Drs. Cartwright Mahfouz & Bullock

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Drs Cartwright Mahfouz and Bullock's practice on 6 January 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring and responsive services and for being well-led. It was also good for providing services for the six population groups: 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 and people experiencing poor mental health (including people with dementia).

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 generally well-managed, although records relating to recruitment and staff training were not well maintained.
- 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 also available and easy to understand.
- The practice had reviewed and made changes to appointments systems in response to patient feedback. Urgent appointments were available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

Summary of findings

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

Importantly the provider should

- Ensure records of staff recruitment and training are well maintained so that the practice can be assured the appropriate checks and training relevant to staff roles have been completed.
- Maintain accurate records of defibrillator checks to ensure that it has been done and the defibrillator is fit for use and of the emergency medicines available to ensure none are missing.
- Ensure audits complete their full audit cycle in order to demonstrate improvements made to practice.
- Implement a robust system to ensure correspondence is handled appropriately when a patient with no fixed abode registers.
- Ensure governance issues discussed at meetings are clearly documented to ensure actions required are not missed and that there are clear lines of accountability for action.

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. In most cases risks to patients were assessed and well managed although there were some areas identified which could be improved upon including risks around legionella and maintaining robust records for the management of training and recruitment checks. There were enough 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 the National Institute for Health and Care Excellence and used it routinely. 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. There was evidence of staff appraisals undertaken and the practice was receptive to the personal development needs of 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 was available to help patients understand the services and support available to them. 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. The practice had taken action to try and improve access to the service and feedback from the GP national patient survey indicated that ease of access was in line with other practices nationally. Urgent appointments were available the same day if required. The practice had good facilities and was well equipped to treat patients and

Summary of findings

meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded appropriately to issues raised. Learning from complaints was shared 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. 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 where information was disseminated.

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. For example diabetes and dementia. The practice offered proactive, personalised care to meet the needs of the older people in its population. Patients over 75 years of age had a named GP to help coordinate their care and those with complex health and palliative care needs were routinely discussed at multidisciplinary meetings. Care plans were in place for older patients with complex needs. The practice was accessible to patients with mobility difficulties and also offered home visits to patients who were unable to attend the surgery. Longer appointments were also available if patients needed them. The practice supported care homes for older patients and feedback on the support provided was positive. The uptake of flu vaccinations for patients in the older age group was in line with other practices nationally. Patients over 75 who had not been seen for a consultation in the last 12 months were also invited to attend a health check. There was a specific area in the waiting room which displayed information of interest to older patients.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The practice held registers of patients with long term conditions and offered structured reviews to check their health and medication needs were being met. Staff undertaking reviews had received additional training in specific long term conditions to help support patients. Patients at risk of hospital admission were identified and regularly discussed at multidisciplinary meetings to ensure their care needs were being met. The practice offered home visits if patients were unable to attend the practice and longer appointments if needed. Patients whose needs were urgent would be seen the same day.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. The practice had a higher proportion of younger patients than the national average. There were systems in place to identify and follow up children living in disadvantaged circumstances and staff were able to give examples of action taken to safeguard children from harm. We saw good examples of joint working with health visitors and school nurses which included regular multidisciplinary team meetings. Immunisation rates were in

line with those expected for all standard childhood immunisations. There was a specific area in the waiting room which displayed information of interest to younger patients including issues such as sexual health. There were various clinics available for this population group including antenatal care and post natal care and family planning. Patients told us that children and young people were treated in an age-appropriate way and we received positive feedback from parents in our comment cards. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice offered a breast feeding friendly service and had toys available for young children which were clean and in good condition.

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 offered extended opening hours at various times to accommodate a wide range of patients who worked or had other commitments during the day. This included early morning, evening and weekend appointments. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group. NHS health checks were available for those of working age, patients who had not had a consultation for three years were also encouraged to attend for a health check.

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 was situated in an area with high levels of deprivation. The practice understood the population it served and were flexible to try and meet those needs. The practice recognised and supported patients living in vulnerable circumstances including patients with no fixed abode, immigrants, carers, patients with a learning disability and drug addictions. It had carried out annual health checks for people with a learning disability. It offered longer appointments for people with a learning disability and support for patients whose language may act as a barrier to health care. The practice had a flexible approach to appointments enabling vulnerable patients to access to the health care they needed.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable

patients about how to access various support groups and voluntary organisations. 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 when needed.

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 told us they had a high proportion of patients with poor mental health and this was a priority area for the practice. The practice supported and undertook ward rounds in care homes which included patients with poor mental health and dementia. A mental health worker was available one day each week on site for patients who required additional support. The practice had a dedicated lead GP for mental health and where possible had a flexible approach to appointments. For example, the practice told us they would see patients without an appointment or encourage them to be seen at quieter times and with longer appointments. Patients with long term conditions were also screened for depression to identify emotional as well as physical support needed.

The practice had information to support patients with poor mental health to access various support groups and voluntary organisations. We found clinical staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. Staff were also trained to manage conflict to help diffuse potentially difficult situations.

Summary of findings

What people who use the service say

As part of the inspection we spoke with four patients who used the practice. We also sent the practice comment cards prior to the inspection inviting patients to tell us about the care they had received. We received 45 completed comment cards. Our discussions with patients and feedback from the comment cards told us that patients were happy with the service they received. Patients described the service as excellent, they told us that were treated with dignity and respect and that they felt they were listened to. Patients described the staff as professional, helpful and friendly. A small proportion of patients told us that they found it sometimes difficult to obtain an appointment when they wanted one but if their problem was urgent they felt they would be seen quickly.

We also looked at feedback from the latest GP national patient survey from 2014 and an in-house patient survey carried out during 2013. Responses received from patients indicated that they were satisfied with the care and support they received from the practice. Patients' overall experience and satisfaction with the practice was similar to other practices nationally. Scores were above the national average for patient's responses in relation to the GPs and nurses listening to them and involving them in decisions about their care. However, patients rated the practice below the national average for being able to see their preferred GP.

We spoke with the managers of two care homes supported by the practice. They told us that they were happy with the support their residents people living in the care home received from the practice.

Areas for improvement

Action the service SHOULD take to improve

- Ensure staff recruitment and training records are well maintained so that the practice can be assured the appropriate checks and training relevant to staff roles have been completed.
- Maintain accurate records of defibrillator checks to ensure that it has been done and the defibrillator is fit for use and of the emergency medicines available to ensure none are missing.
- Ensure audits complete their full audit cycle in order to demonstrate improvements made to practice.
- Implement a robust system to ensure correspondence is handled appropriately when a patient with no fixed abode registers.
- Ensure governance issues discussed at meetings are clearly documented to ensure actions required are not missed and that there are clear lines of accountability for action.

Drs. Cartwright Mahfouz & Bullock

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.

Background to Drs. Cartwright Mahfouz & Bullock

Drs Cartwright, Mahfouz and Bullock's Surgery (also known as Keelinge House Surgery) is registered with the Care Quality Commission (CQC) and currently provides services to patients under the Personal Medical Services contract (PMS) with NHS England. The practice plans to move over to a General Medical Services (GMS) contract in April 2015. Under both the PMS and GMS contract the practice is required to provide essential services to patients who are ill and this includes chronic disease management and end of life care. The practice is part of NHS Dudley Clinical Commissioning Group (CCG).

The practice is open Monday to Friday 8am until 6.30pm. Extended opening hours are available every Tuesday morning 7am to 8am, Tuesday evening 6pm to 8pm (every three out of four weeks) and one Saturday in every three between 9am and 12pm. When the practice is closed patients are able to receive primary medical services through another provider (Primecare) commissioned by the CCG.

The practice has a registered list size of approximately 6,300 patients. It is located in purpose built premises in Dudley and is next door to a walk-in-centre. The practice is located in an area with high levels of deprivation and is among one of the most deprived areas in the country. The practice population is slightly younger than the national average.

There are three GP partners (two male and one female) and a physician's associate (male) who work at the practice. The practice has two practice nurses and a health care assistant (all female). There is a management team consisting of four managers covering finance, administration, reception and clinical management and a team of reception and administrative staff.

The practice has not previously been inspected by CQC.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

Detailed findings

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People 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 about the service. We carried out an announced inspection on 6 January 2015. During our visit we spoke with a range of staff which included two GPs, two practice nurses and administrative staff. We looked at a range of documents that were made available to us relating to the practice. We sent the practice a box with comment cards so that patients had the opportunity to give us feedback. We received 45 completed cards where patients shared their views and experiences of the service. We also observed the way the service was delivered but did not observe any aspects of direct patient care or treatment.

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 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. We reviewed incident reports and minutes of meetings where these were discussed. 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, incidents and accidents. There were records of significant events that had occurred during the last two years and we were able to review these. Significant events and complaints were discussed regularly in the management team meetings. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. The practice nurse told us about an incident relating to the administration of a vaccine and how appropriate action was taken to ensure the patient was safe. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

The practice had systems in place for managing national patient safety alerts received. The clinical manager was responsible for receiving and ensuring relevant safety alerts were acted upon. We saw evidence of timely and appropriate action taken in response to alerts received to ensure patients were not placed at risk.

Reliable safety systems and processes including safeguarding

It was difficult to verify from the way in which staff training records were organised whether all staff had received role specific training on safeguarding. No overall records of training were maintained. However staff we spoke with confirmed that they had received safeguarding training and we saw that safeguarding had been discussed to raise awareness among staff at a recent practice meeting.

Clinical staff we spoke with demonstrated an understanding of safeguarding and how to recognise signs of abuse. They were able to give examples of safeguarding concerns that had arisen at the practice and appropriate action that had been taken in response. Contact details were easily accessible to enable staff to raise safeguarding concerns with the relevant agencies for investigating safeguarding concerns.

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 with a child protection plan. We saw minutes of safeguarding meetings that had been held with the health visitor and school health advisor to discuss patients at risk.

The practice had a dedicated GP lead for safeguarding. During our inspection we were unable to verify training received to fulfil this role. Following our inspection we were forwarded evidence that they had since undertaken level three safeguarding training for children (the expected level for GPs). Staff we spoke with were aware who the safeguarding lead was at the practice if they had a concern they wished to discuss.

Notices were displayed throughout the practice alerting patients of their right to request a chaperone. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Nursing staff acted as chaperones if needed and were aware of their responsibilities.

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 policy for ensuring that medicines were kept at the required temperatures. This was described by the practice staff.

Processes were in place to check medicines stored in the treatment rooms and medicine refrigerators were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Staff were able to describe how they disposed of expired and unwanted medicines safely and in line with waste regulations.

Good

Are services safe?

The practice was supported by a pharmacist who maintained an overview of medicines management at the practice. We saw evidence of prescribing reviews that had taken place in response to prescribing data for example the practice had recently reviewed patients on repeat prescriptions for non-steroidal anti-inflammatory medicines. The pharmacist also told us that they were currently reviewing patients on more than four medicines to check this was appropriate.

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

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. The GP we spoke with described how patients on high risk medicines were managed and we saw examples to demonstrate how procedures had been followed.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were logged and kept securely to reduce the risk of unauthorised access.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. The practice was cleaned by an external contractor and cleaning specifications were in place for each area of the practice. The practice nurse who was the lead for infection control at the practice told us that they undertook cleaning spot checks. We saw records where issues had been identified and fed back to the cleaner. Feedback from patients did not raise any concerns about cleanliness or infection control.

The practice lead for infection control had recently undertaken infection control update training enabling them to provide advice on the practice infection control policy and support other practice staff in this area. The practice had received an external infection control audit in the last month. Although the practice had been rated compliant overall we saw that issues had been raised in the audit in relation to the lack of internal infection control audits and the absence of a personal protective equipment policy. We saw evidence that the practice lead was taking action against the areas identified.

An infection control policy and supporting procedures was available for staff to refer to and at the time of our inspection these were in the process of being updated. Staff had access to personal protective equipment including disposable gloves, aprons and coverings. There were appropriate arrangements in place for the disposal of clinical and non-clinical waste. This enabled staff to minimise the risks of cross infection. Notices about hand hygiene techniques were displayed throughout the practice. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. There was also a policy for needle stick injury so that staff would know what procedure to follow if this should occur.

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). Regular checks were undertaken of water temperatures and action had been undertaken where temperature had fallen outside the required range.

Equipment

Staff had access to equipment to enable them to carry out diagnostic examinations, assessments and treatments. Records were available which showed that equipment had been tested and maintained within the last 12 months. This included portable electrical equipment testing and calibration testing of relevant equipment such as weighing scales and medicines fridge thermometer.

Staffing and recruitment

Recruitment records were not well maintained and it was difficult to verify during the inspection that all appropriate recruitment checks had been carried out prior to employment. We saw that the practice had a recruitment policy that set out the standards to be followed when recruiting new staff. Most staff had been recruited prior to the provider's CQC registration. We reviewed the recruitment file for one new member of staff and saw that they had undergone a formal interview process but did not see evidence of identity checks. We asked about this and were told that they had originally been apprenticed to the practice. We looked at the recruitment files for clinical staff and found no evidence of criminal records checks through the disclosure and barring service. Practice staff told us that these had been completed and forwarded these to us

Good

Are services safe?

after the inspection. Practice staff acknowledged that they needed to review the management of staff recruitment records to provide assurance that appropriate checks and training had been completed.

Staff we spoke with told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. Staff told us that there were sufficient staff to cover each other's leave or sickness absence.

Locum staff were used to cover when GPs were on long term leave. Nursing staff had also been given the skills needed to undertake a wider range of roles reducing the impact if a member of the clinical team was absent. Administrative staff were skilled in a range of duties so that they could also provide cover for each other during staff absences. We were also told that no more than two administrative staff could be on leave at the same time so that there would be enough staff available.

Monitoring safety and responding to risk

The practice had some systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included medicines management, staffing, dealing with emergencies and equipment. We asked but did not see any evidence of regular checks of the building or environment although staff told us about maintenance work that had recently been carried out on the premises and the premises looked well maintained.

We saw that staff were able to identify and respond to changing risks in patients including deteriorating health and well-being or medical emergencies. We were given examples as to how care plans were put in place for patients with new diagnosis of cancer which enabled them to respond to a deterioration in their condition. Staff also appropriately described how they would respond to a patient experiencing a deterioration in their mental health.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that staff had received training in basic life support. Equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Staff we asked knew the location of this equipment. Records were kept to show that the oxygen was checked on a monthly basis to ensure it was in date and fit for use. We were told that the defibrillator was also checked but the checks were not recorded.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. We saw that these included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were in place to check that emergency medicines were within their expiry date and suitable for use. However, no list of emergency medication was maintained for staff to check against to ensure the medication was present when needed. We discussed this with staff who told us that they would be looking at improving the recording. 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 might impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to.

The practice had systems in place to maintain fire safety. These had been discussed with practice staff. We saw that the fire alarm was tested on a monthly basis and fire equipment was regularly maintained.

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 explained how they accessed guidelines from the National Institute for Health and Care Excellence (NICE) and how information was disseminated to other staff at weekly meetings. Staff were able to give examples of changes in approach to care and treatment as a result of new guidelines.

The practice was aware of its performance for prescribing. Data available to us showed that the practice's performance for antibiotic prescribing was comparable to similar practices. Where there was higher prescribing identified such as with hypnotics the practice was aware of the reasons and had policies in place to address this. The practice had used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We saw that the practice had systems in place for following up patients recently discharged from hospital.

The practice showed us data available from the local Clinical Commissioning Group (CCG). This showed the practice referral rates to secondary and other community care services was in line with other practices in the locality. The practice had high rates of A&E attendances. The practice was located close to the local A&E department and there was a walk-in-centre next door. They told us how they were trying to address this through the education of patients and through greater flexibility in their appointment system to accommodate patients.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need.

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 practice showed us two clinical audits that had been undertaken in the last year. Neither of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. There were plans to undertake re-audits but the timescales for this had not yet been reached. The purpose of these clinical audits had been to review the use of non-steroidal anti-inflammatory drugs (NSAIDs) and electrocardiograms in the practice. Any immediate action required as a result of the audits was identified to ensure individual patients received appropriate treatment.

We saw other examples of audits being used to improve the service provided. For example an audit of appointments where patients had not attended was undertaken. As a result text messaging had been introduced to remind patients of their appointment and there were plans for a further audit to assess the impact of text messaging.

The practice also used the information they collected for the quality and outcomes framework (QOF) to improve 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, QOF data from 2013/2014 showed us that the QOF points achieved by the practice were both higher in comparison with the CCG and national average. The practice achieved 98.3% of the total QOF points compared to the CCG average of 96.2% and national average of 96.4%

Staff regularly checked that routine health checks were completed for patients with long-term conditions. Specific clinics were held for patients with asthma, diabetes and heart disease. At the time of the inspection the latest data available showed that 85% of patients with chronic obstructive pulmonary disease had received an annual health review. We received feedback from patients with long term conditions who confirmed that they received reminders when they needed to be seen.

The practice maintained a palliative care register and included all patients with a new cancer diagnosis. Patients were graded on the register according to their level of deterioration and alerts were maintained on the patient records to ensure staff were aware of this. Palliative care meetings were held to discuss the care and support needs of patients and their families and patient records were updated following the meetings.

Good

Are services effective?

(for example, treatment is effective)

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that these were not well organised. It was difficult to verify that staff were up to date with attending training and for the practice to have a clear overview of what training staff had received. Although evidence of training was eventually found in most cases the practice recognised they needed to review how they maintained training records to assure themselves staff remained up to date.

The GPs we spoke with told us that they were up to date with their yearly continuing professional development requirements and all had recently been revalidated. 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, the administration of vaccines and cervical cytology. Those with extended roles such reviewing patients with long-term conditions were also able to demonstrate that they had appropriate training to fulfil these roles. Both practice nurses had additional diplomas in conditions such as asthma, diabetes, coronary heart disease and chronic obstructive pulmonary disease.

Staff undertook annual appraisals that identified learning needs. Our interviews with staff confirmed that the practice was supportive of training. The practice was also a training practice for medical students and GP registrars (doctors who were training to be qualified as GPs). Support was always available for the medical students and GP registrars from a GP partner and one of the partners held a post graduate certificate in medical education.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. Staff were very positive about the way they proactively supported patients who were at risk or vulnerable and told us that the systems in place worked well. We spoke with the managers from two care homes whose residents were supported by the practice, both were very positive about the practice and the way they engaged with them.

The practice received patient information such as blood test results, out-of-hours GP services and walk in services attendances both electronically and by post. The practice told us that they had not been receiving hospital discharge letters which was a concern to them. They told us that the CCG had been made aware and were addressing this issue. There were systems in place for passing on, reading and acting on any issues arising from communications with other care providers. The GP who saw these documents and results was responsible for the action required. Staff we spoke with understood their roles in this.

The practice operated a virtual ward and held weekly multidisciplinary meetings to discuss the case management of patients with complex health needs and who were vulnerable. The aim of the virtual ward is to effectively manage patients in the community and reduce the need for unplanned hospital admissions. Attendance at the virtual ward multidisciplinary team meetings included a GP, practice nurse, case manager, pharmacist, district nurse and representation from the voluntary services. The practice told us that they usually discussed between 30 and 40 patients at the meetings.

The practice also held separate meetings for discussing the care and support needs of palliative care patients and safeguarding meetings were also held. The safeguarding meetings were held monthly to discuss vulnerable children and involved a social worker, health visitor and school health advisor. We saw minutes of the most recent meeting held.

Information sharing

The practice used electronic systems to communicate with other providers. For example, the practice used electronic systems for making referrals, most referral were made using the Choose and Book system. The 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.

For emergency patients, the GP we spoke with told us that they would produce a letter with relevant information for the patient to take with them to hospital. The practice also

Good

Are services effective?

(for example, treatment is effective)

shared information about patients who might need to access the out-of-hours provider. We saw copies of fax transfers that had been sent to the out-of-hours provider to support the continuity of care.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system to coordinate, document and manage patients' care. Staff we spoke with were familiar with the system and knew how to use it. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. The clinical staff we spoke with were able to describe how they implemented it in their practice. We saw evidence of best interest decisions that had been recorded and discussed with relevant professionals outside of the practice.

We spoke with the manager from a home for people with learning disabilities. They told us how the practice supported patients with learning disabilities to make their own decisions. For example they would check the patients understanding of what they had been told and would not rush them. The manager confirmed capacity assessments had been undertaken when required.

Clinical staff also understood Gillick competencies and how this applied to them. 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.

We saw that consent was obtained and documented when undertaking surgical procedures such as joint injections.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant or practice nurse to all new patients registering with the practice. The practice also offered NHS Health Checks to its patients aged 40 to 74 years. These helped identify any new or existing conditions that needed to be addressed. Staff who carried out the reviews told us that they informed the GP of any health concerns detected and depending on the problem the patient would be seen by the GP straight away or an appointment made to see them at a future date.

The practice identified patients who needed additional support, and it was pro-active in offering additional help. For example, the needs of patients who were vulnerable and with complex health needs were reviewed on a weekly basis. A register of patients with a learning disability was maintained and reviews were undertaken. At the time of our inspection there were 65 patients on the learning disability register; 34 of the patients had received their annual health check. Work was in progress to review all patients on the register and maintain care plans for this group of patients. The practice also referred patients with drug addictions to a local service for support and was working with the pharmacist to reduce the dependency on hypnotic medication.

The practice provided a range of health promotion and screening services. This included smoking cessation services and advice on weight reduction and diet with the practice nurse. Patients received blood pressure checks to identify any early issues. Practice data showed that 92% of patients aged over 45 years had received a blood pressure check. Practice performance for cervical screening uptake was 74% for 2013/2014. This was in line with other practices in the CCG area. It was practice policy to send reminders for patients who did not attend for cervical screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations. The practice's performance for childhood immunisations and uptake of flu vaccinations was in line with other practices in the CCG and nationally. There was a clear policy for following up non-attenders by the practice nurse.

There was a range of health information displayed in the waiting area. We saw that information had been set out to cater for different population groups. There were notice boards displaying relevant information for older patients and another for younger patients making the information more accessible.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the 2014 GP national patient survey, a survey of 128 patients undertaken by the practice in conjunction with the patient participation group (PPG) in March 2014 and the friends and family test which asks whether patients would recommend the practice to others. The evidence from these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was in line with other practices nationally for patients who rated the practice as good or very good overall. The practice was above average for its satisfaction scores on consultations with doctors and nurses with 96% of practice respondents saying the GP was good at listening to them and 92% saying the GP gave them enough time. Scores for the nurses were also above the national average.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 45 completed cards and the majority were very positive about the service experienced. Patients described the service as excellent. They said staff treated them with dignity and respect and that they felt listened to. A small percentage of patients commented on difficulties obtaining an appointment but were otherwise satisfied with the service. We also spoke with four patients on the day of our inspection. All told us they were happy with the care provided.

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

We saw that staff were careful to maintain patients' confidentiality when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private. The reception area was also separate from the waiting area which helped reduce the risk of conversations being overheard when patients where speaking with staff. Reception staff told us that if a patient wished to speak with them in private they would use a spare consulting room.

The practice was sensitive to the needs of all groups within the population including those that were vulnerable. The population served by the practice included a mixed population and support for a variety of care homes which catered for people with learning disabilities, mental health and dementia. The practice had clinical leads to support the needs of vulnerable patients. Feedback from the managers at the two care homes we contacted confirmed that the practice was supportive of their residents' needs. One GP told us that where possible they tried to offer patients with poor mental health appointments on a Saturday when it was quieter.

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, data from the GP national patient survey 2014 showed 90% of practice respondents said the GP involved them in care decisions and 93% felt the GP was good at explaining treatment and results. There were similar scores for the nurses. These results were above average compared to other practices nationally.

Patients we spoke with on the day of our inspection 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 their care and treatment. One patient told us that practice staff had used diagrams to explain things to them and another patient told us how the practice would patiently explain things again to their elderly mother who had difficulty hearing. Patient feedback on the comment cards we received was positive and aligned with these views, as was the feedback from the managers of two care homes we spoke with.

Good

Are services caring?

We saw evidence from care plans for patients who were receiving end of life care which demonstrated that the patients had been involved in decision making. Preferences to care and treatment received had been recorded.

Staff told us that translation services were available for patients who did not have English as a first language.

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, 90% of respondents to the GP national patient survey said the GP was good at treating them with care and concern. Scores were even higher for nurses at 97%. The patients we spoke with on the day of our inspection and 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. We received many comments from patients telling us that staff were understanding, caring and would go the extra mile to support them.

We asked staff how they supported patients and carers to cope emotionally with care and treatment. Staff told us how they screened all patients diagnosed with a long term condition for depression and would refer them, if needed, to support services. There was also support for family members that had suffered bereavement. Staff told us that there was already established contact with families as part of end of life care. They maintained a resource file for support services available and were able to show us evidence of a referral for a patient who had recently suffered an unexpected bereavement.

Notices displayed in the patient waiting room told patients about various support groups and organisations. There was information inviting patients who were carers to identify themselves. The practice's computer system alerted GPs if a patient was also a carer so that they could provide support when needed. The GP we spoke told us that carers who were ill would be discussed at the virtual ward meetings. They gave an example of a young carer who was identified and discussed at a safeguarding meeting.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The practice understood the population it served, had identified the needs of the population and adapted services to meet those needs. For example, they told us that they had high levels of patients with mental health needs and with learning disabilities. They had dedicated clinical leads for both patients with poor mental health and learning disabilities as well as for patients with long term conditions.

The practice was located in one of the most deprived areas of the country. The practice told us that there was a transient element to the population due to the number of bed sits and refuge accommodation in the area. The practice had recognised that a proportion of their patients did not want to wait for appointments and they had accommodated this with an open policy so that patients who walked in could be seen. The practice also provided support for care homes for patients with learning disabilities, mental health needs and the elderly.

The practice was one of the pilot sites for the virtual ward programme which they told us had been running for approximately eight years. One of the GP partners was a founding member of this scheme. The virtual ward scheme aims to support and improve outcomes for the most vulnerable patients by effectively managing this group of patients in the community. It does this through effective multi-disciplinary team working and reducing the need for hospital admissions. The practice had well established multi-disciplinary team meetings with a wide range of professionals to discuss the needs of its most vulnerable patients.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. The practice was able to tell us about some of the CCG priorities and how they were delivering them.

The practice had a low turnover of staff which supported the continuity of care for patients and accessibility to a patient's GP of choice. The practice recognised that some patients required longer appointments and this was taken into account when booking appointments for patients such as those with learning disabilities.

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). We spoke with two members of the PPG who told us about some of the changes made such as displaying photographs of staff, the provision of children's toys in the waiting room and provision of the practice newsletter.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice held registers for vulnerable patients, patients with learning disabilities and carers which enabled them to ensure they received appropriate follow up and review of their care and support needs. The GP we spoke with told us that they would see patients with no fixed abode and those in temporary accommodation. They told us that patients in this situation would sometimes tell them where they wanted correspondence to be sent but did not specifically flag temporary accommodation as an alert on a patient record to prevent confidential mail from going to a non-permanent address. We discussed this with the GP so that measures could be put in place to minimise the risk of this happening.

The practice was located in purpose built premises which met the needs of patients with disabilities and of those with young children. There were accessible parking and toilet facilities available. Clinical rooms and waiting areas were all at ground floor level and large enough to accommodate wheelchairs and prams. A hearing loop was in place to help minimise the barriers to patients with hearing difficulties. The practice offered child friendly facilities including toys and baby changing facilities. There were notices displayed advertising a breast feeding friendly service.

The practice was able to accommodate patients where language may also be a barrier in accessing services. Staff we spoke with knew how to access translation services if needed and had contact details for this.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice had both male and female clinical staff which enabled patients to see staff who were the gender of their choice about their health concerns.

Access to the service

The practice was open from 8am to 6.30pm on weekdays. Patients were able to book appointments in advance or obtain urgent same day appointments.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and booking appointments on-line. There were also 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 also provided to patients through the practice leaflet and website.

The practice supported three local care homes and a retirement village. Feedback from the managers of the homes we spoke with was positive. One manager told us that the practice carried out ward rounds and that patients were not rushed. Patients with learning disabilities were routinely offered longer appointments and those with poor mental health were offered appointments if available during quieter times when it was less stressful for them. Staff told us that they would also see patients who walked in without an appointment.

We received feedback from a small proportion of patients who told us they had difficulty obtaining appointments. This had been raised as an action from the practice's in-house patient survey. Action had been taken to improve the flexibility of the appointments for the population served and the introduction of on-line booking and telephone cover during busy times. At the time of our inspection the practice had not yet repeated the survey to see whether changes made had improved satisfaction. However, we saw from the results of the GP national patient survey that patient satisfaction with the appointment system was similar to those of other practices nationally.

The practice offered a range of extended opening hours to meet the different needs of the population it served. This included Tuesday mornings 7am to 8am, three in every four Tuesday evenings 6pm to 8pm and one in every three Saturday mornings 9am to 12pm. This helped cater for a variety of patients and was particularly useful to patients with work commitments and for younger patients so that they did not miss school.

Listening and learning from concerns and complaints

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

We saw that a complaints leaflet was available to help patients understand the complaints system. Detailed information was also available on the practice website and practice leaflet. The information available advised patients how their complaint would be managed. It also informed the complainant how to escalate a complaint should they remain dissatisfied. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at five complaints received in the last 12 months and found that these had been appropriately managed in a timely way. In one instance we saw additional staff training had been given in response to a complaint. Lessons learned from individual complaints were shared with staff. The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review but no specific themes had been identified.

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 mission statement which described their aim as providing a high quality service to all their patients by providing effective and efficient primary health care. This was set out in the practice leaflet and website.

All the staff we spoke with, clinical and non-clinical described a vision to deliver high quality care and give the best service possible for their patients. Throughout our inspection we found staff were proactive and demonstrated values which were caring and patient focused.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the computers within the practice. We saw that some of the policies such as the safeguarding children's policy had been signed by staff to confirm that they had seen the policy.

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. QOF data was regularly discussed and staff were able to tell us about actions taken to maintain or improve outcomes for patients. Staff also told us that they participated in peer review meetings and had taken action to address issues such as higher levels of A&E attendances due to the close location of the practice to A&E and a walk in centre.

The practice had arrangements for identifying, recording and managing risks. Weekly management team meetings were used to discuss significant events, complaints and policies. However, these were not always well documented to ensure that any actions required were implemented.

Leadership, openness and transparency

There was a clear leadership structure with named members of staff in lead roles. The practice had four managers with responsibilities for different aspects of the service. Staff told us that this structure had been implemented on a trial basis in recognition of the level of work involved in running the practice. The management roles included clinical, administrative, reception, finance and quality outcomes. Clinical staff had lead roles in relation to mental health, patients with learning disabilities and long term conditions. There were also clinical leads for infection control and safeguarding. Staff that we spoke with were clear about their own roles and responsibilities. They all told us they felt valued and well supported.

We saw from minutes that practice meetings were held regularly, usually monthly and involved all staff. These enabled important information about the practice to be disseminated. Staff described an open culture within the practice and knew who to go to if they needed support.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys and complaints received. The practice was also participating in the new friends and family test which asks whether patients would recommend the practice to others. Results from both the practices in-house survey and the GP national patient survey were mostly positive. Patient responses showed that the practice was in line with other practices nationally in terms of access and above average for the quality of consultations with the GPs and nurses. We saw that the practice had identified actions from its own in-house patient survey such as improving access.

The practice had an active patient participation group (PPG) which had steadily increased in size. The practice told us that representation in the group membership had improved. We saw evidence of letters and notices used to try and improve membership to the group. The PPG which usually met every three months had been involved in discussions and actions relating to patient surveys. The results and actions agreed from these surveys were available on the practice website. We spoke with two members of the PPG both told us that they felt the practice listened to them and that meetings were attended by a GP and other senior staff who were able to influence changes.

The practice gathered feedback from staff through staff meetings, appraisals and general discussions. Staff that we spoke with told us that they felt able to raise issues if they had any concerns.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training

Are services well-led?

Good

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

and support. We saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and were able to give examples of training attended.

The practice was a GP training practice for GP registrars (qualified doctors training to become a GP) and medical students. There was a dedicated GP lead with a post graduate qualification in education to support the GP registrars and medical students. We were told that a partner would always be on site for support.

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