The Bailey Practice

Quality Report

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

Ratings

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

Summary of findings

Contents

Summary of this inspection

Page

Overall summary 2

The five questions we ask and what we found 3

The six population groups and what we found 5

What people who use the service say 8

Areas for improvement 8

Detailed findings from this inspection

Our inspection team 9

Background to The Bailey Practice 9

Why we carried out this inspection 9

How we carried out this inspection 9

Detailed findings 11

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Bailey Practice on 13 October 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.

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 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.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- 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.

There were areas where the provider should make improvements. Importantly, the provider should:

- Ensure all staff receive updated training in infection control.
- Ensure the practice implements a system compliant with NHS Security of Prescription Forms guidance.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were sufficient staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their

Summary of findings

needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It 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 monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The Patient Participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

The practice had 71 patients in this group; all have a named accountable GP and are offered health checks and medication reviews. The practice runs flu, pneumonia and shingles vaccination programmes. They have a register for patients for unplanned admissions to A&E.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified for priority care. Longer appointments and home visits were available when needed. All patients within the population group had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Care plans were maintained and updated for those with long-term conditions which assisted in prevention of unnecessary referrals and admissions.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. 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.

Summary of findings

Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

The practice contacted patients by telephone to remind them if they were due for cervical smears, vaccinations, antenatal and 6 week post natal checks. Patients not attending their appointments were similarly systematically followed up by telephone. The practice had higher than the national average uptake for childhood immunisations and have increased their cervical smear testing within the last year.

The practice carried out chlamydia screening and whooping cough for pregnant patients. In addition the practice liaised and met regularly with midwives and health visitors. Effective communication was reported with the Improving Access to Psychological Therapies (IAPT) counselling service.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs of this population group.

The practice had extended its opening times and had two early morning openings at 7.30 each Monday and Friday to accommodate working patients. They carry out well person checks on 40-74 year olds and offer health promotion advice. Patients were able to request repeat prescriptions via a secure email address.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability and 95% of these patients had received a follow-up. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Staff knew how to

Summary of findings

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.

Patients with a learning disability are known by all the staff so that they are more at ease and find it easier to engage. Longer appointments are offered to these patients and if they attend as a walk-in patient they are seen immediately. The practice have a carers list so that all staff know who to contact and information about a patient may be shared with their consent 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). Of 15 patients on the mental health register 86% had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice advised patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

Patients were generally very happy with the services provided by the Bailey Practice. The national GP patient survey showed that patients responding to 19 out of 22 outcome measures scored the practice at or above 90% satisfaction. Ninety six per cent of patients regarded their overall experience of the practice as good.

The NHS Choices website rated the practice with 4.5 out of 5 stars. The majority of patient feedback was very positive indeed; the small amount of negative feedback was almost entirely from prospective patients unable to register with the practice due to its list being closed.

CQC comment cards had been completed by 44 patients, all of whom made highly positive and complimentary remarks about the practice; although a small number additionally made suggestions for further improvements.

Seven patients spoke with inspectors during the inspection, and others made comments directly to CQC. All of them expressed the kindness and concern shown by the practice, for some over many years and in challenging circumstances. Several patients expressed a preparedness to wait for their appointment on occasion as they believed the practice allocated appropriate time to the length of appointments, and that this meant they would in turn receive appropriate time for their consultation.

Areas for improvement

Action the service SHOULD take to improve

- Ensure all staff receive updated training in infection control.
- Ensure the practice implements a system compliant with NHS Security of Prescription Forms guidance.

The Bailey Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor and CQC Inspection Manager. All members of the team had the same powers of entry and inspection.

Background to The Bailey Practice

The Bailey Practice is a small family-run practice which provides primary medical care to approximately 2300 patients in the Walthamstow area of East London. This area is socio-economically diverse, but with areas of increased deprivation with a high number of income deprived children and older people. There is a higher than the national average number of people between the ages of 25 and 50 years and a lower number of older people over the age of 75.

The practice operates from a single converted premises which is accessible to wheelchair users as all services can be provided on the ground floor. The practice is registered to carry on the regulated activities of diagnostic and screening procedures, family planning, maternity and midwifery services and the treatment of disease, disorder or injury.

There are two GP partners, an Advanced Nurse Practitioner, a practice manager and one receptionist/administrator. All of the staff are related family members except for the practice manager. The senior partner has worked at the practice for 30 years and works full time. The other partner GP is due to start working at the practice in December 2014 after taking maternity leave and will work two days a week. A long term locum GP provides cover during periods of leave and sickness. The advanced nurse practitioner works for four days each week. All of the staff are female.

GPs have opted out of providing out-of-hours services to their own patients and they hold a general medical services (GMS) contract with NHS England.

It was anticipated that shortly after the inspection the practice would form a new partnership, with an existing member of the practice joining the practice as a partner.

The practice currently has no website or other online services for patients – this will be required by April 2015.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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

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

Detailed findings

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We reviewed comments left by patients about the practice on the NHS Choices website. We asked the practice to place comment cards in the reception area, where patients and carers/relatives could share their views and experiences of the practice.

We carried out an announced visit on 13 October 2014. During our visit we spoke with a range of staff (Senior GP partner, GP partner, advanced nurse practitioner and practice manager) and spoke with patients who used the service including two members of the Patient Participation Group (PPG). We spoke with the Community Matron who works with the practice in caring for patients in the community. We observed how people were being cared for and reviewed treatment records of patients. We looked at the practice's policies, procedures and audits. We reviewed management and staff files. Forty four patients wrote comments on the cards which we reviewed.

Good

Are services safe?

Our findings

Safe Track Record

The practice had safe systems in place for reporting and recording incidents. Staff understood their role and the processes for reporting incidents that affected patient's safety. The practice had an incident reporting procedure which defined these incidents, known as a significant event analysis (SEA). There was an incident report form and we noted that different staff had completed these forms. They included details on discussion and learning points for staff.

Staff told us that when an incident occurred they often discussed it straight away with the Senior Partner before completing a report form. The incident was then discussed at the monthly, minuted practice meetings at which all staff were present. We reviewed the minutes of two staff meetings and found that incidents had been discussed in November 2013 and February 2014. We also saw evidence that the agreed actions had been implemented.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We reviewed three Significant Adverse Event (SAE) forms. One event involved the Advanced Nurse Practitioner who noticed the fridge thermometer appeared to show the fridge operating at an abnormal temperature of 100C even though a normal temperature had been recorded earlier in the morning at 5oC. The temperature was rechecked after 30 minutes and found that it was then showing the correct temperature. This event had led to improvements in the procedure for maintaining the cold chain storage of vaccines because it was discussed at a team meeting following the incident. An action arising had been to purchase a second fridge and thermometer to ensure that there was a backup procedure in the event of a fridge breakdown.

Clinical staff demonstrated awareness of national patient safety alerts, describing how their regular discussion of these assisted to ensure consistently safe patient care.

Reliable safety systems and processes including safeguarding

Safeguarding policies for both children and vulnerable adults were in place. All staff knew who the safeguarding lead was and were able to describe the different forms of abuse and how they would report a concern. Each consultation room had a flowchart detailing the referral process to the local authority should a clinician have concerns about a child or vulnerable adult. Where relevant, alerts were placed on patient records on the practice database to ensure effective, secure and confidential sharing of information between clinicians.

The senior partner was the practice's safeguarding lead and knew who the lead GP for safeguarding was in the local area and the means by which they could be accessed for reporting or consultation. The senior partner had training in child protection to Level 3 as well as vulnerable adults training which was in line with national safeguarding guidance. All the other staff had up to date safeguarding training at the required level for children and for vulnerable adults.

There was a chaperone policy which detailed who the chaperones were and in what situations they may be used. A notice was clearly identified on the wall in the patient waiting area which explained that patients could request a chaperone. Clinical staff told us they asked patients if they wanted a chaperone present when patients were undergoing an intimate examination and noted this in patient records. All staff whose function included acting as chaperone were trained, had been subject to checks and clearly described their support and safeguarding role. As there were only female staff, there were no male chaperones available should a patient have requested this.

Medicines Management

The practice had a system for reviewing repeat prescriptions using the practice database to identify when patients were in need of a review. Quality and Outcomes Framework (QOF) data showed that the practice was performing well in carrying out medicines reviews on patients who were prescribed four or more repeat medicines as well as those patients requiring repeat medicines. The senior partner told us that they had achieved 90% of completed reviews with regard to those patients on four or more repeat medicines exceeding the standard of 80% completed reviews.

Patients we spoke to said it was easy to get a repeat prescription and it was often ready on the day they requested it. Although there was no online facility to request repeat prescriptions patients could do so using a dedicated email address.

The practice had maximum points in all QOF areas relating to patients with long term conditions. Most patients on

prescribed anti-coagulants attended a dedicated clinic but some patients came for a repeat prescription. There was no anti-coagulant protocol in place but we were told that a clinician issued the prescription for patients after reviewing blood and other test results to ensure the correct level of medicine was prescribed for this group of patients.

The practice did not have a system based on the NHS Security of Prescription Forms guidance, for controlling and recording prescription movement. Although prescription stationery was stored securely in a locked cupboard the serial number data was not recorded or electronically logged which was important to ensure they were accounted for and could not be misused or stolen.

Vaccines were stored in a fridge in the nurse's room and fridge temperatures were monitored and recorded daily by the practice manager. The fridge had an internal and also secondary thermometer to verify temperatures. In the event of a fridge breakdown contact details of an engineer were at hand and the practice had purchased a spare fridge so that vaccines could be transferred into it to preserve the cold chain in the event of breakdown. Stocks of vaccines were checked and they were all within expiry date.

The practice had 71 patients over the age of 75 and they all had a named accountable GP. Both flu and shingles vaccinations were offered and practice staff phoned patients who met the criteria for these vaccinations to encourage them to attend if they had not done so.

Cleanliness & Infection Control

The practice infection control policy was based on national NHS guidance. All staff members we spoke to were aware of the policy and that the nurse led on infection control for the practice. We saw the results of two infection control audits which had been carried out in 2013 and 2014. The audits had identified a number of shortfalls which had all been actioned with the exception of infection control training for all staff. We checked staff files and found that some staff had not received up to date infection control training. We discussed this with the lead and they told us they would ensure all staff underwent infection control training annually in the future.

The practice was visibly clean and tidy throughout. A cleaner attended every working day and followed a cleaning schedule which included daily weekly and monthly tasks. There was detail on blood and bodily fluid spillage. Clinical staff were responsible for cleaning some items such as couch surfaces and toys in their own rooms. The practice manager carried out regular cleaning checks of the practice. Toys had been introduced into the waiting area and these were cleaned every day by the practice manager to minimise the risk of cross infection. Cleaning equipment was clean and appropriately marked for use in different areas.

Clinical waste was cleared from rooms on a daily basis and stored in a locked facility at the rear of the practice before being collected by a specialist waste contractor.

We saw evidence that all clinical staff had hepatitis B immunity blood test checks in order to minimise the risk of spreading infections.

The practice had a Legionella policy and we were advised that a Legionella risk assessment which included checks on water temperatures had been undertaken, although relevant documentation was unavailable at the time of inspection.

Equipment

We found there were arrangements in place for checking equipment within the practice. We saw test and calibration records for equipment such as scales and blood pressure monitors, which demonstrated they were regularly serviced and calibrated. We saw a gas safety certificate which showed that the heating system had been maintained and checked this year and was safe.

Staffing & Recruitment

All of the staff except the practice manager and a long term locum GP were family members. Most staff had worked at the surgery for a number of years prior to its registration with the Care Quality Commission. The locum GP did not regularly work at the practice and just covered periods of annual leave and sickness. The new GP partner said they were undergoing induction training and were due to start working at the practice in December 2014.

Criminal records checks were undertaken before staff started to work at the practice. On the day of the inspection we were not able to see all of the recruitment checks such as those on identity, right to work in the UK and employer references however we were shown documentation after the inspection which verified these checks on staff had been completed.

Good

Are services safe?

Monitoring Safety & Responding to Risk

The practice had carried out a health and safety risk assessment which detailed risks to staff and patients such as slipping and tripping on cables or objects left on the floor and actions taken to minimise those risks. This was reviewed every six months.

We saw a business continuity plan was in place to deal with emergencies such as loss of electrical power, which might interrupt the smooth running of the service. A reciprocal agreement had been made with another local practice to run the service from there in the event of a major incident.

Arrangements to deal with emergencies and major incidents

We were told that staff underwent annual mandatory training in basic life support (BLS). Information in staff files evidenced the training undertaken. Staff we spoke with told us they knew where the emergency equipment was located and what to do in the event of a medical emergency. The practice had an emergency medical kit, and oxygen cylinder with face masks for adults and children, which were within date and we saw records that they were regularly checked by the Advanced Nurse Practitioner. There was no pulse oximeter or defibrillator (used to start a person's heart in an emergency) but we were told that these had been ordered in the last month.

An anaphylaxis kit was within its use by date, accessible and available for use.

Fire Safety drills and checks of the alarm system and fire safety equipment were regularly carried out within the building. One staff member was a nominated fire marshall. The practice had a fire policy which said that annual fire training would be carried out by all staff, records confirmed that staff had received fire training. We saw records of two fire drills which had been carried out in 2014.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

When planning patient's care and treatment both GPs used a variety of guidance such as National Institute for Health and Care Excellence (NICE) clinical knowledge summaries and GP notebook. They told us how they accessed guidance during consultations.

The senior partner GP regularly attended Clinical Commissioning Group (CCG) locality meetings and both partner GPs and the nurse were booked to attend the next GP update training to keep informed. They also received update information by email and these were discussed both informally and at practice meetings.

The practice received prescribing updates by email and the GP attended the prescribing meetings at the CCG. The prescribing lead visited the practice once a year. The partner GP told us they used local antibiotic prescribing guidance. However the prescribing of cephalosporins and quinolones was higher than the national average. We discussed this with the senior partner GP who said they used clinical experience to determine prescribing of these medicines and they were actively trying to reduce prescribing them.

Clinical staff were familiar with the principles of the Mental Capacity Act 2005 and were able to explain how they would assess patients for capacity. There were 13 patients on the learning disability register and they were seen annually for a health check. Clinical staff explained how they had liaised with the psychiatrist and the community mental health team for a patient with learning disabilities who had capacity in some areas and not in others.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles which included an audit diary to prompt when audits were due for review. The practice used the results to improve learning. We reviewed examples of clinical audits which included A & E attendances, diclofenac prescribing, Proton Pump Inhibitor (PPI) prescribing and benzodiazepine prescribing.

The audits were used to improve patient outcomes. The practice used health analytics to audit attendances of their patients at hospital A&E departments over a three month period in 2013 and then re-audited in the same period in 2014. This showed that they had a reduction from 144 to 126 attendances, which was below the CCG average. To achieve this they already had walk-in clinics every morning and introduced extended early opening hours for two mornings a week. They also had telephone consultations and Advanced Nurse Practitioner and GP emergency appointments as well as responding rapidly to urgent home visits. New patients were given relevant information about other healthcare providers such as NHS 111. Patients who frequently attended A & E were flagged on the clinical database so that staff could discuss and educate them about options rather than going to A & E, opportunistically when they attended the practice. A nominated staff member continued to monitor A & E activity in conjunction with discharge letters to contact relevant patients to investigate further reasons for avoidable attendance and raise awareness.

Diclofenac prescribing had reduced in the last year. Auditing of patients on repeat benzodiazepines over the course of a year to September 2014 showed that of 23 patients on repeat prescriptions for this medicine, 11 had either stopped using benzodiazepines or had reduced their dose. Going forward the practice had increased the frequency of medicine reviews for this group of patients.

Referral rates were discussed at meetings with the Clinical Commissioning Group (CCG) and the referral rate for the practice was very low compared to other practices in the CCG. The Advanced Nurse Practitioner explained how the practice were able to refer patients quickly when needed; for example to the rapid access chest pain clinic.

Effective staffing

Regular practice meetings were held so that information and updates were conveyed to all staff. Because it was a small practice, discussion and information was shared on a daily basis. Both GPs had been revalidated and had personal development plans resulting from their appraisals. 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.

The Advanced Nurse Practitioner was due for re-registration in September 2015. Staff felt supported and able to develop their skills and professional training. They

were able to go for training and extend their learning through study days. The GPs and the nurse were booked on a GP update course in November 2014 and the nurse had recently completed an Advanced Nurse Practitioner course.

Although there was no formal supervision in place, all staff demonstrated receipt of frequent informal supervision, and a formal system of annual appraisal identified and addressed any continuing professional developmental needs. A structure - suited to the size of the practice - was in place for efficient line management reporting for all staff.

Working with colleagues and other services

The practice had systems in place for managing blood and other test results. Results came into an electronic mailbox every day which all went to the senior GP and Advanced Nurse Practitioner for review. Results were downloaded onto the patient records on the computer database. If results were abnormal patients were contacted by the GP or the receptionist depending on the issue. Patients we spoke with confirmed that they received results without delay.

Outpatient letters and hospital discharge summaries were received in the post. They were scanned on the day of receipt and entered onto the patient record database. We were able to confirm from observation at inspection that correspondence was well managed and the system employed facilitated timely review by a clinician at the practice. The GPs reviewed and either visited the patients or contacted them to ask them to attend the practice if necessary.

Care for patients was integrated with the out of hours provider, Partnership of East London Cooperatives (PELC), and out of hours reports were received every morning so that patient records could be updated as soon as possible. Reports were allocated to the senior partner GP for review on the day they arrived.

Information Sharing

Clinical staff told us they had frequent engagement and communication with other healthcare professionals. They attended three monthly multidisciplinary team meetings to coordinate care for 40 patients in the top 2% at risk of being admitted to hospital, those with a long term condition and/or chronic obstructive pulmonary disease (COPD). Patients were given emergency numbers and those with COPD an emergency pack of drugs with relevant instructions.

The GP met at least once a month with district nurses to discuss the needs of palliative care patients when they had them. They also had regular contact with the community matron. Before the inspection we spoke to the community matron who confirmed that they had a good working relationship with the GP to improve care for patients with long term conditions.

Clinical staff gave examples of how they worked with the different patient groups and had contacts with other specialist services. They referred patients with depression and mental health needs to Improving Access to Psychological Therapies (IAPT) for counselling. The practice also worked with patients with gender dysmorphia and shared information with specialist clinics to support these patients.

Consent to care and treatment

There was a consent policy in place setting out the definitions of different kinds of consent such as implied or expressed. Clinical staff told us they always asked patients for their consent and noted it in their records. Staff were familiar with the principles of the Mental Capacity Act 2005 and the partner GP explained how they would assess patients for capacity by speaking to them and their carer/family member where appropriate. They would assess them by checking that the patient can understand, retain and explain back to the GP what they have told them. They understood that capacity could change and so patients may need to be reassessed.

Staff were aware of the Gillick competencies, the means by which patients under 16 can be assessed as competent to give consent to certain treatment. We looked at anonymised records of four teenage patients requesting contraception and found that there was clear documentation of this assessment.

Care plans evidenced that relevant consent had been obtained when treatment was reviewed and changed.

Health Promotion & Prevention

New patients were offered a health check that was completed by the Advanced Nurse Practitioner and included checking weight and blood pressure whilst also giving patients an opportunity to discuss lifestyle factors affecting their health and wellbeing such as smoking, drugs and alcohol consumption.

Systems were in place to ensure that patients received their childhood immunisations and the childhood immunisation

Good

Are services effective?

(for example, treatment is effective)

rates were above the CCG average with over 90% for some vaccinations for babies and children up to 24 months old. Letters were sent out about seasonal flu and shingles vaccinations for vulnerable groups and older patients. Parents with babies and small children could attend the weekly baby clinic to seek advice about their child's health and wellbeing.

Other screening programmes included cervical smear, chlamydia and whooping cough for pregnant patients. The uptake in cervical smear screening had increased following changes to the practice's protocol whereby patients who failed to attend appointments now received a telephone call from the Advanced Nurse Practitioner to explain the importance of smear tests. Travel vaccinations were available.

The practice did not have a website and the practice leaflet had information on the services provided.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

The national GP patient survey found that the practice was "among the best" within the Clinical Commissioning Group (CCG) for patients describing their overall experience as "good" or "very good", with 92% of patients saying they would recommend the practice to someone new to the area, comparing favourably with the CCG average of 68%. The practice's own survey indicated that 95% of patients were "very" or "fairly happy" with their care and would recommend it to a friend.

During our inspection we observed staff speaking to patients respectfully and kindly even though they were working in a busy environment. We saw instances of kindness and staff taking time to explain things to patients. Comment cards completed by 44 patients reported very positive experiences with regard to care and respect. All patients we spoke with during the inspection and members of the Patient Participation Group (PPG) we spoke with before our visit, told us they received a personal service and that practice staff knew all their family.

In treatment and consulting rooms, clinicians told us that privacy curtains and window blinds were used to preserve privacy for patients. Reception staff told us that if a patient wanted to speak with them confidentially, they would take them to a room next to the reception to do so. There was information on display to inform patients about this service. There was also information about a chaperone service explaining to patients that they could have a chaperone present if they wanted when they saw the doctor or nurse. Patients awaiting appointments at the time of inspection confirmed they were aware of the chaperone service.

Care planning and involvement in decisions about care and treatment

Clinical staff took all reasonable steps to enable patients to make decisions about their own care and treatment wherever possible. They told us they accessed a medical website from which they could download explanatory leaflets and there was a facility on the website to have that information in different languages. They sometimes drew diagrams and used models to support patients to understand their diagnosis.

Patients described being supported to understand their diagnosis and being given options for care and treatment. The GP and nurse said they always involved patient's in their own treatment and care. Patients commented that they felt engaged in the decision-making process in their treatment plans.

Patient/carer support to cope emotionally with care and treatment

There were no patients on the palliative care list at the time of the inspection but when they did have them the senior GP had regular contact with McMillan and district nurses for case review discussions to ensure these patients were managed well. Patient feedback indicated that practice staff had a particularly sensitive approach to end of life care, it was also clear that staff made time to listen, which patients experienced as supportive.

The practice held a carers list. By reference to the carers list a member of practice staff could be assured that the patient had given consent for the alternative contact to receive information about them without breaching patient confidentiality. All recently bereaved relatives/carers received a phone call from the practice and were given consultation time if they wanted it. We spoke to one patient who confirmed the practice had telephoned them when a relative passed away and signposted them for further support to a bereavement group.

Information in the waiting room advised patients of the availability of a range of support agencies and local groups to provide additional assistance to patients and their carers at times of crisis and emotional difficulty.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The premises were designed to meet the needs of patients with poor mobility. There was level access to the practices and treatment and consulting room was on the ground floor. The entrance and waiting area were spacious enough to accommodate patients with pushchairs and wheelchairs.

The practice had a Patient Participation Group (PPG) and consulted with them before running a patient survey to find out the priority areas for patients. Last year patients had requested that they have toys in the waiting area for young children and a new noticeboard. The practice had responded and delivered this by providing toys and laminated notices on the noticeboard along with up to date information leaflets.

Tackling inequity and promoting equality

The practice provided services for a number of vulnerable groups. They saw patients with gender dysmorphia and patients who had been sexually and physically abused and ensured they were treated with sensitivity by all staff including those on reception who were briefed on how to address patients. Staff had received training in learning disabilities and reception staff ensured that patients with a learning disability were prioritised when they attended the practice as it was the experience of the practice that some patients had found waiting for appointments anxiety provoking.

Interpreters were booked when this was needed to communicate with patients whose level of understanding of English was poor. Reception staff were well informed about the needs of the patient population with regards to ensuring that appointments were arranged when appropriate support could be provided. Clinical staff were also able to download informative leaflets for patients in different languages to ensure they had equality of understanding of their care and treatment.

Access to the service

Patient surveys, comment cards and patients we spoke to told us they were easily able to access the practice. The national GP patient survey reported that 98% of patients found it easy to get through to the practice by telephone, 91% describing their experience of making an appointment as good. They were additionally able to have a telephone consultation with the GP. One patient told us that if they phoned to speak to the GP whilst the GP was unavailable they would always have their call returned.

The practice operated walk-in clinics every morning from 8.30-11am with extended hours on Mondays and Fridays starting at 7.30am. Appointments could be made for afternoon surgeries between 4 and 6.30pm. Longer appointments were available for those with complex needs such as long term conditions or those with mental health needs.

Patients were able to be seen urgently on the same day because of the availability of the walk-in clinic. Sometimes they may have to wait to be seen but surveys and comments made by patients indicated they were happy to do so knowing they could see their GP that day.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and there was a designated responsible person who handled all complaints in the practice.

Complaints and suggestions, including written suggestions left in the comments box, made by patients were discussed at the monthly practice meetings. We looked at the complaints book and found there had been no formal complaints received by the practice from April 2013 to September 2014. However, comments and suggestions made by patients were discussed in team meetings. For example, two patients said they were not happy with the manner of a locum GP who had worked at the practice. Staff discussed this and the clinical lead GP checked the medical records of the patients then telephoned them to assure them that the clinical treatment they had received was correct but the locum GP had a different manner. The practice then changed the locum GP that they used and had not had further complaints regarding this for the last year. In July 2013 several patients had commented that the waiting room was very hot and in response the practice staff purchased and installed an air conditioning unit and water dispenser for this area.

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

Both GP partners expressed their vision and strategy as providing a personal, patient-centred service delivering good continuity of care. They placed a strong emphasis on listening and communicating well with both patients and staff. They were aware of potential risks to the quality of care they provided because of an increasing practice population. Their objective for the future was to expand the practice and improve the premises so that they could provide more services to more patients such as the fitting of intrauterine devices (IUDs) and implants. The Bailey Practice had been a single GP service for a number of years and had brought in another partner due to start in December 2014 so had met some of this objective. The premises had recently undergone a partial refurbishment which had provided another consulting room.

Staff were able to describe similar values and the Advanced Nurse Practitioner felt that the there was a good relationship and communication between all of the staff and between staff and patients. Because the senior partner GP had run the practice for over 30 years they knew patients and their family's history well. Patients were often personally contacted by phone to remind them to attend appointments for screening tests for example.

Governance Arrangements

The practice had a clinical governance policy which set out the framework for continually improving the quality of their services and safeguarding high standards of care. Emphasis was placed on education and training, clinical audit and effectiveness, openness and risk management.

Although the Clinical Governance lead was the senior partner GP it was clear that there was engagement and involvement of all of the staff in taking responsibility in delivering the service. Staff were clear on governance arrangements and were aware of who the leads were in each area such as infection control, safeguarding and the PPG.

Leadership, openness and transparency

Staff reported an open and transparent working relationship. One member of the staff described it as a no-blame culture. Staff felt safe to report incidents and mistakes knowing they would be treated as a learning opportunity. They said their views were listened to and if needed action would be taken. We observed how staff interacted and found they treated one other with care and respect.

We saw evidence that the practice monitored the quality of service it provided. They carried out internal and external audits and patient surveys and used the information from them to implement changes and improvement.

The provider was not subject to external peer review.

Practice seeks and acts on feedback from users, public and staff

The practice did not carry out formal staff surveys although all staff felt their views were listened to and acted upon if necessary.

A Patient Participation Group (PPG) had been set up in 2013 and the practice had made attempts to include as many patients as possible so that the group reflected the demographics of their practice population. Members of the group had the option to attend meetings, and/or exchange information by email, telephone and post. The PPG had been invited to put forward priority areas for inclusion into the most recent patient survey in 2014. One hundred completed survey forms were returned and an action plan drawn up. One suggestion which was implemented was to set up a secure email account for patients to request repeat prescription electronically rather than attend the surgery.

The practice had a suggestion box in the waiting area where patients could post comments or suggestions. Comments were discussed at the monthly meetings and reflected in minutes. Staff also noted verbal comments from patients. There was an annual report of patients complaints and suggestions to ascertain learning points. We saw the report for 2013/14 which was shared with the team at a practice meeting. They had received several comments in the suggestion box about how patients valued the continuity of care and easy access to the practice. Two verbal comments were reported that patients were not happy with the locum GP and following that the practice had changed their locum GP.

Management lead through learning & improvement

Staff objectives were set out during annual appraisals. Learning needs were addressed and there was evidence

Are services well-led?

Good

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

that practice performance was reviewed and discussed at monthly meetings. Lessons were shared informally day to day, through minuted meetings and externally through CCG peer review.