% of the patients who responded said they found it easy to get through to this surgery by phone compared to the Clinical Commissioning Group (CCG) average of 70% and a national average of 73%.
- 87% of the patients who responded said they were able to get an appointment to see or speak to someone the last time they tried (CCG average 82%, national average 85%).
- 90% of the patients who responded described the overall experience of their GP surgery as fairly good or very good (CCG average 81%, national average 85%).
- 88% of the patients who responded said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (CCG average 71%, national average 78%).

As part of our inspection we also asked for Care Quality Commission (CQC) comment cards to be completed by patients prior to our inspection. We received 15 comment cards which were overall positive. Patients said they were happy with the practice, they were treated with respect and dignity, staff were caring and helpful, they were given the time needed, excellent care and advice was given to them by the doctors and staff were very professional.

We also spoke with three patients on the day of our inspection, which included a member of the patient participation group (PPG). PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services. Their comments were in line with the comments made in the cards we received. The practice monitored the results of the friends and family test monthly. The results for 2015 to 2016 showed that of the 166 responses 147 patients were extremely likely to recommend the practice to friends and family if they needed similar care or treatment 17 patients were likely to recommend the practice and two patients responded 'Don't know'.

Areas for improvement

Action the service SHOULD take to improve

Ensure that patients have easy access to information about how they can make a complaint.

Dr Sharma

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector**.** The team included a GP specialist advisor and a practice manager specialist advisor.

Background to Dr Sharma

Dr Sharma is located in a residential area of Wolverhampton. It is situated in a purpose built single storey building. The practice is located in an area of high deprivation and falls within the 10% most deprived in England. The practice provides medical services to approximately 3,219 patients. The practice has a higher proportion of patients aged 85 plus compared with the practice average across England.

The practice team consists of one lead GP and two salaried GPs (one male and two female), who provide services which equate to 1.9 whole time equivalent GPs. The practice used GP locums occasionally to cover long term staff absences only. The clinical practice team includes two practice nurses. One of the nurses is an independent prescriber. The clinical staff are supported by a practice manager, a deputy practice manager and seven receptionists and administration staff. In total there are 11 staff employed who all work part time hours. The practice is accredited with a number of universities for the training of undergraduate doctors and postgraduate nurse training.

The practice is open Monday, Tuesday, Wednesday and Friday between 8am and 6.30pm and Thursday from 8am to 1pm. Extended surgery hours are available on Friday evenings from 6.30pm to 8pm. Patients are offered appointments with a GP during the following times;

Monday, Tuesday and Wednesday 9am to 12pm and 4pm to 6pm, Thursday 9am to 12pm and Friday 9am to 12pm, 4pm to 6pm and 6.30pm to 8pm. The practice does not provide an out-of-hours service to its patients but has alternative arrangements for patients to be seen when the practice is closed. Patients are directed to the out of hours service Primecare, the NHS 111 service and the local Walk-in Centres.

The practice has a contract to provide General Medical Services (GMS) for patients. This is a contract for the practice to deliver primary medical services to the local community. They provide Directed Enhanced Services, such as the childhood vaccination and immunisation scheme and minor surgery. The practice provides a number of clinics for example long-term condition management including asthma, diabetes and high blood pressure.

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. The 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.

Detailed findings

How we carried out this inspection

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 inspection on 23 February 2016.

During our visit we:

- Spoke with a range of staff including GPs, practice nurses, and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

We also looked at how well services were provided for specific groups of people and what good care looked 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 whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

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.

Good

Are services safe?

Our findings

Safe track record and learning

There was an open and transparent approach to learning and a system was in place for reporting and recording significant events. Staff told us they would inform the lead GP and or practice manager of any incidents to ensure appropriate action was taken. The practice carried out a thorough analysis of the significant events.

The practice maintained records of the significant events. The records showed that they were reviewed and that the action taken prevented further occurrence. We saw that the minutes of meetings demonstrated that appropriate learning from events had been shared with staff and external stakeholders. We found that when there were unintended or unexpected safety incidents, patients received reasonable support, relevant information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again.

We reviewed safety records, national patient safety alerts and incident reports where these were reported and discussed. Lessons were shared to make sure action was taken to improve safety in the practice. The practice had recorded two significant events between January 2015 and January 2016. One of the events showed that a patient was given the wrong injection. The patient had not come to any harm, an apology was given and the correct injection given. Procedures were reviewed following an investigation. Learning for staff was identified for example, the importance of checking all injectable products before administering them to patients and also avoiding all unnecessary distractions when providing treatment.

Overview of safety systems and processes

Arrangements were in place to safeguard adults and children from the risk of abuse that reflected relevant legislation, local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. One of the GPs was the lead for safeguarding. Staff we spoke with demonstrated that they understood their responsibilities and told us they had received training relevant to their role. Certificates for safeguard training were seen in the six staff files we looked at. The practice had updated the records of vulnerable patients' to ensure safeguarding records were up to date. This involved where necessary providing reports and meeting with external agencies when required. One of the GPs was the lead for safeguarding children and had completed a diploma in child health. The GP had attended the locality child protection meetings and had been involved in a serious case review. Our review of records showed appropriate follow-up action was taken where alleged abuse occurred to ensure vulnerable children and adults were safeguarded.

The practice had an infection control policy in place and supporting procedures were available for staff to refer to. There were cleaning schedules in place and cleaning records were kept. Treatment and consulting rooms in use had the necessary hand washing facilities and personal protective equipment which included disposable gloves and aprons. Hand gels for patients and staff were available. Clinical waste disposal contracts were in place. One of the practice nurses was the clinical lead for infection control. An infection control audit was undertaken by the local CCG infection control team and we saw evidence that action was taken to address recommendations made.

A notice was displayed in the waiting room, advising patients they could access a chaperone, if required. All staff who acted as chaperones were trained for the role. Staff files showed that criminal records checks had not been completed for non-clinical staff through the Disclosure and Barring Service (DBS) for staff who carried out chaperone duties. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. These staff had an appropriate risk assessment carried out to demonstrate why a DBS check was not in place and how patients would be protected from the risk of abuse during an examination. The risk assessment stated that reception staff would not be left alone with patients.

The practice had reviewed its arrangements for managing medicines, including emergency medicines and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Regular medication audits were carried out with the support of the local CCG pharmacy advisor to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. The practice had reviewed its systems to ensure that prescription pads and forms

were securely stored. The revised systems ensured that all consulting rooms were locked when not in use and prescription forms were not left in the reception printer overnight or at weekends.

The practice had a practice nurse who was a qualified independent prescriber and could prescribe medicines for specific clinical conditions. The nurse received mentorship and support from the medical staff for this extended role. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.

We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and checks through the Disclosure and Barring Service. Non-clinical staff without a criminal records check had an appropriate risk assessment in place. The practice occasionally used locum GPs. We saw that systems were in place to ensure appropriate checks were carried out to confirm their suitability to work with patients.

Monitoring risks to patients

The practice had a robust risk assessment process in place. The practice had assessed risks to those using or working at the practice. The practice had completed comprehensive risk assessments which identified the level of risk using an identified coding system. The practice had completed a risk assessment log where specific risks related to the practice were documented. We saw that each risk was rated and mitigating actions recorded to reduce and manage the risk.

Records dated 05/12/15 showed that electrical equipment had been checked to ensure the equipment was safe to use. Clinical equipment was regularly maintained to ensure it was working properly, records dated 22/04/15 showed that this had been completed. The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal) and a Legionella risk assessment had been carried out.

Staff we spoke with told us that children were provided with an on the day appointment at the practice if required following discussion and referral to a GP. We saw that robust systems were in place to monitor children that did not attend planned appointments at the practice. These reviews were completed three monthly and all patients were followed up. Contact was made with the family and relevant professionals. Patients with a change in their condition were reviewed appropriately. Patients with an emergency or sudden deterioration in their condition were referred to a GP for quick assessment.

Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The practice operated a culture that encouraged a positive work life balance for all staff whilst ensuring that the care needs of its patients could be met. To support this the practice ensured that there were sufficient permanent staff to cover absences taken at short notice over the short term. There was a rota system in place for all the different staffing groups to ensure that enough staff with appropriate skills were on duty.

Arrangements to deal with emergencies and major incidents

There were emergency procedures and equipment in place to keep people safe. 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 cardiac arrest, anaphylaxis (a severe allergic reaction) and 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.

All staff had received annual basic life support training. We found that the practice did not have oxygen at the premises to assist in the emergency care of patients with breathing difficulties or other conditions. A risk assessment had been completed to support staff in what alternative action they should take in absence of this equipment. The practice had agreed shared purchase of oxygen with another practice located at the health centre.

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. The practice had a business continuity plan in place for major incidents such as power failure or loss of access to medical records. The plan included emergency contact numbers for staff and mitigating actions to reduce and manage the identified risks.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and systems were in place to keep all clinical staff up to date. The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records. One of the GPs told us that recent NICE guidelines for the diagnosis of cancer was planned to be discussed at the next practice meeting.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework system (QOF). This is a system intended to improve the quality of general practice and reward good practice. The practice used the information collected for the QOF and reviewed their performance against the national screening programmes to monitor outcomes for patients. The practice achieved 99.6% of the total number points available for 2014-2015 which was above the local Clinical Commissioning Group (CCG) average of 92% and national average of 95%. The practice clinical exception rate of 4.8% was lower than the local CCG average of 7.5% and national average of 9.2%. Clinical exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects. Further practice QOF data from 2014-2015 showed:

- Performance for diabetes assessment and care (96%) was higher than the local average of 88% and national average of 91%. The practice clinical exception rate of 5.9% for this clinical area was lower than the local CCG average of 8.8% and national average of 10.8%.
- The percentage of patients with hypertension having regular blood pressure tests (90%) was higher than the local average of 84% and lower than the national average of 93%. The practice clinical exception rate of 1.9% for this clinical area was lower than the local CCG average of 3.1% and national average of 3.8%.
- Performance for mental health assessment and care (93%) was higher than the local CCG average of 88% and national average of 88%). The practice clinical exception rate of 3.7% for this clinical area was lower than the local CCG average of 8.4% and national average of 11.1%.
- The dementia diagnosis rate for the practice 84% was comparable to the local CCG average of 82% and national average of 84%). The practice clinical exception rate of 9.5% for this clinical area was higher than the local CCG average of 7.7% and national average of 8.3%.

The practice was performing well when compared to the local average across England. However there was one indicator that required further enquiry. Data for the period July 2014 to June 2015 showed that the practice had a lower ratio of reported versus expected prevalence for Coronary Heart Disease (CHD) (0.44 compared to the local CCG figure of 0.62 and national figure of 0.71). However the exception rate for this indicator was lower, 5.1% compared to the local CCG average of 7.9% and the England average of 8.4%. The lead GP told us that they had accurately coded the condition affecting this group of patients. The practice had regular meetings and completed checks of the register to monitor performance and action required to identify the areas of patient's care that needed to be reviewed. The management of patients diagnosed with a chronic respiratory condition and patients diagnosed with diabetes was supported by consultants from secondary care who specialised in these conditions.

Clinical audits were carried out to facilitate quality improvement and all relevant staff were involved in the practice aim to improve care and treatment and patient outcomes. The practice encouraged all staff to carry out audits and this included the practice nurses. We saw three clinical audits had been carried out over the last 12 months. One of the audits looked at the reasons why patients with a diagnosis of cancer were not diagnosed using the 'Fast Track' system and in line with NICE guidance (The patient is seen within the national target of two weeks for cancer referrals, or sooner). The audit showed that approximately 60% of patients were not referred via the fast track system. The outcome of the audit was presented

Good

Are services effective?

(for example, treatment is effective)

and lessons learnt were discussed at a practice meeting. The audit was repeated 12 months later. This showed that the number of patients diagnosed with cancer through the fast track referral system had increased to 75%.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. The practice had a formal appraisal system in place. All staff, which included the GPs, management team, nurses, reception and administration staff had had an appraisal within the last 12 months. All GPs and practice nurses had an agreed learning plan. Our interviews with staff confirmed that the practice provided training opportunities. Staff had also received training that included safeguarding, fire procedures, basic life support and information governance awareness.

The practice could demonstrate how they ensured clinical staff attended role-specific training and updating for relevant staff for example, the practice nurses had received training and attended regular updates for the care of patients with long-term conditions and administering vaccinations. There was a training schedule in place to demonstrate what training staff had received or were due to receive. Staff had access to and made use of e-learning training modules and in-house training

The learning needs of staff were identified through a system of meetings and reviews of practice development needs. This included ongoing support during one-to-one meetings and appraisals. One of the reception staff had completed training to be the dementia champion for the practice. GPs were up to date with revalidation requirements. The practice was discussing with the practice nurses the support needed for revalidation (A process to be introduced in April 2016 requiring nurses and midwives to demonstrate that they practise safely).

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their shared computer drive. This included risk assessments, care plans, medical records and investigation and test results. Information such as NHS patient information leaflets were also available. The practice shared relevant information with other services in a timely way, for example when referring patient's to secondary care such as hospital or to the out of hours service.

To support the practice to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment the practice worked closely with other health professionals. These staff included palliative care nurses, community matron and consultants from secondary care. Multi-disciplinary team meetings to discuss patients on the practice palliative care register took place on a three monthly basis. The practice monitored and ensured that care plans were routinely reviewed and updated. Joint home visits were carried out with the palliative care consultant. A community dermatologist was based at the practice every two to three months. The practice ensured that the needs of patients were met when they moved between services, including when they were referred, or after they were discharged from hospital.

Consent to care and treatment

We found that staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and where appropriate, recorded the outcome of the assessment. We saw that patients' consent had been recorded clearly using nationally recognised standards. For example, when consenting to certain tests and treatments such as vaccinations and in do not attempt cardio-pulmonary resuscitation (DNACPR) records.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. This included patients with conditions that may progress and worsen without the additional support to monitor and maintain their wellbeing. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet and smoking. Patients were then signposted to the relevant service for example, smoking cessation clinics and dietary advice. We saw that information was displayed in the waiting area and also made available and accessible to patients on the practice website. Patients had access to appropriate health assessments and checks.

Good

Are services effective?

(for example, treatment is effective)

The practice offered a full range of immunisations for children, travel vaccines and influenza vaccinations in line with current national guidance. Data collected by NHS England for 2014 -2015 showed that the performance for all childhood immunisations was comparable to the local CCG average. For example, childhood immunisation rates for the vaccination of children under two years of age ranged from 75% to 100%, children aged two to five 88% to 98% and five year olds from 80%% to 97%.

We saw that the uptake for cervical screening for women between the ages of 25 and 64 years for the 2014-2015 QOF year was 92% which was higher than the national average of 82%. However the exception reporting rate of 21.6% was much higher than the local CCG and national average of 6.3%. Information available showed that the practice was proactive in following these patients up by telephone and sent out reminder letters. Public Health England national data showed that the practice was comparable with local and national averages for screening for cancers such as bowel and breast cancer but was lower for the screening of cervical cancer.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous, helpful to patients and treated them with dignity and respect. Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard. We saw that reception staff knew when patients wanted to discuss sensitive issues or appeared distressed and patients were offered a private area where they could not be overheard to discuss their needs.

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 15 completed cards. All the comments made about the practice and staff were positive. Patients commented that the service was excellent, that they were treated with respect and dignity and that GPs and staff were knowledgeable and caring. We also spoke with three patients on the day of our inspection which included a member of the patient participation group (PPG). PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services. Their comments were in line with the comments made in the cards we received.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was mostly above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 91% of the patients who responded said the GP was good at listening to them compared to the CCG average of 83% and national average of 89%.
- 92% of the patients who responded said the GP gave them enough time (CCG average 84%, national average 87%).
- 94% of the patients who responded said they had confidence and trust in the last GP they saw (CCG average 93%, national average 95%).
- 91% of the patients who responded said the last GP they spoke to was good at treating them with care and concern (CCG average 80%, national average 85%).
- 94% of the patients who responded said the last nurse they spoke to was good at treating them with care and concern (CCG average 89%, national average 91%).
- 80% of the patients who responded said they found the receptionists at the practice helpful (CCG average 85%, national average 87%).

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were above the local and national averages. For example:

- 96% of the patients who responded said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 83% and national average of 86%.
- 89% of the patients who responded said the last GP they saw was good at involving them in decisions about their care (CCG average 77%, national average 81%).
- 88% of the patients who responded said the last nurse they saw was good at involving them in decisions about their care (CCG average 85%, national average 85%).

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. There were 246 carers on the practice carer's registers, which represented 7.6% of the practice population. The practice offered carers registered as patients' annual health checks and flu vaccinations. The practice recorded the mobile telephone number for the

Good

Are services caring?

lead carer to be contacted if required. The practice gave carers an information pack which contained the details of local support groups and health and social care professionals to help them seek the appropriate support to meet their needs. All practice staff had completed dementia friends training and one of the reception staff had completed training to be the dementia champion for the practice. The practice planned to develop this role to support meeting the needs of patients diagnosed with dementia and their carers.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local clinical commissioning group (CCG) to plan services and to improve outcomes for patients in the area. Services were planned and delivered to take into account the needs of different patient groups, flexibility, choice and continuity of care. For example:

- There were longer appointments available for patients with a learning disability, older people and patients with long-term conditions.
- An easy read (pictorial) letter was sent to patients with a learning disability inviting them to attend the practice for their annual health check.
- All patients aged 75 years plus had a named GP.
- Appointments were regularly reviewed for example, the practice created extra appointments when the practice was busy to meet the needs of patients
- Home visits were available for older patients and patients who would benefit from these, which included patients with long term conditions or receiving end of life care.
- Telephone consultations were available every day after morning and afternoon clinics.
- The practice worked with hospital consultants who specialised in the care of patients diagnosed with respiratory conditions and diabetes. This enhanced the skills available at the practice and supported the active treatment of patients.
- The practice provided facilities for a counselling service to offer community based appointments for patients at the practice.

Access to the service

The practice was open Monday, Tuesday, Wednesday and Friday between 8am and 6.30pm and Thursday from 8am to 1pm. Extended surgery hours were available on Friday evenings from 6.30pm to 8pm. Patients were offered appointments with a GP during the following times; Monday, Tuesday and Wednesday 9am to 12pm and 4pm to 6pm, Thursday 9am to 12pm and Friday 9am to 12pm, 4pm to 6pm and 6.30pm to 8pm. The practice did not provide an out-of-hours service to its patients but had alternative arrangements for patients to be seen when the practice was closed. Patients were directed to the out of hours service Primecare, the NHS 111 service and the local Walk-in Centres. This information was available on the practice answerphone, patient leaflet and practice website.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was higher than the local and national averages.

- 87% of patients were satisfied with the practices' opening hours compared to the CCG average of 76% and national average of 75%.
- 84% patients said they could get through easily to the surgery by phone (CCG average 70%, national average 73%).
- 67% patients said they always or almost always see or speak to the GP they prefer (CCG average 58%, national average 59%).

Patients told us on the day of the inspection that they were able to get appointments when they needed them.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. However information was not easily accessible to help patients understand the complaints system. There were no complaints leaflets available in the reception area and the complaints procedure on the practice website could not be opened. However patients we spoke with were aware of the process to follow if they wished to make a complaint.

We saw records for four complaints received over the past year and found that all had been responded to, satisfactorily handled and dealt with in a timely way. Records we examined showed that the practice responded formally to both verbal and written complaints. Lessons were learnt from concerns and complaints and action was taken to improve the quality of care. For example following the investigation of one of the complaints the practice arranged for reception staff to attend communication and signposting workshops.

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 provide high quality services and promote good outcomes for patients. Staff and patients felt that they were involved in the future plans for the practice, for example the practice sought the views of patients and input of the patient participation group (PPG) during the building and refurbishment of the premises. PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the practices strategy for good quality care. This outlined the structures and procedures in place and ensured that:

- A programme of clinical and internal audit had been implemented and was used to monitor quality and to make improvements. All staff were encouraged to be involved in carrying out individual audits.
- Staff had received training in governance arrangements and monthly meetings were held to discuss clinical governance issues.
- The GPs, nurses and other staff were all supported to address their professional development needs.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- Health and safety risk assessments had been conducted to limit risks from premises and environmental factors.
- There was a clear staffing structure and staff were aware of their own roles and responsibilities
- Practice specific policies and procedures were implemented. Records showed that they were regularly updated and were easily accessible to all staff.

Leadership and culture

We found that systems were supported by a strong management structure and clear leadership. We saw a supportive atmosphere led by the lead GP The GPs in the practice had the experience, capacity and capability to run the practice and ensure high quality care. The GPs and the management team were visible in the practice and staff told us they were approachable and always took the time to listen to all members of staff. The practice operated and encouraged a culture of work life balance for all staff.

The provider was aware of and complied with the requirements of the Duty of Candour. The GPs and the management team encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents. We saw information in records that showed how patients were encouraged to be open about incidents and mistakes that had occurred. When there were unexpected or unintended safety incidents the practice gave affected people reasonable support, relevant information and a verbal and written apology.

There was a strong sense of active management and clear leadership at the practice. Staff we spoke with were positive about working at the practice. Staff told us that they felt listened to and included. They told us they felt comfortable enough to raise any concerns when required and were confident these would be dealt with appropriately. Staff described the culture at the practice as open, transparent and very much a team approach and staff felt supported to maintain a work life balance.

Regular practice, clinical, management and team meetings involving all staff were held and staff felt confident to raise any issues or concerns at these meetings. All staff were involved in discussions about how to run and develop the practice. There was a practice whistle blowing policy available to all staff to access on the practice's computer system. Whistle blowing occurs when an internal member of staff reveals concerns to the organisation or the public, and their employment rights are protected. Having a policy meant that staff were aware of how to do this, and how they would be protected.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service. The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The practice had a core PPG membership group. To create opportunities for all patients to work with the practice to develop and improve

Are services well-led?

Good

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

the services offered the practice also advertised the PPG meetings to its wider patient population. The practice had developed an action plan which addressed feedback from patients. For example patients had said that they sometimes waited too long at their appointment to see a GP. To help address this the practice introduced 20 minute appointments for patients who had multiple and/or complex health needs.

The practice had an open door policy. Staff were aware that they could raise concerns with the management team at any time. Feedback from staff was also gathered through staff meetings, appraisals and informal discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and the management team. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

The practice had completed reviews of significant events and other incidents. We saw records to confirm this. A formal performance review and development plan was in place for all staff. Staff were encouraged by the practice to monitor their own performance. For example, one of the practice nurses carried out an audit of cervical smears carried out when concerned about the results. Inadequate sample results were received for six of the 22 women tested. The outcome of the audit was discussed with the manager at the local cytology laboratory and was reassured that current guidelines were followed. The practice nurse had arranged to attend a training session to ensure that their practice was up to date. One of the reception staff with an interest in dementia care had completed a dementia training course and appointed a dementia champion at the practice. A presentation of the role had been presented at a practice meeting. The practice planned to extend the presentation to patients and other practices.

The lead GP was a member of the local Clinical Commissioning Group (CCG) board and was the clinical lead on the CCG practice support visits (PSV) group. The group carried out annual visits to local GP practices to provide support for ongoing quality improvement. The practice was accredited with a number of universities for the training of undergraduate doctors and postgraduate nurse training.