Derby Family Medical Centre

Quality Report

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

Ratings

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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Derby Family Medical Centre on 02 December 2014. Overall the practice is rated as good.

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

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

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Most patients said they found it easy to make an appointment and urgent appointments were available the same day.
- Information about services and how to complain was available and easy to understand.
- 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.
- 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.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and the Patient Participation Group (PPG).
- 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 management. The practice proactively sought feedback from staff and patients, which it acted on.

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

Importantly the provider should:

Summary of findings

- Continue to take steps to try and improve the process for making appointments and investigate ways to improve telephone access to ensure patients can access appointments when needed.
- Strengthen the system for recording and analysing significant events to ensure lessons are identified and learned to prevent events reoccurring.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Suitable arrangements were in place to ensure all staff had the required checks prior to employment and to safeguard children, and vulnerable adults against the risk of abuse. There were enough staff to keep patients safe.

Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. The practice was visibly clean and robust infection prevention and control procedures were in place. Staff had undertaken appropriate training to deal with medical emergencies and emergency medicines and equipment were securely stored.

Are services effective?

Good

The practice is rated as good for providing effective services.

Data showed most patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it to improve their practice and patient outcomes. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health.

Staff had received training appropriate to their roles, and any further development needs had been identified and there were plans in place to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams to ensure the effective case management of patients care. This included the community matron, pharmacist and hospital services.

Are services caring?

Good

The practice is rated as good for providing caring services.

The 2014 national patient survey results showed patients rated the practice higher than others for some aspects of care. This included GPs treating patients with care and concern, involving them in decisions about their care and being good at explaining tests and treatments. Patients told us they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.

Summary of findings

Information to help patients understand the services was available in English and other languages appropriate for the languages spoken by the practice population. We saw positive examples to demonstrate how patient's choices and preferences were valued and acted on. Staff treated patients with kindness and respect, and maintained confidentiality. Views from other health professionals we spoke with was very positive and aligned with our findings.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice leadership demonstrated awareness of cultural and language differences amongst its diverse practice population.

The practice population comprised of 95% black and minority ethnic groups with the majority of registered patients being of Asian origin. Translation and interpreting services were available on site to cater for this need and most staff were bi-lingual.

Most patients said they found it easy to make an appointment with urgent appointments available the same day for all population groups. Some people told us improvements were still required to improve telephone access, reducing waiting times and availability of non-urgent appointments with a named GP to ensure continuity of care.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand, and records reviewed showed the practice responded quickly to issues raised. Staff acted on suggestions for improvements and changed the way they delivered services in response to feedback.

Are services well-led?

Good

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

The practice had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.

There were systems in place to identify risks and improve quality the quality of services delivered. The practice proactively sought

Summary of findings

feedback from patients and the patient participation group (PPG), which it acted on. Staff had received inductions, regular performance reviews. There was a high level of staff satisfaction and engagement with leadership.

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.

Staff demonstrated a caring approach to the needs of older people, and respected their dignity and independence. They were able to recognise signs of abuse and knew the appropriate action to take to safeguard older people. The practice offered proactive and personalised care to meet the needs of older people. All patients aged 75 and above, had a named GP to ensure continuity of care.

A range of enhanced services, for example, in dementia and end of life care was offered. Nationally reported data showed outcomes for conditions commonly found in older people were good. The practice was also responsive to the needs of older people, and offered home visits and same day appointments and / or telephone consultations for patients over 75.

The practice team had introduced a system whereby they thoroughly reviewed prescribed medicines for all newly registered older patients to ensure these were appropriate for their medical conditions.

People with long term conditions

Good

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

The practice had identified high rates of chronic diseases in the practice population. They understood the needs of their patients and worked towards improving the service for them.

Nursing staff had lead roles in chronic disease management, and clinics were available for patients with diabetes, asthma, chronic obstructive pulmonary disease (lung disease) and hypertension. Information was also made available to patients and their carers in relation to their medical conditions and organisations offering support.

Patients at risk of hospital admission were identified as a priority and suitable care planning arrangements were put in place. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. All these patients had a structured annual review to check that their health and medication needs were being met.

Summary of findings

Patients told us repeat prescription requests were available in person and on-line, and were ready to collect within 48 hours. Rapid access appointments and home visits were also available when needed, and this was acknowledged positively in feedback from patients.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

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. 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 accident and emergency (A&E) attendances.

Staff demonstrated a good awareness of safeguarding children and we saw good examples of joint working with midwives and health visitors.

Immunisation rates were high for all standard childhood immunisations. Antenatal and pre-conceptual care was offered to mothers and the premises were suitable for children and babies. Same day appointments were offered for children under the age of five as well as appointments outside of school hours.

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. This included regard to their cultural and linguistic differences, as the practice population comprised of 95% black and minority ethnic groups. The practice was proactive in offering interpreting services, online services, same day telephone access and extended hours on a Tuesday evening.

A full range of health promotion and screening services that reflected the needs for this age group were available. This included NHS health checks for people aged 40 to 75 years, smoking cessation advice and cervical screening. The practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

Summary of findings

The practice held a register of patients living in vulnerable circumstances including people with a learning disability and those receiving end of life care. Annual health checks and a regular review of care plans were undertaken for these population groups. Staff were flexible in arranging suitable appointments, this included longer appointments were needed.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Vulnerable patients were offered advice and information on how to access various support groups and voluntary organisations. This included carers direct, cruse bereavement and counselling services.

The practice staff were responsive to the needs and circumstances of vulnerable patients and avoided booking appointments at busy times for people who may find this stressful. They also offered to book convenient appointments to ensure that vulnerable patients such as those with learning disabilities could attend with their carer.

People experiencing poor mental health (including people with dementia)

Good

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

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. We saw evidence to demonstrate patients experiencing mental ill health had received regular physical health checks from the GP.

There was evidence of good liaison and information sharing between the practice and psychiatrists including the prescribing of medicines to ensure patients received coordinated care.

Some staff had received training on how to care for people with mental health needs and dementia. We found dementia screening and assessments were carried out, and patients were referred to the memory clinic where appropriate. Staff carried out advance care planning for patients with dementia.

Summary of findings

Annual physical health checks, including checks on alcohol consumption and blood pressure were offered for patients with mental health needs. The practice had a system in place to follow up patients who may have been experiencing poor mental health and were at risk of long term health conditions.

Patients experiencing poor mental health were signposted to various support groups, voluntary organisations and counselling services were appropriate.

Summary of findings

What people who use the service say

During our inspection, we spoke with 12 patients including the chair of the practice's patient participation group (PPG). The PPG chair told us they worked well with the practice staff and that patient feedback was acted on to improve the service.

We also received comment cards from 41 patients. Most patients were complimentary about the staff, and the care and treatment they received. Patients described the staff as friendly, professional, supportive and caring. They felt they were treated with kindness and respect, and were involved in decisions about their care.

Patients told us the premises were clean, and that the facilities were accessible and appropriate for their needs. Some patients told us it was difficult to book an appointment in the morning, see their preferred GP and waited for up to 15 minutes before they saw their GP.

These overall views were reflected in the most recent results from the national GP survey from July 2014. 456 surveys were sent out to patients and 89 were returned which was a 19% response rate. The practice performed better than other practices in the local area in respect of the percentage of patients who said the GP was good at: treating them with care and concern; involving them in decisions about their care, and explaining tests and treatment.

Areas where the practice did not perform as well related to the appointment system and access. For example: 55% described their experience of making an appointment as good and 34% said they usually get to see or speak with their preferred doctor. The practice's recent survey results showed patients felt improvements had been made to access and the appointment system.

Two external health professionals we spoke with praised the staff for working in partnership with them to ensure patients received good care. They said the practice staff had a caring and responsive approach to the needs of patients, and worked towards improving patient care and medicines management.

Areas for improvement

Action the service SHOULD take to improve

- Continue to take steps to try and improve the process for making appointments and investigate ways to improve telephone access to ensure patients can access appointments when needed.
- Strengthen the system for recording and analysing significant events to ensure lessons are identified and learned to prevent events reoccurring.

Derby Family Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector. The team included an expert by experience, a GP and practice manager.

Background to Derby Family Medical Centre

Derby Family Medical Practice provides primary medical services to 6,182 patients from a single location. The registered address with the Care Quality Commission (CQC) is 1 Hastings Street, Derby, Derbyshire, DE23 6QQ. The practice serves the local areas of Normanton, Peartree, Sunnyhill, Littleover and Sinfin. Public Health England data shows the area served by the practice has high unemployment and deprivation levels, which are above the practice average across England. In addition, there is a high rates in respect of the prevalence of chronic diseases such as type 2 diabetes.

The practice population is multicultural with 95% of the practice patients having a black or minority ethnic background. Patients have access to translation and interpreting services, including an Urdu and Punjabi interpreter based at the practice. A wide range of services are offered, for example: a range of clinics for patients with long term conditions such as diabetes and asthma, minor surgery, family planning, maternity care, immunisations and health screening .

The practice comprises two male GP partners, a female salaried GP and three sessional GPs. The nursing staff includes one advance nurse practitioner, two practice nurses and a health care assistant. The clinical staff are supported by a practice manager and ten reception / administrative staff. This is a training practice.

The practice is open from 8:00am to 6:30pm weekdays with the exception of a Tuesday evening when the surgery is open until 8:00pm. The practice has opted out of providing out-of-hours services to their own patients. There is information on the website and on the practice answer phone advising patients of how to contact the out of hour's service outside of practice opening hours. The out of hours service is provided by Derbyshire Health United.

The practice was previously inspected by the CQC on 11 February 2014. They met all of the required standards which were inspected.

The CQC intelligent monitoring placed the practice in band 6. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Why we carried out this inspection

We inspected this service as part of our new 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 provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

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 02 December 2014. During our visit we spoke with a range of staff (two GPs, a practice nurse, a practice manager and four administrative staff). We also spoke with two external health care professionals.

We spoke with 12 patients who used the service. We observed how people were being cared for and reviewed the practice records. We received 41 comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents, accidents and national patient safety alerts, as well as comments and complaints received from patients.

The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, there had been a near miss when a patient had not received a blood test following a request from a hospital outpatient department. Meeting minutes we saw demonstrated the incident was discussed by the practice team to promote shared learning. This also ensured the safety of the patient.

National patient safety alerts were disseminated via email and in person to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. For example, the practice received the South Derbyshire Clinical Commission Group (CCG) monthly report. This report included, drug safety updates, and new guidance from the medicines and healthcare products regulatory agency (MHRA), and Derbyshire joint area prescribing committee. Records reviewed showed alerts were discussed at clinical meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

We reviewed a sample of safety records, incident reports and minutes of meetings where these were discussed within the last 12 months. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We reviewed four significant events that had occurred during the last 12 months. The records provided a summary of: what happened, what could have been done, action taken and learning points for most of the incidents.

Minutes of meetings showed significant events was a standing item on the practice meeting agenda. Staff we spoke with knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. For example, following two significant events the practice introduced same day appointments and / or telephone consultations for patients over 75; and all GPs were required to thoroughly review medicines for all newly registered older patients to ensure these were appropriate for their medical conditions.

Reliable safety systems and processes including safeguarding

The practice had safe systems to manage and review risks to vulnerable children, young people and adults. For example, training records showed all staff had up to date training for safeguarding of vulnerable adults and children that was relevant to their role. This included level three children's training for the GP safeguarding lead and attendance at educational sessions organised by the local safeguarding board. The GP demonstrated they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the lead GP was and who to speak with if they had a safeguarding concern.

The provider had safeguarding policies in place and staff had a clear understanding of these procedures. Staff we spoke with were able to describe what constituted abuse; and knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities to record and report the safeguarding concerns, as well as share information with relevant agencies. Contact details of the local safeguarding teams were easily accessible to staff on notice boards. Staff gave examples of actions taken in response to safeguarding concerns involving children, young adults and the welfare of older people.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans, patients who had experienced domestic violence and families living in disadvantaged circumstances. GPs we spoke with told us they used the required codes on patient records to ensure risks were clearly flagged and reviewed. Records reviewed demonstrated good liaison with partner agencies such as the police, social services and midwives.

A chaperone policy was visible in the waiting room noticeboard and in consulting rooms. 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. All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Records reviewed showed all receptionists had undertaken chaperone training and satisfactory criminal record checks had been completed. All staff we spoke with understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines management

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

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines.

A member of the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role, as well as updates in the specific clinical areas of expertise for which she prescribed.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Prescriptions not collected were also reviewed to ensure that patients still required the medicines. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. Each request was reviewed by a GP including checks on the patient's details, blood test results, and ensuring that a medication review had been undertaken or was planned. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. We saw records of meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice.

The practice held weekly meetings with the Southern Derbyshire CCG medicines management pharmacist. We spoke with the pharmacist and they confirmed positive working relationships with the staff and the practice staff's engagement in the prescribing quality scheme. This scheme aims to ensure cost effective prescribing whilst maintaining and improving quality.

In line with this scheme, the practice had produced an action plan which focused on key areas to improve patient's care and treatment. For example: all clinical staff carrying out respiratory clinics were to receive inhaler technique training, and the practice had agreed to the use of PINCER indicators to improve patient safety. The aim of the PINCER audit tool is to identify at-risk patients who are being prescribed drugs that are commonly and consistently associated with medication errors; so that corrective action can be taken to reduce the risk of occurrence of these errors.

Cleanliness and infection control

Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. We observed the premises to be visibly clean and tidy. Cleaning schedules were in place and records reviewed showed the areas cleaned and the frequency of cleaning.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training on infection control practices that were specific to their role, and refresher training updates in line with the practice policy. The immunisation status of staff including Hepatitis B immunity was obtained as part of pre-employment

checks to ensure the safety of patients. An infection control audit had been undertaken in March 2014, and improvements identified for action had been completed. Minutes of practice meetings showed that the findings of this audit was discussed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy.

Other infection control policies were in relation to; hand washing, spillage of body fluids and needle stick injury. Staff knew the procedures to follow in the event of a spillage or injury. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Appropriate arrangements were in place for the storage and disposal of sharps bins and waste.

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).We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw records that confirmed this. For example, all portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. We saw evidence of calibration of medical equipment such as weighing scales, spirometers and blood pressure measuring devices.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. However, this policy did not include all the pre-employment checks required by law including the process of risk assessment to determine whether DBS checks for non-clinical staff who acted as chaperones were necessary.

The four staff records that we looked at showed appropriate recruitment checks had been undertaken prior to staff's employment. Information obtained included: proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS).

Staff told us about the arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included checks of the building, the environment, electrical installations, and fixture and fittings. We saw records to confirm that annual and regular checks were completed. A health and safety policy was in place, and relevant information was displayed for staff to see.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, where increases in demand were identified additional clinical sessions were added to the normal weekly pattern to ensure that all patients needing to be seen were able to obtain an appointment.

Emergency processes were in place to refer patients whose health deteriorated suddenly or were acutely ill. Staff we spoke with gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment. The practice also monitored repeat prescribing for patients receiving medication for mental ill-health to evaluate treatment responses and any side effects.

Good

Are services safe?

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records reviewed showed all staff had received training in basic life support and / or cardio pulmonary resuscitation (CPR). Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff we spoke with knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia were available in a secure area of the practice. Appropriate arrangements were in place to ensure emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. The plan identified risks such as unplanned staff absences, adverse winter weather, flu pandemic, loss of electricity and water supply. The mitigating actions for each risk were recorded to ensure staff were aware of how to manage the risks. The plan also contained relevant contact details for staff to refer to. This included local health services and contact details for companies providing utilities such as gas and electricity.

Records reviewed showed the practice had carried out a fire risk assessment in May 2014. This assessment detailed the fire hazards within the practice, people at risk and actions required to maintain fire safety. For example, all staff had received fire awareness training and were familiar with the fire evacuation procedures. Regular maintenance and testing of fire equipment was also undertaken. This included annual servicing of the fire alarm system and fire extinguishers, as well as weekly fire alarm tests.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed, and required actions agreed.

The staff we spoke with and the evidence we reviewed confirmed these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of different health conditions; and our review of the clinical meeting minutes confirmed that this happened.

The practice used computerised tools to risk assess and identify patients at high risk of developing long term conditions and / or with complex needs who had multidisciplinary care plans documented in their case notes. A traffic light colour coding system was used to recognise and identify patient's with palliative care needs. This enabled GPs to assess patients' needs early, leading to better planning of their care.

We found the practice worked towards the gold standards framework for end of life care and maintained a palliative care register. Records reviewed showed regular multidisciplinary meetings were held to discuss the care and support needs of these patients and their families. The meetings were attended by the GPs and community matron for example and patients recently discharged from hospital were assessed according to need.

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

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated to support the practice to carry out clinical audits and improve the service. The practice showed us four clinical audits that had been undertaken in the last year. One of these audits was a completed cycle where the practice was able to demonstrate the changes resulting since the initial audit.

For example, an audit was undertaken to review patients on methotrexate and azathioprine were receiving appropriate blood monitoring, in accordance local prescribing guidance. These two medicines are used in the treatment of rheumatoid arthritis. The first audit completed identified that 61% of patients had received monitoring in accordance with the guidance. However, the second cycle completed a year later showed 100% of the patients had received the appropriate blood monitoring, and an effective recall system was in place to remind patients to attend blood tests every three months. This was a significant improvement and evidenced that changes to treatment were made where needed to ensure outcomes for patients had improved.

The practice had undertaken a minor surgery audit of 56 patients that had received a steroid joint injection between 01 April 2013 and 09 January 2014. The audit results showed no reported incidences of an infection or complication to all patients' condition after the surgery.

The GPs told us clinical audits were often linked to medicines management information and safety alerts. For example, the practice audited the use of allopurinol which is a medicine taken to prevent gout. The GPs had carried out a review of patients who were prescribed this medicine to check the effectiveness in treating the patient's condition. As a result of this audit, GPs ensured that patients had attended relevant blood tests to monitor their condition.

Good

Are services effective?

(for example, treatment is effective)

We found clinical audit work informed the GPs' prescribing practice to ensure they were offering care and treatment in line with best practice guidelines. Records were maintained to show how they had evaluated the service and documented the success of any changes. This also included support from the CCG medicines management pharmacist. We reviewed data from the local Clinical Commissioning Group (CCG) of the practice's performance for antibiotic prescribing, which was better than the average for similar practices in the area.

The practice had a repeat prescribing policy in place which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice used the information collected for the quality and outcomes framework (QOF) and performance against national screening programmes to monitor outcomes for patients. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. For example, 88.9% of patients with diabetes had received an annual medication review. The practice met all the minimum standards for QOF in asthma, cancer, epilepsy and chronic obstructive pulmonary disease (lung disease) for example. This practice was not an outlier for any QOF or other national clinical targets.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example, the rates of accident and emergency admissions, referral rates to secondary and other community care services. We saw minutes from meetings where reviews of acute admissions data, elective and urgent referrals were discussed, and that improvements to practice were shared with all clinical staff.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending courses such as annual basic life support, information governance and safeguarding vulnerable adults and children.

We found the practice was committed to staff development and had an appraisal policy in place to encourage the evaluation of learning needs. All staff undertook annual appraisals that identified learning needs from which action plans were documented for most staff. The action plans were then used to assess a staff member's progress in achieving their set targets. Our interviews with staff confirmed the practice was proactive in providing staff training.

All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and prescribing. Those with extended roles for example seeing patients with long-term conditions such as asthma, diabetes and osteoporosis were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with

Good

Are services effective?

(for example, treatment is effective)

complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post.

The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. We found the use of assigning tasks to specific staff within the electronic patient record system ensured accountability and an audit trail of information processed.

The practice was commissioned for the enhanced service to prevent unplanned hospital admissions. Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract. Admission avoidance care plans were agreed with patients, regularly reviewed and shared with other providers to ensure their care needs were being met. We saw that the policy for actioning hospital communications was working well in this respect.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by the community matron and palliative care nurses, and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

We were also shown an example of multi-disciplinary working and case management of a patient with mental health needs and a long term condition. We saw that the patient had received regular physical health checks from the GP. The psychiatrist had also shared a report detailing the outcome of their mental health review including use of anti-psychotic medicines to ensure coordinated care.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We found the practice had also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours.

Electronic systems were also in place for making referrals, and this included the Choose and Book system. Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital. Staff reported this system was easy to use.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record (EMIS) to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that reviews had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

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

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff

Good

Are services effective?

(for example, treatment is effective)

demonstrated a clear understanding of Gillick competencies. These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, written consent was obtained and a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way.

We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering smoking cessation advice to smokers and flu vaccinations to older people. The QOF data showed the practice had identified the smoking status of 98.7% of patients with physical and / or mental health conditions, whose notes contained an offer of smoking cessation support and treatment within the preceding 12 months. This was above the national average of 95.3%.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. We found the practice used computerised disease registers and a structured recall system to invite patients for their health checks. For example, the practice kept a register of all patients with a learning disability and mental health needs and they were all offered an annual physical health check. Where appropriate, patients were signposted to relevant support groups and counselling services. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years; and further investigations were scheduled if risk factors were identified at the health check.

Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and these patients were offered further support in line with their needs. For example 76.1% patients aged 65 and older had received a seasonal flu vaccination which was above the national average of 73.2%. One clinician we spoke with told us they encouraged patients to participate in the management of their health needs and promoted eating a healthy diet and exercise. Documentation of health promotion lifestyle advice was also noted in the patient's notes.

The practice's performance for cervical smear uptake was 84.6%, which was above the national average of 81.9%. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend. There was also a named nurse responsible for following up patients who did not attend screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for most immunisations was slightly above average for the CCG, and a clear policy for following up non-attenders by the named practice nurse was in place.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with 12 patients on the day our inspection and most of them told us they received a very good service . 11 patients told us they were satisfied with the care provided, and said their dignity and privacy was respected. Some patients named specific GPs and administrative staff they felt went an extra mile in providing a caring and pleasant service. We observed positive interactions between staff and patients.

Patients also completed CQC comment cards to tell us what they thought about the practice. We received 41 completed cards and the majority were positive about the service experienced. Most patients commented that the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Six comments were less positive and the common theme related to improving telephone access and the appointment system.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the 2014 national GP patient survey and the practice's own survey for 2013/14. The evidence from all these sources showed patients were satisfied with how they were treated and this was with compassion, dignity and respect. For example, out of 86 patients who responded to the national patient survey: 76% found the receptionists at this surgery helpful; 83% said the last GP they saw or spoke to was good at treating them with care and concern; and 84% said the last nurse they saw or spoke to was good at listening to them.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and incoming telephone calls were answered in a separate room which helped keep patient information private. Signs were in place requesting one patient to approach the reception desk at a time. This prevented people overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

Staff demonstrated sensitivity when describing examples of how they supported vulnerable patients to access the practice without fear of stigma or prejudice. This was also in line with the practice's values to reduce any barriers to patients receiving care and treatment. There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment, and generally rated the practice well in these areas. For example, the 2014 national patient survey data showed 81% of practice respondents said the GP involved them in decisions about their care and 87% felt the GP was good at explaining tests and results. 85% said the last nurse they saw or spoke to was good at explaining tests and treatments, and 82% said the last nurse they saw or spoke to was good at involving them in decisions about their care.

10 out of the 12 patients we spoke with told us that health issues were discussed with them and 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 they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Good

Are services caring?

Patients had access to online and telephone translation services for those patients whose first language was not English. The most commonly spoken languages of patients at the practice were Urdu and Punjabi and we found most practice staff were bi-lingual. About 80% of patients spoke Urdu and / or Punjabi.

The practice also had access to an Urdu and Punjabi speaking interpreter who was based at the practice to ensure that patients could understand their health, care and treatment and ask any questions they may have. This service facilitated and enabled patients who spoke these languages to be involved in decisions about their care and treatment. We spoke to one patient via the interpreter and they confirmed they could express their views and they told us they had confidence in their GP.

Staff told us they worked together with patients to ensure they were partners in their own care, particularly people with long term conditions, mental health needs and those receiving end of life care. This was supported by: the patient feedback we received, care plans reviewed and the 2013/14 Quality Outcomes Framework (QOF) data we reviewed.

For example, 92% of patients with a diagnosis of schizophrenia, bipolar affective disorder and / or other psychoses had a comprehensive, agreed care plan documented in their patient record. This was above the national average of 86.1%. In addition, 88.9% of patients diagnosed with dementia had received a face-to-face review of their care compared to a national average of 83.8%.

Records reviewed showed weekly multi-disciplinary meetings were held to discuss the care needs and support required for patients on the palliative care register, as well as their carers. An external health professional who attended these meetings commented positively about practice staff providing person centred care, knowing their patients very well and having robust care planning arrangements for patients receiving palliative care.

The GPs also acknowledged cultural factors which made it a challenge to discuss and agree end of life care planning arrangements with some of the older patients. Clinical staff we spoke with showed us examples of care plans that had been developed and agreed with the patient. This included personalised care plans required as part of the avoiding unplanned admissions enhanced service to reduce hospital admissions.

Patient/carer support to cope emotionally with care and treatment

The 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, some patients told us they had received help to access support services to help them manage their physical and mental well-being. The comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and patient website told patients how to access a number of support groups and organisations. These included carer's direct, improving access to psychological therapies and cruse bereavement. The practice's computer system alerted GPs if a patient was a carer and a carers register was maintained. This ensured carers needs were reviewed and that written information was provided to ensure they understood the various avenues of support available to them.

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

Records reviewed showed bereavement care, respite care and caring arrangements were discussed in relation to patients receiving end of life care and the support required for their carers. The practice was sensitive to accommodate cultural factors relating to patients care and treatment. For example, completing death certificates promptly to enable burials to take place according religious practices.

People with long-term conditions were assessed for symptoms of anxiety and depression. Where appropriate, a patient was referred for counselling and talking therapy services with their consent. The practice staff also recognised that social isolation was a risk for some of their patients, and worked with other professionals to improve their overall health and well-being.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw records where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population.

One example included providing integrated services for older people and people with long term conditions so as to improve their experience of health and social care services. Meeting minutes showed staff worked in partnership with other service providers to ensure coordinated care for these patients; as well as timely communication of changes in their care and treatment. Patients could also access nurse led clinics for long term conditions such as asthma, hypertension, heart disease and chronic obstructive pulmonary disease (COPD is a lung disease).

The needs of the practice population were understood and suitable systems were in place to address identified needs in the way services were delivered. For example, the practice population comprised of 95% of people from black and other minority ethnic groups; with most registered patients being of Asian origin. The practice staff knew that patients from particular ethnic backgrounds were more likely to experience particular health challenges. For example, the prevalence of type two diabetes was relatively high and this was an identified priority area for the practice.

As a result of this priority, all new patients identified as potentially being at risk of having diabetes were offered screening to enable early diagnosis, treatment and opportunities for self management. All patients with a diagnosis of diabetes were offered an annual health review. The 2013/14 QOF data showed the percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification within the preceding 12 months was 94.5%; which was above the national average of 88.4%.

Some staff we spoke with told us of how they supported patients with a diagnosis of diabetes during religious festivals such as Ramadan. Patients observing Ramadan were required to fast and not to eat food at specific times which potentially could affect the management of their diabetes. One GP we spoke with told us patients were offered advice in a sensitive way so as encourage eating plans that took account of their health needs whilst also enabling them to observe their customs and practice. Patients could access information about diabetes in Urdu.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example, a clock was placed in the waiting room and a baby changing unit in the ladies toilet.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice was located in a diverse multi-cultural area where English was not the first language for a large number of the patients. Most of the staff were bi-lingual and spoke the same languages as the majority of the patient population; for example Urdu, Punjabi, Arabic and Russian.

We found translation services were available for patients who did not have English as a first language; for example patients from Eastern European countries such as Romania and Czechoslovakia. This included access to an interpreter who was based at the practice or a telephone interpreting system called language line.

The practice was accessible to patients with disabilities and those with prams. The practice was situated on the ground floor and there was sufficient space within the waiting area, consultation rooms and corridors to manoeuvre a wheelchair. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events. This was supported by training records we reviewed.

The practice maintained a register of people who may be living in vulnerable circumstances and had a system in place for flagging vulnerability in individual patient records. This included people with a learning disability, mental health needs and carers. Records reviewed showed the practice worked in partnership with other health and social care professionals to support their needs.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits, and how to book appointments through the website. The practice had suitable services in place to ensure different population groups could access appointments when necessary. For example, the practice offered extended opening hours on a Tuesday, an online booking system for appointments and telephone consultations. This was useful to the student and working age population group as they could access the service outside of school hours and work commitments.

Longer appointments were available for patients who needed them and those with long-term conditions. Home visits were offered to patients who were housebound due to illness or disability. This also included appointments with a named GP or nurse.

The practice was open between 08:30am and 6:00pm on weekdays, with the exception of Tuesday when the practice closed at 8:00pm. There were arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Most patients we spoke with were generally satisfied with the appointment system and the comment cards we received mirrored these findings. Patients confirmed they could see a doctor on the same day if they were in urgent need of treatment and could pre-book GP appointments up to four weeks in advance. They also said they could see another doctor if there was a wait to see the doctor of their choice.

The practice's internal survey results for 2013/14 showed 75% of respondents described their overall experience of making an appointment as good and 88.89% found it easy to get through to staff on the phone.

Some patients we spoke with felt improvements were required to the appointment system. Telephone access particularly in the morning and an increase in the availability of non-routine appointments were identified as areas for improvement. This feedback was reflected in the 2014 national patient survey results which showed patient access and the appointment system were areas requiring improvement.

For example, out of 86 surveys received: 61% of respondents were able to get an appointment to see or speak to someone the last time they tried; 34% usually got to see or speak to that GP and 55% of respondents described their experience of making an appointment as good. These values were below the local clinical commissioning group rates of 87%, 60% and 74% respectively.

The practice staff were aware of this data and had monitoring systems in place to evaluate patient demand on the appointment system so as to inform service provision. This included working in partnership with the PPG to help improve the service. We found it was practice policy to offer same day appointments to children under the age of five, people aged 75 and over, and those on care plans to ensure they received timely care. The practice operated a duty doctor system where patients with acute or urgent health needs were attended to.

Robust systems were in place to reduce the number of patients who did not attend appointments. For example, practice staff telephoned patients a day before their pre-booked appointment as a reminder and to confirm attendance. Staff described access to the service as being flexible and were able to give examples to demonstrate this. For example: avoiding booking appointments at busy times for people who may find this stressful; and booking convenient appointments to ensure that vulnerable patients such as those with learning disabilities could attend with their carer.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated person who handled all complaints in the practice. We saw that information was available to help patients understand the complaints system. This included posters displayed within the practice, patient leaflets and information on the practice website. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We looked at complaints received in the last 12 months and found they were satisfactorily handled and dealt within a timely way. Staff we spoke with told us an open and transparent culture was promoted when dealing with complaints.

Minutes of team meetings showed that complaints were discussed with all staff to ensure they were able to learn and contribute to determining any improvement action that might be required. For example, following a complaint changes had been made to ensure the chaperone policy was available in different languages and was displayed by the examination couch for patients to see; this was in addition to the existing policy.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on.

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. We found details of the vision and practice values were included as information for patients in a leaflet titled "practice charter" and the statement of purpose. These values were clearly displayed in the waiting areas and in the staff room.

The practice vision and values included offering patient centred care and choice wherever possible as well as providing the best possible modern healthcare within available resources, whilst retaining the best features of a traditional family practice.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop of any computer within the practice. We looked at 13 of these policies and procedures, and most staff had completed a cover sheet to confirm that they had read the policies and when. All 13 policies and procedures we looked at had been reviewed and were up to date. Staff we spoke with knew where to find these policies if required.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes. For example, meeting minutes for October 2014 showed an action plan had been put in place to ensure the practice met the targets in respect of dementia screening and diagnosis and were fulfilling their contract with the CCG. The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us records which addressed a wide range of potential issues, for example information governance, lone working and access to the building. Identified risks were discussed at practice meetings and where risk assessments had been carried out action plans had been produced and implemented. The practice held monthly governance meetings which were mainly attended by the GPs and non-clinical senior management. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They told us flexible working patterns were in place to promote team working across all roles. They also said they enjoyed working at the practice, felt valued and knew who to go to in the practice with any concerns.

We saw from minutes that practice meetings were held regularly, at least monthly. Staff told us there was an open and transparent culture within the practice, and they had the opportunity to raise any issues at these meetings. The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, recruitment and confidentiality of records which were in place to support staff. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, a suggestion book placed at the reception desk and complaints received. We looked at the results of the practice's internal patient survey and found patients were satisfied with the service and the care they received. For example, out of 72 respondents: 97.22% felt the reception staff were helpful when they last visited the practice and 86.11% said the last appointment they were given was convenient to them. In response to patient feedback, the practice had purchased a wheelchair for use at the surgery by patients with reduced mobility.

The practice had an active patient participation group (PPG) which included nine members; and representatives from older people and working age population group. The PPG had carried out annual surveys and met every quarter. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website.

Are services well-led?

Good

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

The practice had gathered feedback from staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff were aware of the whistleblowing policy and had no cause to use it. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had protected learning time and regular training sessions. One non-clinical staff member was undertaking a medicines management course and explained how they had used their learning to identify and recommend areas within the repeat prescribing process that could be improved. The practice was a training practice.

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