Imeary Street Surgery

Quality Report

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South Shields
South Tyneside
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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?	Outstanding
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 comprehensive inspection at Imeary Street Surgery on 17 June 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, responsive and well-led services. It was also good for providing services for the following population groups: People with long-term conditions; Families, children and young people; Working age people; People experiencing poor mental health (including people with dementia); People whose circumstances may make them vulnerable. We found the practice to be outstanding for providing caring services as well as for services for older people.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients, staff and visitors to the practice were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- The majority of patients said they found it easy to make an appointment with a GP and that there was continuity of care, with urgent appointments available the same day.
- The practice offered an extended opening time up to 7pm one night per week which improved access for patients who worked full time.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw several areas of outstanding practice:

- The practice had been pro-active in ensuring that their older patient population were able to access online patient services such as booking appointments and requesting repeat prescriptions by arranging IT training sessions in the surgery waiting room. This had not only enabled older patients to register for online services but had led to some patients enrolling to undertake additional IT training with the provider leading to the development of improved social networking opportunities.
- The practice had achieved a high level of attainment in ensuring its patient population over the age of 65 and those in clinical risk groups had received a flu vaccination through opportunistic targeting during routine appointments and by holding specific flu vaccination clinics. This attainment had been recognised by NHS England. The percentage of patients in the 'influenza clinical risk group', who had received a seasonal flu vaccination, was 69.5% (national average 52.2%) and the percentage of patients aged 65 or older who had received a seasonal flu vaccination was 84% compared to a national average of 73.2%.
- The practice was proactive in identifying and responding to the needs of carers and had established an effective working relationship with the local carers association and other non-profit support groups. A comprehensive carer's pack had been developed giving information on support and services available for carers and family members.
- The practice was working with health quality checkers from Healthwatch, and a local charity that advocates for people with a learning disability, to ensure practice literature and leaflets were in an easy to understand format and to assess how the practice responded to patients with a learning disability.

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 with regard to raising concerns, recording safety incidents and reporting them both internally and externally. The partners and practice management team took action to ensure lessons were learned from incidents, concerns and complaints and shared these with staff as and when required to support improvement. There were enough appropriately trained staff on duty at all times to keep patients safe. The practice was clean and hygienic and there was evidence to confirm that cleaning and infection control audits were regularly completed. All staff had attended training on infection control. The practice had a chaperone policy in place and staff called upon to act as a chaperone had received the appropriate training. All staff had been checked with the Disclosure and Barring Service (DBS).

Are services effective?

Good

The practice is rated as good for providing effective services.

Nationally reported data showed patient outcomes for effectiveness were in line with other practices in the local Clinical Commissioning Group (CCG) and England. Patients' needs were assessed and care was planned and delivered in line with current legislation and best practice guidance produced by the National Institute for Health and Care Excellence (NICE). This included assessing capacity and promoting good health. The practice had systems in place for completing clinical audit cycles to review and improve patient care and to support multi-disciplinary working with other health and social care professionals in the local area. Staff had access to the information and equipment they needed to deliver effective care and treatment. Arrangements were in place to support clinical staff with their continual professional development and all staff had received training appropriate to their roles and responsibilities. Staff received yearly appraisals which gave them the opportunity to formally discuss personal and performance issues and identify training and development needs.

Are services caring?

Outstanding

The practice is rated as outstanding for providing caring services.

Nationally reported data showed patient outcomes for caring were generally better than the national average. Patients said they were treated well and were involved in making decisions about their care

Summary of findings

and treatment. Patients had access to information and advice on health promotion, and they received support to manage their own health and wellbeing. We saw staff treated patients with kindness and respect and were aware of their responsibilities with regard to maintaining patient confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

Nationally reported data showed patient outcomes for this area were generally better than the national average. Services had been planned so they met the needs of the key population groups registered with the practice. Patient feedback about the practice was good and most stated they found it was easy to make an appointment with a GP within an acceptable timescale. The practice were taking steps to reduce emergency admissions to hospital for patients with complex healthcare conditions by ensuring these patients had fully comprehensive personal care plans. Systems were in place to ensure patients discharged from hospital were supported. The practice had made improvements as far as possible to ensure the premises were well equipped to treat patients and meet their needs. Easy to understand information about how to complain was available and evidence showed the practice responded quickly and appropriately to issues raised. The practice had ensured its patient population had the skills required to enable them to book appointments and request repeat prescriptions online. The practice had also established effective working relationships with the local carers association, non-profit support groups and health quality checkers from Healthwatch to ensure the practice was meeting the needs of its vulnerable and older patient population.

Are services well-led?

Good

The practice is rated as good for being well-led.

The leadership and management of the practice assured the delivery of person-centred care which met patients' needs. The practice had a clear vision for improving the service and promoting good patient outcomes. Staff were clear about their roles and responsibilities and felt well supported and valued. The practice had a range of policies and procedures covering its day-to-day activities which were easily accessible by staff. The practice proactively sought feedback from patients, which they acted upon. The practice had an active patient participation group (PPG) which met regularly. The practice worked collaboratively with the PPG to provide an

Summary of findings

innovative range of services aimed at enabling better access for its older and vulnerable patient population. Comprehensive induction guidance was available for staff. Regular staff meetings were held and staff received yearly appraisals.

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

Outstanding ☆

The practice is rated as outstanding for the care of older patients.

Nationally reported data showed the practice had achieved good outcomes in relation to the conditions commonly associated with older people. Patients over the age of 75 had a named GP and were routinely invited to attend an over 75 health check. Home visits were available following triage to ascertain whether the more appropriate course of action was immediate referral to the local acute care team. The acute care team is a nurse led team which provides urgent care, treatment and support to patients in their own homes (including nursing and residential homes) with the aim of reducing unnecessary visits and admissions to hospital.

The practice had developed an effective working relationship with a local care home and undertook weekly visits to the home. Staff told us that this collaborative working had resulted in a reduction in the number of unnecessary admissions to hospital for care home residents.

The percentage of patients aged 65 and older who had received a seasonal flu vaccination was higher than the national average. This high attainment rate had been recognised by the NHS England Flu Team who had arranged to meet with practice staff to gain an understanding of how this had been achieved with the intention of promoting this as an example of best practice to other providers. The practice reported that it had achieved this attainment by being opportunistic in offering patients a flu immunisation during routine appointments with both GPs and the practice nurse administering vaccinations and by arranging coffee mornings and specific flu clinics.

The practice also actively identified and flagged palliative care patients to ensure they were supported appropriately. Six weekly multi-agency palliative care meetings were held which involved the community matron, district nurse and Macmillan nurse.

The practice had been pro-active in ensuring that their older patient population were able to access on-line patient services. This had been achieved by inviting Healthwatch and a local non-profit church organisation into the practice to provide informal IT training sessions and support. This had not only enabled older patients to

Summary of findings

register for on line services such as the ordering of repeat prescriptions and booking appointments but led to some patients enrolling to undertake additional IT training at a local church which in turn led to the development of improved social networking.

People with long term conditions

Good

The practice is rated as good for the care of patients with long term conditions.

The practice was able to demonstrate comprehensive and regularly reviewed care planning for patients with long-term or complex conditions and had a system in place to ensure patients were recalled for reviews when required. The practice was in the process of promoting self-held care plans for patients with chronic diseases which enabled patients to consult their plans as and when required to assist in self-managing their condition. In addition this ensured that these care plans were also readily available for any other health care professional to view if necessary.

Chronic disease management clinics were held to cover a wide variety of diseases and the practice was in the process of reviewing the way in which these clinics were delivered to ensure that patients with multiple chronic diseases need only attend one review clinic. The practice nurse was encouraged to seek and given time to attend continuous professional development training courses in the treatment of such diseases.

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 looked after children or children subject of a child protection plan. The practice had identified one of the GPs as safeguarding lead who was responsible for attending multi-agency safeguarding forum meetings and serious case reviews. The practice also held regular meetings with health visitors and midwives to discuss safeguarding cases and concerns.

The practice had a recall system in place for childhood immunisations and rates were broadly in line with local averages for all standard childhood immunisations. For example, meningitis c vaccination rates for 12 month old children were 81.3% compared to 84.8% locally; for two year old children 95.5% compared to 98.2% locally; and for five year old children 100% as compared to 98.5% locally. Appointments were available outside of school hours and up

to 7pm one night per week. Telephone appointments were routinely available and requests for email consultations were considered on a case by case basis. Cervical screening rates for women aged 25-64 were above the national average at 91% (national average 81.9%).

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age patients (including those recently retired and students).

Nationally reported data showed that 55.4% of the practice population either worked or was in full time education (national average 60.2%). The practice was proactive in meeting the needs of these patients by offering online services such as being able to order repeat prescriptions, book appointments and view parts of their medical records. The practice was open until 6pm every weekday night and offered extended opening hours up to 7pm one night per week. Telephone consultations were also available and consideration was given to consultation by email on a limited case by case basis. Repeat prescriptions could be ordered at any time either online or by phone and the practice was in the process of migrating to an electronic prescription service where prescriptions could be sent electronically to a patient's nominated pharmacy. The practice were also involved in the Choose and Book scheme which enables patients referred to a hospital or clinic to choose the provider of their choice and at date and time which is convenient.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of patients whose circumstances may make them vulnerable.

The practice had a register of patients aged 18 or over with a learning disability and had a recall system in place to ensure these patients were offered an annual health check, some of which were carried out during a home visit. Patients with a learning disability were also sent a letter annually to invite them to relevant cancer screening programmes. Longer appointments were routinely available for this group of patients and the practice ensured that they contributed towards the development of their own health action plans.

The practice was working with health quality checkers from Healthwatch and Your Voice Counts (a local charity that advocates for people with a learning disability) to ensure practice literature and leaflets were in an easy to understand format and to assess how the practice responded to patients with a learning disability. It was hoped that this would improve health care access for learning disability patients.

Summary of findings

Staff knew how to recognise signs of abuse in vulnerable adults and children and how to raise safeguarding concerns with the relevant agencies. The practice had identified a clinical lead for dealing with vulnerable adult and vulnerable children cases and all practice staff had undertaken safeguarding training at a level appropriate to their role. Multi-disciplinary safeguarding meetings were held on a regular basis and both GPs had attended multi-agency risk assessment conference (MARAC) training to help identify and deal appropriately with concerns around domestic violence. The practice also worked collaboratively with a substance misuse practitioner who attended the practice one day per week and saw patients who had either been referred by a practice GP or who had self-referred. Joint consultations involving a GP and the practitioner were also available.

The practice was proactive in identifying and responding to the needs of carers and military veterans.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of patients experiencing poor mental health (including people with dementia).

The practice had exceeded the national average in ensuring comprehensive and agreed care plans were in place for patients with schizophrenia, bipolar affected disorder and other psychoses (100% compared to an England average of 86%) and was in line with the England average for ensuring patients diagnosed with dementia had received a face-to-face review within the preceding 12 months.

The practice was committed to proactively offering assessment to patients at risk of dementia and to continually improving the quality and effectiveness of care provided to this group of patients.

One of the GPs had attended Mental Capacity Act (MCA) and Deprivation of Liberty Safeguard (DoLS) training and had subsequently written a policy on the matter which had then been adopted by all other practices within the South Tyneside Clinical Commissioning Group (CCG). As well as being the Clinical Director for South Tyneside CCG this GP had also been nominated as the mental health and learning disability lead. Practice clinicians had downloaded the 'Deciding Right' app onto their mobile phones and IT equipment as an aide to assist them with any queries concerning the MCA and to ensure compliance with issues such as best interest decision making. Deciding Right is an initiative developed by the NHS aimed at promoting advance care planning and shared decision making between patients and clinicians.

Summary of findings

What people who use the service say

During the inspection we spoke with two patients, reviewed 188 Care Quality Commission (CQC) comment cards completed by patients and a letter from a local pharmacist which had been posted into our comment card post box. The feedback we received indicated the vast majority of patients were very happy with the care and treatment they received, felt they were treated with dignity and respect and received a service which met their needs.

Findings from the 2014 National GP Patient Survey published in January 2015 for the practice indicated most patients had a good level of satisfaction with the care and treatment they received. The results were generally in line with or better than other GP practices within the local Clinical Commissioning Group (CCG) area and nationally. For example:

- 82.8% of respondents said the last GP they saw or spoke to was good at involving them in decisions about their care. Local CCG average 79.5% and national average 74.6%
- 89% of respondents said the last GP they saw or spoke to was good at treating them with care and concern. Local CCG average 87.6% and national average 82.7%
- 82.1% of respondents said the last nurse they saw was good at treating them with care and concern. Local CCG average 80.7% and national average 78%

These results were based on 111 surveys that were returned from a total of 311 that were sent out (response rate of 35.7%)

Outstanding practice

We found the practice to be outstanding for providing caring services and services for older people for the following reasons:

- The practice had been pro-active in ensuring that their older patient population were able to access online patient services such as booking appointments and requesting repeat prescriptions by arranging IT training sessions in the surgery waiting room. This had not only enabled older patients to register for on line services but had led to some patients enrolling to undertake additional IT training with the provider leading to the development of improved social networking opportunities.
- The practice had achieved a high level of attainment in ensuring its patient population over the age of 65 and those in clinical risk groups had received a flu vaccination through opportunistic targeting during routine appointments and by holding specific flu vaccination clinics. This attainment had been recognised by NHS England. The percentage of patients in the 'influenza clinical risk group', who had received a seasonal flu vaccination, was 69.5% (national average 52.2%) and the percentage of patients aged 65 or older who had received a seasonal flu vaccination was 84% compared to a national average of 73.2%.
- The practice was proactive in identifying and responding to the needs of carers and had established an effective working relationship with the local carers association and other non-profit support groups. A comprehensive carer's pack had been developed giving information on support and services available for carers and family members.
- The practice was working with health quality checkers from Healthwatch and a local charity that advocates for people with a learning disability to ensure practice literature and leaflets were in an easy to understand format and to assess how the practice responded to patients with a learning disability

Imeary Street Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

A Care Quality Commission (CQC) Lead Inspector and a GP specialist advisor.

Background to Imeary Street Surgery

The practice is based within a residential area of South Shields and provides care and treatment to 2,650 patients from the surrounding area. The practice is part of the South Tyneside Clinical Commissioning Group (CCG) and operates on a General Medical Services (GMS) contract.

The practice provides services from the following address, which we visited during this inspection:

Imeary Street Surgery, 78 Imeary Street, South Shields, South Tyneside, NE33 4EG

The practice was fully refurbished in August 2011 to generally modernise the premises and provide additional consultation rooms. On-street parking is readily available close to the premises and the building provides fully accessible treatment and consultation rooms on the ground floor for patients with mobility needs. The practice is open between 8.30am to 7.00pm on a Monday and 8.30am to 6.00pm on a Tuesday to Friday.

The service for patients requiring urgent medical attention out-of-hours is provided by the NHS 111 service and Northern Doctors Urgent Care (NDUC).

Imeary Street Surgery offers a range of services and clinic appointments including chronic disease management clinics, family planning, cervical screening, NHS health checks, immunisations, vaccinations and foreign travel advice. The practice consists of two GP partners (one male and one female), a practice nurse (female), healthcare assistant/prescribing clerk (female), practice manager, assistant practice manager, three receptionists and a cleaner. The practice is a teaching and training practice and provides training for medical students.

The Care Quality Commission (CQC) intelligent monitoring tool placed the area in which the practice is located in the fourth (out of ten) most deprived decile. In general people living in more deprived areas tend to have greater need for health services.

The practices age distribution profile showed higher percentages of patients aged over 50 than the national average. Average life expectancy for the male practice population was 77 (national average 79) and for the female population 81 (national average 83).

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme.

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 registered 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

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 Care Quality Commission (CQC) at that time.

How we carried out this inspection

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

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

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 whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 17 June 2015. During our visit we spoke with a range of staff including two GPs; the practice manager; assistant practice manager; practice nurse; the healthcare assistant and members of the reception team. We spoke to two patients, both of whom were members of the practice patient participation group (PPG) and observed how staff communicated with patients who visited or telephoned the practice on the day of our inspection. We reviewed 188 Care Quality Commission (CQC) comment cards that had been completed by patients and a letter from a local pharmacist that had been placed in the CQC comment card post box. We also looked at the records the practice maintained in relation to the provision of services.

Good

Are services safe?

Our findings

Safe track record

As part of planning our inspection we looked at a range of information available about the practice including information from the latest GP Survey results published in January 2015 and the Quality and Outcomes Framework (QOF) results for 2013/14. None of this information identified any concerning indicators about the practice. The local Clinical Commissioning Group (CCG) did not raise any concerns with us about how the practice operated. Patients we spoke to told us they felt safe when they attended appointments and comments from patients who completed Care Quality Commission comment cards reflected this.

The practice used a range of information to identify potential risks and to improve quality in relation to patient safety. This included reported incidents, national patient safety alerts, comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report accidents and near misses. For example, an incident had been recorded where a repeat prescription for a controlled drug had been reissued before staff had carried out the required checks. The practice was able to demonstrate that it had reported the incident to the local Clinical Commissioning Group as a significant event, analysed how the error had occurred and discussed the issue and findings with staff at a practice meeting. As a result changes were made to the way the practice dealt with requests for repeat prescriptions and they had employed a prescription clerk. The practice had also issued a written apology to the family of the patient concerned. Other incidents had been used to inform thematic reviews.

We reviewed a sample of significant event audit records and serious incident reports, and minutes of meetings where these were discussed. We were satisfied that the practice had managed these consistently over time and taken all necessary action to avoid possible recurrences.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We found the practice had recorded 14 significant events/ incidents during the period 1 April 2014 to 31 March 2015 covering a wide range of issues. The practice was able to demonstrate the action taken to ensure these issues did not happen again and also how information regarding such incidents was disseminated to staff by way of minuted practice meetings. Clinical and non-clinical staff knew how and when to raise an issue immediately or for future consideration at staff meetings.

The healthcare assistant was responsible for cascading national patient safety alerts to the clinical staff, practice manager and assistant practice manager by way of 'read' receipt emails which ensured that staff had received and read alerts sent to them. Clinical staff would then ensure appropriate action was taken which included medication reviews, contacting affected patients and amending their care plans.

Reliable safety systems and processes including safeguarding

The practice had effective systems in place to manage and review risks to vulnerable children, young people and adults. Safeguarding policies and procedures were in place and information about how to report safeguarding concerns and contact the relevant agencies was easily accessible. One of the GPs had been identified as the lead for safeguarding vulnerable children and adults and effective working relationships had been established with multi agency practitioners. For example, bi-monthly multi-disciplinary meetings were held involving the GP, health visitor and midwife. Staff we interviewed stated they would feel confident in making a safeguarding referral and were aware of who the nominated safeguarding lead was within the practice. We saw practice training records that confirmed staff had received the appropriate level of safeguarding training relevant to their individual roles. A system was in place to highlight vulnerable patients on the practice's electronic records so staff were aware of any relevant issues when they rang to make or attend for appointments.

A chaperone policy was in place and information about this was displayed in the practice waiting room. The reception staff had received training on their roles and responsibilities as a chaperone (a chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure) and all staff had received Disclosure and Barring Service (DBS) check.

Good

Are services safe?

Patients' records were kept on an electronic system which stored all relevant medical information. As well as flagging vulnerable children and adults the system also flagged patients with dementia, mental health issues, learning difficulties and those receiving palliative care which helped ensure risks to patients were clearly identified and reviewed.

Staff were able to easily access the practice's policies and procedures. This helped to ensure that when required, all staff could access the guidance they needed to meet patients' needs and keep them safe from harm.

Medicines management

Effective arrangements were in place to ensure medicines requiring cold storage, such as vaccines, were stored appropriately. A policy was in place to ensure refrigerator temperatures were checked and recorded twice daily and a cold chain audit was carried out every six to eight weeks. This ensured that medication stored in the refrigerators was safe to use.

The practice held a register of emergency drugs held on the premises. These drugs were stored in a locked cabinet with restricted access. During our inspection we found that a process was in place to check these drugs on a monthly basis to ensure they were in date, destroyed appropriately and re-ordered when required.

Patients were able to re-order repeat prescriptions in a variety of ways including ordering at the practice, by telephone, online or by post. A prescription clerk had been appointed in October 2014 as the lead for dealing with repeat prescriptions. All staff were well aware of the processes they needed to follow in relation to the authorisation and review of repeat prescriptions and were clear about what action to take when a patient had reached the authorised number of repeat prescriptions or when prescriptions were not collected. Blank prescription forms were stored securely and in line with best practice guidance issued by NHS Protect.

We saw evidence to confirm that the practice recorded medicines incidents and prescribing errors as significant events to ensure that similar errors did not recur. An example of this was when a patient was prescribed the incorrect dosage of Warfarin (an anticoagulant use to prevent heart attacks, strokes and blood clots). The matter was reported to the CCG as a significant event and practice staff where reminded of the importance of ensuring that the dosage prescribed was correct by checking patients' medical records.

The practice nurse used patient group directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance to administer vaccines and other medicines. Both the practice nurse and the practice manager (who also practiced as a physiotherapist) administered injections using patient specific directions (PSDs) that had been produced by the prescriber.

Cleanliness and infection control

The premises were clean and hygienic throughout. None of the patients we spoke with or who completed CQC comment cards had any concerns regarding the level of cleanliness at the practice. A cleaning schedule was in place and audits of cleaning standards were carried out on a regular basis.

An infection control policy was in place which provided guidance to staff about the standards of hygiene they were expected to follow. This included guidance on the use of personal protective equipment (PPE) such as aprons and latex gloves as well as how to deal with patient specimens, needle stick injuries and the disposal and management of clinical waste. The practice nurse had been designated as the infection control lead and provided advice and guidance to colleagues when needed. Both clinical and non-clinical staff had received infection control training. Infection control audits had been carried out on a monthly basis. Unannounced spot checks took place on an ad hoc basis took place to ensure staff were following the practice's infection control policy and that the policy was effective in the prevention and control of infections. One such audit had led to a recommendation that posters in clinical rooms should be laminated.

The clinical rooms we inspected contained PPE and there were paper covers and privacy curtains for the consultation couches. A process was in place to ensure the curtains were checked for cleanliness and replaced every six months or more regularly if required.

Spillage kits were available to enable staff to deal safely with any spills of bodily fluids. Sharps bins were available in treatment rooms and were appropriately labelled, dated and initialled. The treatment rooms also contained hand

washing sinks, hand soap, antimicrobial spray and wipes and hand towel dispensers to enable clinicians to follow good hand hygiene and infection control practice. The practice had a protocol for the management of clinical waste and a contract was in place with NHS England for all but the disposal of cytotoxic waste (waste that may be toxic, carcinogenic, mutagenic or toxic for reproduction). Staff told us that this was because the CCG were in the process of negotiating a contract for the disposal of cytotoxic bins and were able to show us evidence that the practice had been proactive in trying to resolve this issue with the CCG. All waste bins were visibly clean and in good working order.

The practice was able to demonstrate that a process was in place for the management, testing and investigation of legionella (a bacterium that can grow in water and can be potentially fatal) on a six monthly basis. This was confirmed by records we viewed dating back to 2012 which also confirmed that the last risk assessment was carried out in March 2015.

We also viewed building maintenance records which confirmed that an asbestos report had been completed for the premises and that a contract was in place to service the boiler on a regular basis.

Equipment

Staff had access to the equipment they needed to carry out diagnostic examinations, assessments and treatments. We saw evidence to confirm the equipment was regularly inspected and serviced. This included the practice defibrillator (a device used to restart the heart in an emergency) which was next due to be checked in March 2016 and oxygen equipment which was due to be checked in August 2015. The spirometer (a device that measures the volume of air inspired and expired by the lungs) was calibrated daily and all portable electrical equipment was routinely tested on an annual basis and displayed stickers indicating the last test date was March 2015.

Staffing and recruitment

The practice had a recruitment policy that set out the standards they intended to follow when recruiting staff. This included seeking proof of identification, evidence of a legal entitlement to work in the UK, references, qualifications, licence to practice if appropriate and Disclosure and Barring (DBS) checks. We viewed staff files and found this to be the case. We also checked the General Medical (GMC), Nursing and Midwifery Council's (NMC) and Health and Care Professions Council (HCPC) records to confirm that all of the clinical staff were licensed to practice. In addition we found that all clinical staff had the necessary medical indemnity insurance. DBS checks had been carried out for all practice staff.

The assistant practice manager told us about the arrangements that were in place to ensure there were enough staff on duty at all times. This meant that certain staff members were not allowed to be on annual leave together (i.e. the two GPs; practice manager and assistant practice manager; practice nurse and health care assistant; the reception staff). The practice rarely relied on using locum GPs but when this was necessary we saw evidence of a comprehensive locum induction pack and locum handbook.

At times of extra pressure staff were flexible and would temporarily increase their working hours to ensure that extra surgeries could be held. This included additional or extended surgeries after Christmas closures and flu clinics on a Saturday morning.

Staff and patients we spoke to on the day of our inspection told us they felt there were enough staff to maintain the smooth running of the practice and to keep patients safe.

Monitoring safety and responding to risk

The practice had systems in place to manage and monitor risks to patients, staff and visitors to the practice. This included regular checks of medicines management, premises, equipment and staffing. The practice had a health and safety policy and staff had received health and safety training. We checked the premises and found it to be safe and hazard free.

Staff told us of the process they would follow if there was a medical emergency on site. The member of staff alerted about the incident would activate an alarm on the practice computer system which would alert clinical staff that their immediate attendance was required. Emergency bags and equipment were readily available. During our inspection we witnessed this process in action when a patient suffered a medical emergency that required immediate admittance to hospital via ambulance. Practice staff remained calm and in control and were clearly aware of their roles and responsibilities.

Good

Are services safe?

The practice had systems in place to monitor risks to patients, staff and visitors to the practice by way of risk assessments which also recorded what mitigating action had been taken to reduce identified risks. Health and safety information was displayed for staff to see.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records confirming that staff had received training in basic life support, cardio-pulmonary resuscitation (CPR) and the treatment of anaphylaxis (acute allergic reaction).

Emergency equipment was available including a defibrillator and oxygen. Emergency medicines held on site were in line with national guidelines, stored securely and only accessible by relevant practice staff. This included medicines for the treatment of cardiac arrest and life threatening allergic reactions. Arrangements were in place to regularly check these were within their expiry date and suitable for use.

The practice had a comprehensive business continuity plan for dealing with a range of potential emergencies that could impact on the day-to-day operation of the practice. Mitigating actions had been recorded to reduce and manage the risks. Risks identified included the loss of the building, utilities, equipment (including IT and telephones), personnel and supplies.

The practice carried out a fire risk assessment on an annual basis and held weekly fire alarm tests. Fire extinguishers had been subject to an annual check and fire exits were clearly signposted.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The clinical staff we spoke with were able to clearly explain why they adopted particular treatment approaches. They were familiar with current best practice guidance and were able to access National Institute for Health Excellence guidelines. From our discussions with clinical staff we were able to confirm they completed thorough assessments of patients' needs and these were reviewed when appropriate.

Practice staff regularly attended Clinical Commissioning Group (CCG) Time In Time Out (TITO) and other training sessions. Learning would then be disseminated to colleagues through regular practice quality improvement meetings which covered discussions such as new guidelines, case and medication reviews and safety audits. The practice had also taken steps to ensure there were effective protocols in place to monitor the prescribing of antibiotics and other drugs. We saw evidence of audits covering the use of co amoxiclav (an antibiotic) and quinolones (antibacterial antiseptic). This helped to ensure that these drugs had not been over prescribed.

Chronic disease management clinics were held to cover a wide variety of diseases and the practice was in the process of reviewing the way in which these clinics were delivered to ensure that patients with multiple chronic diseases need only attend one review clinic. A process was in place to ensure patients with certain chronic diseases, such as chronic obstructive pulmonary disease (COPD) and diabetes, held their own self-management plans.

The practice used an alert system on the computer system to identify patients at high risk of unplanned admission to hospital and had ensured these patients had a comprehensive personalised care plan. These plans included details of past and current medical history, prescribed medication, advanced care planning and decision making, other involved agencies and next of kin details.

Interviews with the clinical staff demonstrated the culture in the practice was that patients were referred to relevant services on the basis of need. Patients age, sex and ethnicity was not taken into account in the decision making process unless there was a clinical reason for doing so.

Management, monitoring and improving outcomes for people

The GP partners monitored how well the practice performed against key clinical performance indicators such as those contained within the Quality and Outcomes Framework (QOF) (QOF is a voluntary incentive scheme for GP practices in the UK which financially rewards practices for managing some of the most common long term conditions and for the implementation of preventative measures).

The practice was able to demonstrate that it was undertaking clinical audit cycles to help improve patient outcomes. We saw examples of a number of audits including completed two cycle audits in relation to the prescribing of the antibiotic co amoxiclav and a review of treatment for patients diagnosed with iron deficiency anaemia. Both audits showed improvement between cycles and the audit into iron deficient anaemia had resulted in a reduction of the use of certain non-steroidal anti-inflammatory drugs (NSAIDS) which can cause side effects following long term use.

The practice used the information collected from QOF and performance against national screening programmes to monitor outcomes for patients. For example 100% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive care plan documented in their record in the preceding 12 months which had been agreed with the patient and their family/ carers. 94.6% of patients with diabetes had received a foot examination and risk classification within the preceding 12 months. 90.4% of patients with hypertension in whom the last blood pressure reading measured within the preceding 9 months was 150/90mmHg of less. The practice had scored above the England average in the majority of QOF indicators with the only exception being that the practice was just below the England average regarding providing patients with dementia a face-to-face review within the preceding 12 months. The practice was aware of this and were trying to address this issue by implementing a system where the health care assistant as well as the practice nurse carried out dementia reviews and cognitive screening. We confirmed the practice had obtained the maximum number of points available to them for delivering a good standard of care to patients with a range of conditions including asthma, chronic obstructive

Good

Are services effective?

(for example, treatment is effective)

pulmonary disease, depression, heart failure, hypothyroidism, rheumatoid arthritis, stroke & ischaemic heart failure and to patients with a learning disability or those in need of palliative care.

There was a protocol for repeat prescribing which was in line with national guidance. Staff were aware of the action to take when a patient had reached the authorised number of repeat prescriptions or when a prescription had not been collected.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of palliative care patients and their families.

Effective staffing

The staff team included medical, nursing, managerial and administrative staff. The partnership consisted of two GP partners. We reviewed staff training records and found that staff had received a range of mandatory and additional training. This included basic life support, fire safety, information governance, information governance, safeguarding, equality and diversity, infection prevention and control and more clinical based training for clinical staff.

The GPs were up to date with their yearly continuing professional development requirements and had been revalidated (every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list). The practice nurse reported they were supported in seeking and attending continual professional development and training courses. The practice was also a teaching and training practice and provided training for medical students.

All staff undertook annual appraisals that identified learning needs. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses and staff training files confirmed this.

We looked at staff cover arrangements and identified that there was always sufficient GP cover on duty when the practice was open. Holiday, study leave and sickness were covered in house whenever possible. The GPs, management team and reception staff covered for each other and the practice rarely relied on the use of locum GPs. One of the GPs told us that the practice had only used a locum to provide two days cover in the previous year. When the practice had needed to use a locum GP a comprehensive locum induction pack and handbook was in place.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. The practice received written communication from local hospitals, the out-of-hours provider and the 111 service, both electronically and by post. Staff we spoke to were clear about their responsibilities for reading and actioning any issues from communications with other care providers. They understood their roles and how the practice's systems worked.

The practice demonstrated they worked with other services to deliver effective care and treatment across the different patient population groups. The practice held 6 weekly multidisciplinary team meetings to discuss palliative care patients and bi monthly safeguarding meetings to discuss vulnerable children. However, minutes of these meetings were not always recorded which could increase the risk that actions arising from previous meetings might not always be reviewed or followed up. The practice was also able to demonstrate effective multi-agency working with substance misuse practitioners, the acute care team, district nurses, health visitors, community midwives and Macmillan nurses.

The practice had identified their patients most at risk of an unplanned hospital admission and had sent a letter to all of these patients notifying them of their named GP and inviting them to cooperate in the development of a fully comprehensive personal care plan. In addition the GPs and practice nurse had received training on shared decision making (SDM) which is a process designed to ensure that there is a two way dialogue between patients and healthcare providers regarding treatment and care plans.

The practice had a system in place to ensure that hospital discharge letters were reviewed and patients contacted, if appropriate to review their medication and ensure the patients' needs were being met. In addition the practice was also involved in a better outcomes scheme aimed at

Good

Are services effective?

(for example, treatment is effective)

ensuring patients with certain long term conditions such as cancer, chronic obstructive pulmonary disease (COPD) and cardiovascular disease were reviewed by the practice within 6 weeks of diagnosis.

The practice had also developed an effective working relationship with the local linked care home, Garden Hill. Practice GPs visited the care home on a weekly basis to carry out consultations and medication reviews and were proactive in arranging and supporting palliative care plans, reducing unnecessary hospital admissions and enabling preferred place of death decisions.

We found appropriate end-of-life care arrangements were in place. The practice maintained a palliative care register. We saw there were procedures in place to inform external organisations about any patients on a palliative care pathway. This included identifying such patients to the local out-of-hours provider.

Emergency hospital admission rates for the practice were slightly higher than the national average at 18.7% (national average 13.6%). The practice had a process in place to follow up patients discharged from hospital and for dealing with hospital communications.

Information sharing

The practice used electronic systems to communicate with other providers. Electronic systems were in place for making referrals, and the practice made referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use and patients welcomed the ability to choose their own appointment dates and times.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to co-ordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

Patients were supported to express their views and were involved in making decisions about their care and treatment. Of the 111 patients who participated in the 2014 National GP Patient Survey published In January 2015, 82.8% reported the last GP they visited had been good at involving them in decisions about their care. This compares to a national average of 74.6% and local CCG average of 79.5%. The same survey revealed that 70.3% of patients felt the last nurse they had seen had been good at involving them in decision about their care compared with a national average of 66.2% and local CCG average of 72.7%.

Staff told us that they asked patients for their consent before undertaking any care or treatment and acted in accordance with their wishes. Staff told us that they ensured they obtained patients' written, verbal or implied consent to treatments. We saw a copy of the patient consent form used by the practice for muscular skeletal injections and staff told us that a signed copy of the consent form would be saved on a patient's electronic medical record.

GPs we spoke with showed they were knowledgeable of Gillick competency assessments of children and young people. Gillick competence is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. Clinicians we spoke with were able to demonstrate an understanding of the Mental Capacity Act (MCA) 2005 and their responsibilities in relation to this. Practice clinicians had downloaded the 'Deciding Right' app onto their mobile phones and IT equipment as an aide to assist them with any queries concerning the MCA including best interest decision making. The practice had electronic mental capacity assessment forms to record decisions made in accordance with the Mental Capacity Act 2005.

Health promotion and prevention

There was a range of information on display within the practice reception area which included a number of health promotion and prevention leaflets, for example on mental health, dementia, sexually transmitted diseases, stress and addictions. The practice website also included links to a range of patient information including family health, long-term conditions and minor illnesses.

We found patients with long-term conditions were recalled to check on their health and review their medications for

Good

Are services effective?

(for example, treatment is effective)

effectiveness. The practice's electronic system was used to flag when patients were due for review. Processes were in place to ensure the regular screening of patients was completed, for example, cervical screening. Performance in this area for 2013/14 at 91% was above the national average of 81.9%.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice performance for immunisations was in line with averages for the CCG. For example, meningococcal C (Men C) vaccination rates for 12 month old children were 81.3% compared to 84.8% locally; for two year old children 95.5% compared to 98.2%; and for five year old children 100% as compared to 98.5% locally. The percentage of patients in the 'influenza clinical risk group', who had received a seasonal flu vaccination, was 69.5% (national average 52.2%) and the percentage of patients aged 65 or older who have received a seasonal flu vaccination was 84% compared to a national average of 73.2%. This high attainment rate had been recognised by NHS England who were due to meet with the practice to establish how this had been achieved as an example of best practice.

The practice also offered NHS health checks for patients between the age of 40 and 74 and new patient health checks.

Outstanding ☆

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients we spoke with said they were treated with respect and dignity by the practice staff. Comments made by patients on Care Quality Commission (CQC) comment cards reflected this. Of the 188 CQC comment cards completed 170 were positive. Words used to describe the practice and staff included excellent, professional, empathetic, supportive, efficient, remarkable and first class. Negative comments received were in respect of delays in getting appointments, not being able to get through to the practice by phone, lack of flexibility with appointment times and delay in being called in by the clinician at the appointed time.

Data from the National Patient Survey, published in January 2015, showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was also above average for its satisfaction scores on consultations with doctors. For example:

- 95.4% said the GP was good at listening to them compared to the Clinical Commissioning Group (CCG) average of 91.7% and national average of 87.2%.
- 93.6% said the GP gave them enough time compared to the CCG average of 90.8% and national average of 85.3%.
- 96.4% said they had confidence and trust in the last GP they saw compared to the CCG average of 94.4% and national average of 92.2%

We observed staff who worked in the reception area and other staff as they received and interacted with patients. Their approach was considerate and caring whilst remaining respectful and professional. This was clearly appreciated by the patients who attended the practice. We saw that any questions asked or issues raised by patients were handled appropriately and the staff involved remained polite and courteous at all times. National GP Patient Survey results showed that 85.5% of respondents found the receptionists at the practice helpful compared with the CCG average of 89.6% and national average of 86.9%.

Reception staff made efforts to ensure patients' privacy and confidentiality was maintained. Voices were lowered and personal information was only discussed when absolutely necessary. A separate room was available if a patient wished to speak to a receptionist in private and the practice had installed a television in the waiting room to reduce the chance of conversations being overheard

Staff were familiar with the steps they needed to take to protect patients' dignity. Consultations took place in consultation rooms with an appropriate couch for examinations and curtains to maintain privacy and dignity. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in those rooms could not be overheard.

Staff were aware of the need to keep records secure and maintain confidentiality. We saw that patient records were computerised and systems were in place to keep them safe in line with data protection legislation. The practice manager was nominated as a Caldicott Guardian (a person responsible for protecting the confidentiality of a patient and enabling appropriate information sharing). Staff who needed to discuss patients with other members of staff, including reception staff avoided using patients names wherever possible instead identifying patients by their medical record number.

Care planning and involvement in decisions about care and treatment

The National GP Patient Survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment, and generally rated the practice well in these areas. For example, the survey showed 82.8% of the 111 patients who responded to the survey said the last GP they saw or spoke to involved them in decisions about their care and 70.3% said the last nurse they saw or spoke to involved them in decisions about their care. Both these results were higher than the national averages.

The majority of the survey results for the practice were above the national averages. For example, 96.2% of respondents described their overall experience at the GP surgery as fairly good or very good compared to the CCG average of 90.6% and national average of 67.9%. The percentage of patients who stated they would recommend the surgery to someone new to the area was 85.4% (CCG average 81.9%, national average 78%).

We saw that a translation and interpreter service was available for patients who did not have English as their first

language and a sign language service was available for patients with a hearing impairment. Providing this type of service helps to promote patients' involvement in decisions about their care and treatment.

Clinicians had received training on shared decision making, a process designed to ensure that there is a two way dialogue between patients and healthcare providers regarding treatment and care plans.

Longer appointments were available for vulnerable patients, including carers or those with additional needs such as a learning disability or mental health issue. The health care assistant was able to give us an example of what additional provision the practice made for such patients by describing how the practice ensured a patient with a certain condition, who suffered from anxiety in the waiting room was escorted straight to a clinical room when attending the surgery.

The practice was proactive in identifying and responding to the needs of carers. One of the patient participation group members was also a board member of the Carers Association which had helped to ensure that there were effective links between the two organisations and a good flow of information regarding services and support available for carers. A comprehensive carer's pack was readily available for patients which included information on what support, both general and financial was available and signposted carers to relevant agencies. The practice was also working with another local non-profit organisation, Bliss=Ability (an information service providing information on all aspects of disability in the appropriate accessible formats) and would regularly signpost patients to this service. Bliss=Ability are able to provide information on local support groups, how to access equipment, who a patient can contact to ensure they are in receipt of appropriate benefits and how to obtain support as a carer or family member.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our visit told us staff responded compassionately when they needed help and provided support when required. The CQC comment cards we received were also consistent with this feedback. For example, patients commented that staff were helpful, thoughtful, caring, respectful, supportive, honest and empathetic.

We saw there was a variety of patient information on display throughout the practice. This included information on health conditions, health promotion and support groups.

The practice was proactive in identifying and responding to the needs of carers and had forged effective working relationships with the local Carers Association and other support agencies to which patients could be signposted. A comprehensive carer's pack was available giving carer's information on various support mechanisms and groups. The GPs had tear off carers' pads on their desks which enabled them to immediately give patients with a caring responsibility information regarding what support was available for them. Nationally reported data indicated 20.9% of the practice population had a caring responsibility (national average 18.2%).

Patients who had experienced an unplanned admission to hospital were contacted by practice staff following discharge to ensure all their needs were being met and to discuss any medication changes.

The National GP Patient Survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

- 89% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 87.6% and national average of 82.7%.
- 82.1% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 80.7% and national average of 78%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked collaboratively with other agencies and regularly shared information to ensure timely communication of changes in care and treatment. For example, the practice had a palliative care register and held six weekly multidisciplinary meetings to discuss patients and their families' care and support needs. Practice staff were also able to demonstrate that they worked closely with other health care professionals such as community psychiatric nurses and the heart failure team.

The practice held a register of those patients with a learning disability or mental health condition. These patients were offered an annual health check and flu vaccination. An alert was placed on the practice computer system for all vulnerable patients which enabled staff to identify them and ensure their needs were met when requesting appointments or during consultations. The practice had taken steps to ensure all dementia patients were identified and received appropriate treatment and services.

The practice had a higher than England average number of patients over the age of 75 (12.2% compared to the national average of 7.6%) but ensured that all of these patients had a named GP and were offered a health check.

As well as a comprehensive carers pack the practice also had a pack for military veterans and a poster in reception alerted patients to services available for veterans to help them settle back into civilian life. This included support in finding employment, accommodation, schools, healthcare and welfare.

The practice could demonstrate that it had considered suggestions for improvement and changes to the way services were delivered as a consequence of feedback from patients. This had included:

- Appointing a male GP
- Appointing a health care assistant to ease appointment demand with the practice nurse.
- Reviewing the range of information available in the waiting room.
- Making a room available for patients to speak to receptionists in private.
- Installing a TV in the waiting room to provide background noise with a view to improving privacy at the reception desk.
- Implementing an online appointment booking and repeat prescription ordering service.

The practice had an active patient participation group (PPG) consisting of 12 members of mixed gender who met on a bi monthly basis.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups of people in the planning of its services. The practice had access to a telephone translation service if required for those patients for whom English was not their first language. The practice also maintained registers for patients with caring responsibilities, patients with learning disabilities and patients receiving palliative care.

The premises were situated on the ground floor of the building which met the needs of people with disabilities. The reception area, treatment and consultation rooms were all accessible by those with mobility difficulties and there was step free and wheelchair access to the building although the entrance door was not electrically operated. The practice did not have a car park but on street parking was readily available free of charge nearby

The practice had a male and a female GP, which gave patients the ability to choose to see a doctor of a particular sex if preferred.

Patients were easily able to register with the practice and patients who were not registered, such as holiday makers or those of no fixed abode were able to access appointments as temporary residents.

Access to the service

Surgery opening times were between 8.30am to 7pm on a Monday and between 8.30am and 6pm on a Tuesday to Friday.

The practice had recognised the needs of different groups in the planning of its services. For example, the practice offered an extended opening time up to 7pm one night per week and telephone consultations to ensure the needs of people who worked and students could be accommodated.

The majority of the patients we spoke with and those who completed Care Quality Commission (CQC) comment cards

Good

Are services responsive to people's needs?

(for example, to feedback?)

said they were satisfied with the appointment system operated by the practice. Of the patients who participated in the 2014 National GP Patient Survey published in January 2015, 88.5% said they could easily get through to someone at the practice on the telephone (national average 71.8%) and 80.2% stated they were satisfied with the practice opening hours (national average 75.7%).

Appointments could be booked in the surgery, by telephone or online. We looked at the practice's appointment system during our inspection and found that a routine appointment was available with either GP or the practice nurse that same day. Two GP appointments per day were held open for urgent appointment requests and patients requesting emergency appointments were seen at the end of surgery. Telephone consultations were available by appointment and requests for email consultation were considered on a case by case basis. Requests for home visits were triaged to ascertain whether the more appropriate course of action was immediate referral to the local acute care team.

Practice staff were due to attend 'Think Pharmacy First' training which is a scheme that allows patients who receive free prescriptions to go straight to their pharmacist to receive treatment without needing to visit their GP to obtain a prescription first.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed there was an answerphone message advising the called to ring the NHS 111 service for further advice and guidance.

The practice had been pro-active in ensuring that their older patient population were able to access online patient services. This had been achieved by inviting Healthwatch and a local non-profit church organisation into the practice to provide informal IT training sessions and support. This had not only enabled older patients to register for online services such as the ordering of repeat prescriptions but led to some patients enrolling to undertake additional IT training at the church which in turn led to the development of improved social networking.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager and assistant practice manager were designated to handle all complaints and would investigate complaints in conjunction with the GP partners.

We saw that information detailing how to make a complaint was included in the practice information leaflet, on a poster displayed in the waiting room and on the practice website.

The practice recorded all complaints as significant events and felt this demonstrated they had an open and transparent system in place. From the complaints we looked at we found that they had been dealt with appropriately and apologies issued where a complaint was felt to be justified. Lessons learned and matters arising from complaints were disseminated to practice staff via team meetings with the aim of trying to identify trends and themes.

Staff were able to give us examples of where action had been taken when concerns had been identified. This had included ensuring reception staff checked to see if a patient had additional needs before providing advice or signposting to another service (i.e. a pharmacy) to ensure individual patient needs were being met.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. This was clearly outlined in their mission statement which stated 'At Imeary Street Surgery our patients are at the heart of everything we do. We strive for continuous improvement and take pride in providing the highest quality care. We understand the value of continuity and are friendly and caring in our approach. We are connected to our community and are committed to being flexible and responsive to their needs'. All staff were involved in developing the mission statement and told us they understood and were committed to their roles and responsibilities in relation to this.

The practice did not have a written business plan but the practice manager told us staff had developed their long term strategy during regular weekly partner meetings. Issues such as succession planning for reception staff nearing retirement age, managing increased workload and demand and size constraints of the premises as patient list size increases had been considered. Risk assessments had subsequently been recorded for these issues and mitigating actions recorded.

The practice was committed to improvement and cited examples of this as being their move towards combined chronic disease management clinics for patients with complex health needs and the use of health checkers to ensure the practice was meeting the needs of patients with a learning disability by ensuring practice literature and leaflets were in an easy to understand format.

Governance arrangements

There was a clear leadership structure with named members of staff in lead roles. For example, the practice nurse was the lead for infection control and medicines management, one of the GPs was the lead for safeguarding and the other acted as the QOF performance lead. The practice manager was the nominated Caldicott Guardian (member of staff responsible for protection patients' confidentiality and enabling appropriate information sharing) and there was a dedicated prescription clerk. Members of staff we spoke with told us they were clear about their own roles and responsibilities as well of the roles of others. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the shared drive on any computer within the practice. We looked at a sample of these policies and procedures which were up to date.

The practice held regular staff, clinical and practice meetings. We looked at minutes from recent meetings and found that performance, quality, risks and issues outstanding from previous meetings had been discussed.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented. For example risk assessments had been carried out for each room within the premises. Any risks relating to individual patients were recorded on the patient's record to alert staff of any potential concerns.

Leadership, openness and transparency

The practice manager and assistant practice manager were responsible for human resource policies and procedures. A staff handbook was available and policies and procedures were easily accessible both electronically and in paper format. All new staff went through an induction process and an induction pack was available.

We found there were good levels of staff satisfaction which had resulted in a stable workforce and good staff retention rates. Staff we spoke with were proud of the practice and felt it was well led and a good place to work. They told us there was an open and honest culture within the practice and they were happy to raise issues both informally and during team meetings.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comments and complaints received.

The practice had carried out a patient survey in December 2013. The results had been considered by practice staff and the patient participation group and had led to an action

Are services well-led?

Good

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

plan to put improvements in place by March 2014. This had included implementing an online appointment and prescription ordering service, the recruitment of a male GP and improved information on the practice website

The practice had considered reviews posted on the NHS Choices website and had signed up to the 'I Want Great Care' campaign where patients can provide feedback on the care afforded to them by GP practices and hospitals. Comments we viewed on both the NHS Choices and 'I Want Great Care' websites about the practice were very positive. The practice had been rated as five stars out of five from 10 reviews posted on the 'I Want Great Care' website with both GPs also receiving a 5 star rating.

The practice had an active patient participation group (PPG) which had identified several aims and objectives for the coming year. This included ensuring easy to read health information leaflets were available for patients with a learning disability and all practice patients had a named GP. Past improvements as a result of PPG involvement had included ensuring that patients were aware that a room was available should they wish to speak to a receptionist in private and implementing online services to book appointments and request repeat prescriptions. PPG members we spoke to during the inspection told us that they felt the practice regularly sought their views and involvement and that their meetings were successfully and productive.

The practice gathered feedback from staff through staff meetings and on a more informal day to day basis. Staff we spoke with told us they regularly attended staff meetings and felt these provided them with the opportunity to discuss the service being delivered, feedback from patients and raise any concerns they had. They said they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice which they said helped to improve outcomes for both staff and patients.

A whistle blowing policy was in place which was available to all staff electronically on any computer within the practice. Staff we spoke with were aware of the policy, how to access it and said they would not hesitate to raise any concerns they had.

Management lead through learning and improvement

The practice provided staff with opportunities to continuously learn and develop. The practice nurse told us she had opportunities for continuous learning to enable her to retain her professional registration and develop the skills and competencies required for chronic disease management. Regular staff appraisals were taking place and personal development plans identified.

The practice had regularly reviewed significant events and other incidents with a view to identifying any trends or themes and determine learning opportunities. These events were shared with relevant staff as and when appropriate through team meetings.