The GP Suite (also known as Dr Dowsett and Overs)

Quality Report

The Palmer Community Hospital, Wear Street,
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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 The GP Suite on 10 August 2016. Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses.
- Risks to patients were assessed and well managed.
- Outcomes for patients who use services were good.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff were consistent and proactive in supporting patients to live healthier lives through a targeted approach to health promotion. Information was provided to patients to help them understand the care and treatment available
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice had a system in place for handling complaints and concerns and responded quickly to any complaints.
- Patients said they were able to get an appointment with a GP when they needed one, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure in place and staff felt supported by management. The practice sought feedback from staff and patients, which they acted on.
- Staff throughout the practice worked well together as a team and they received opportunities for development.
- The practice was aware of and complied with the requirements of the Duty of Candour.

The areas where the provider should make improvements are:

- Review the system in place for the checking and reading of hospital discharge and letters from out of hours services.

Summary of findings

- Review the signs in place in the practice regarding oxygen to reflect which cylinders are in use.
- Review the stock of emergency medicines and risk assess the medicines held in the doctor's bags.

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.

We found significant events were recorded, investigated and learned from. There was a system in place to manage patient safety alerts. Arrangements were in place to safeguard adults and children from abuse.

There were procedures in place for monitoring and managing risks to patients and staff safety. Appropriate recruitment checks had been carried out for staff including Disclosure and Barring Service (DBS) checks. There were infection control arrangements in place and the practice was clean and hygienic. There were systems and processes in place for the safe management of medicines, although the practice should review the stock of emergency medicines. There was enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services.

Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Clinical audits were carried out and these assured the practice endeavoured to improve the quality of their care. All relevant staff were involved in this process. Staff worked with multidisciplinary teams.

The practice was supportive of further development for staff. They had received regular appraisals and training appropriate to their role.

Are services caring?

Good

The practice is rated as good for providing caring services.

Data showed that patients rated the practice in line or just below local and national averages for being caring. Patients we spoke with and comment cards indicated that patients were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. The practice computer system alerted staff of which patients were a carer.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

Summary of findings

They reviewed the needs of their local population and engaged with the clinical commissioning group (CCG) in an attempt to secure improvements to services where these were identified.

Services were planned and delivered to take into account the needs of different patient groups and to help to provide flexibility, choice and continuity of care. There were specialist clinics which included minor surgery. The practice had good facilities. Patients said they could make an appointment with a GP and that there was continuity of care, with urgent appointments available the same day. The practice had a system in place for handling complaints and concerns and responded quickly to any complaints received.

Are services well-led?

Good

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

The leadership, governance and culture were used to drive and improve the delivery of high-quality person centred care. The practice had a clear vision with quality and safety as its top priority. They had good governance arrangements that supported improvement. They had processes to monitor the service, identify any risks and areas for improvements. The provider was aware of and complied with the requirements of the Duty of Candour.

There was an active patient participation group (PPG) and the practice had acted on feedback from the group to improve services. Staff had received inductions and regular performance reviews. They were given the opportunity for further development.

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. For example, the practice had two nominated residential care homes for elderly patients where they provided care; care plans were in place for the patients. The nurse practitioner visited the homes weekly. All care plans for the elderly included preferences with respect to end of life arrangements.

There were older person's health checks available and prescriptions could be sent to any local pharmacy electronically. Housebound annual reviews were carried out by the district nurse. They offered immunisations for pneumonia and shingles to older people.

The practice had a palliative care register and used a traffic light system used to identify the most vulnerable and in need patients on the register in order to manage their treatment and support.

People with long term conditions

Good

The practice is rated as good for the care of patients with long-term conditions. The practice had a register of patients with long term conditions which they monitored closely for recall appointment for health checks with the assistance of the reception team. Patients who did not attend reviews were monitored closely; the practice had introduced telephone reviews for chronic disease management to increase the numbers of those having an annual review. Patients with more than one long term condition were offered one review appointment to cover all of their conditions.

Nationally reported Quality and Outcomes Framework (QOF) data (2014/15) showed the practice had achieved good outcomes in relation to the conditions commonly associated with this population group. For example, performances for related indicators for patients with chronic obstructive pulmonary disease (COPD) were above the national average (100% compared to 96% nationally).

The nursing team had areas of specialism which included COPD and diabetes. They had received training for this and received support from the full practice team to manage long term conditions. There were protocols in place for conditions such as for example chronic kidney disease and diabetes.

Summary of findings

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 accident and emergency attendances. Immunisation rates were comparable to CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 95% to 98%, compared to the CCG averages of 85% to 99% and for five year olds from 88% to 100%, compared to CCG averages of 92% to 100%.

The practice had a cervical screening programme. The practice's uptake for the cervical screening programme was 73.8%, which was comparable to the national average of 74.3%. Appointments were available outside of school hours and the premises were suitable for children and babies.

Antenatal clinics were run by a midwife attached to the practice Child immunisations were carried out by the practice nurse.

The practice participated in a CCG initiative 'change makers' to see if they were 'young person friendly' in 2015. Young people completed a questionnaire which resulted in changes being made in the practice. For example, information was made available for young people in the waiting room and a young person's information leaflet on the practice was sent to them on their 14th birthday.

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 which included appointment booking and ordering repeat prescriptions. There were telephone appointments available. There was a full range of health promotion and screening including health checks for patients aged between 40 and 75. Flexible appointments were available as well as extended opening hours.

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 carried out annual health checks for people with a learning disability. Communication needs for vulnerable patients were identified and recorded on their records.

Summary of findings

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. They had told vulnerable patients about how to access various support groups and voluntary organisations. The practice cared for substance misuse patients in conjunction with another local service. Patients were signposted to drug and alcohol services.

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

The practice's computer system alerted GPs if a patient was a carer. There were 203 patients recorded on the practice's computer system as a carer which is 4% of the practice population. The practice said this was an area they wanted to co-ordinate better.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health.

Performance for mental health related indicators was above the national average (100% compared to 92.8% nationally). For example, 88.4% of patients with schizophrenia, bipolar affective disorder and other psychosis had a comprehensive agreed care plan documented within the preceding 12 months. This compared to a national average of 88.5%.

Performance for dementia indicators was comparable to the national average. The practice carried out advanced care planning for patients with dementia. The percentage of patients diagnosed with dementia whose care was reviewed in a face-to-face review within the preceding 12 months was 84.5%; the national average was 84%.

Summary of findings

What people who use the service say

We spoke with five patients on the day of our inspection, which included two member of the practice's patient participation group (PPG).

All of the patients we spoke with were satisfied with the care they received from the practice. Words used to describe the practice included good and very caring. They told us staff were friendly and helpful and they received a good service.

We reviewed 22 CQC comment cards completed by patients prior to the inspection. Patients who completed the comment cards were generally satisfied with the service they received. Common words used to describe the practice included, caring, helpful, excellent, good and nice. However, four patients said it could sometimes be difficult to obtain a suitable appointment.

The latest GP Patient Survey published in January 2016 showed that most scores from patients were above national and local averages. The percentage of patients who described their overall experience as good was 87%, which was comparable to the local clinical commisioning group (CCG) average of 88% and the national average of 85%. Other results from those who responded were as follows;

- The proportion of patients who would recommend their GP surgery – 82% (local CCG average 79%, national average 78%).
- 87% said the GP was good at listening to them compared to the local CCG average of 91% and national average of 89%.
- 91% said the GP gave them enough time compared to the local CCG average of 89% and national average of 87%.
- 95% said the nurse was good at listening to them compared to the local CCG average of 92% and national average of 91%.
- 93% said the nurse gave them enough time compared to the local CCG average of 94% and national average of 92%.
- 86% said they found it easy to get through to this surgery by phone compared to the local CCG average 79%, national average 73%.
- 77% described their experience of making an appointment as good compared to the local CCG average 77%, national average 73%.
- Percentage of patients who find the receptionists at this surgery helpful – 88% (local CCG average 89%, national average 87%).

These results were based on 113 surveys that were returned from a total of 266 sent out; a response rate of 42% and 2.2% of the overall practice population.

Areas for improvement

Action the service SHOULD take to improve

- Review the system in place for the checking and reading of hospital discharge and letters from out of hours services.
- Review the signs in place in the practice regarding oxygen to reflect which cylinders are in use.
- Review the stock of emergency medicines and risk assess the medicines held in the doctor's bags.

The GP Suite (also known as Dr Dowsett and Overs)

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 The GP Suite (also known as Dr Dowsett and Overs)

The GP Suite provides primary medical services to the town of Jarrow which is the NE32 postcode. The practice provides services from one location, The Palmer Community Hospital, Wear Street, Jarrow, Tyne and Wear, NE32 3UX. We visited this address as part of the inspection.

The surgery is located in Palmer Community Hospital, there are other services in the building including another GP practice, an outpatients and phlebotomy clinic. The practice is located on the ground floor of the building. There is step free access at the front of the building with full disabled access. There is a pay and display car park to the front of the building and three disabled parking bays.

The practice has two GP partners, one male and one female. There is a nurse practitioner and two practice nurses, of which one is part time and a healthcare assistant. There is a practice manager and eight reception and administration staff.

The practice provides services to approximately 5000 patients of all ages. The practice is commissioned to provide services within a General Medical Services (GMS) contract with NHS England.

The practice is open weekdays from 8:30am until 6pm Tuesday to Friday. There are extended opening hours on a Monday evening when the practice is open until 7:15pm.

Consulting times with the GPs and nurses are from 8:30am – 11am and from 2pm every afternoon. Consulting time run to: Monday 7:10pm, Tuesday 5:40pm, Wednesday 4pm, Thursday 5:10pm (the nurse practitioner has appointments to 6pm) and Friday 4.30pm.

The service for patients requiring urgent medical attention out of hours is provided by the NHS 111 service and 'Vocare', which is also known locally as Northern Doctors Urgent Care'.

Information taken from Public Health England placed the area in which the practice was located in the third most deprived decile. In general, people living in more deprived areas tend to have greater need for health services. The average male life expectancy is 76 years and the female is 80. Both of these are lower than the CCG and national averages. The average male life expectancy in the CCG area is 77 and nationally 79. The average female life expectancy in the CCG area is 81 and nationally 83. The practice has a higher percentage of patients over the age of 50+ and lower levels of patients aged 30-50, when compared to national averages. The percentage of patients reporting with a long-standing health condition is slightly higher than the national average (practice population is 56% compared to

a national average of 54%). The proportion of patients who are in paid work or full-time employment or education is 61% compared to the CCG average of 55% and the national average of 62%.

Why we carried out this inspection

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

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

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 we hold about the practice and asked other organisations to share what they knew. This included the local clinical commissioning group (CCG) and NHS England.

The inspection team:

- Reviewed information available to us from other organisations, for example, NHS England.
- Reviewed information from CQC intelligent monitoring systems.
- Carried out an announced inspection visit on 10 August 2016.
- Spoke to staff and patients.
- Looked at documents and information about how the practice was managed.
- Reviewed patient survey information, including the NHS GP Patient Survey.

Reviewed a sample of the practice's policies and procedures.

Good

Are services safe?

Our findings

Safe track record and learning

There was a good system in place for reporting and recording significant events. The practice manager assisted by one of the secretaries was responsible for their collation. They maintained a schedule of events, there had been six in the last 12 months. Significant events were discussed monthly at a specific meeting for significant events and the outcomes and learning were then discussed with all staff at the monthly practice meeting. We reviewed safety records, incident reports and minutes of meetings where these were discussed.

Staff we spoke with were aware of the significant event process and actions they needed to take if they were involved in an incident. They could all tell us about significant events they had reported and they told us about some which had been discussed at the practice meetings and where changes had been made to processes and policies as a result of the significant events. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).

Safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance and national safety alerts. The practice manager managed the dissemination of national patient safety alerts. The clinical commissioning group (CCG) pharmacist who gave support to the practice reviewed medicines alerts.

Overview of safety systems and processes

The practice could demonstrate its safe track record through having systems in place for safeguarding, health and safety, including infection control, and staffing.

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. One of the practice GP partners was the lead for safeguarding adults and children. Patient records were tagged with alerts for staff if there were any safeguarding issues they needed to be aware of. There was a monthly safeguarding meeting at the practice. Community health care staff attended the meetings. Staff demonstrated they understood their responsibilities and had all received safeguarding children training relevant to their role, however not all administration staff had received safeguarding adults training; the practice manager told us this was to be addressed in the coming months. The safeguarding lead, other GP partner and all the nurses had received level three safeguarding children training.
- There was a notice displayed in the waiting area, advising patients that they could request a chaperone, if required. The practice nurses and some of the reception staff carried out this role. They had received chaperone training, this was out of date but they were booked on a training course in the following few weeks. The nurses had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). However, not all reception staff who acted as chaperone had received a DBS check. The practice manager assured us that this would no longer be permitted and that they would only use DBS checked staff as chaperones in future.
- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy, patients commented positively on the cleanliness of the practice. One of the practice nurses was the infection control lead. They had not received any recent lead infection control training. The practice manager told us that the practices in the area were trying to source this training for their infection control leads. The lead nurse had carried out hand hygiene training for staff. Regular infection control and hand hygiene audits had been carried out and where actions were raised these had been addressed. The building the practice was in was owned by South Tyneside Foundation NHS Trust. The practice manager had contacted the landlord to ask for a copy of the most recent legionella risk assessment they were told this had been carried out but it had not been made available to them by the day of the inspection, following the inspection a copy was forwarded to us by email.

Good

Are services safe?

- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording and handling). The practice complied fully with the CCG scheme assuring that prescribing was appropriate to need. They were the only practice out of 28 practices in the local area to achieve maximum points. However, we saw that the stock of emergency medicines held was fuller in the doctor's bags than in the central emergency medicines store. We were concerned that this posed a risk to any locums working at the practice who may not know about this. All medicines were in date. The practice should review how it stores emergency medicines and risk assess the medicines held in the doctor's bags.
- Prescription pads were securely stored and there were systems in place to monitor their use. The practice carried out regular medicines audits, with the support of the local CCG pharmacist.
- We saw the practice had a recruitment policy which was updated regularly. Recruitment checks were carried out. We sampled recruitment checks for both staff and locum GPs and saw that checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate DBS checks. We saw that the clinical staff had medical indemnity insurance.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patients and staff safety. There was a health and safety policy and risk assessments for each room. The practice manager had carried out health and safety training with staff. The practice had fire risk assessments in place. Two members of staff had been trained as fire warden and there were annual fire drills. All staff had received formal fire safety training, which was provided by the landlord. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The practice occasionally used locum GP cover.

Arrangements to deal with emergencies and major incidents

All staff received basic life support training and there were emergency medicines available in the practice. The practice had a defibrillator and oxygen with adult and children's masks. However, there were two sources of oxygen on the premises, one provided by the landlord which was not in use and one which the practice maintained. The oxygen which was not in use still had signs displayed to say it could be used and not all staff were aware it was out of order.

There was also a first aid kit and accident book available. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location.

The practice had a business continuity plan in place for major incidents such as building damage. The plan included emergency contact numbers for staff and was updated on a regular basis.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to ensure all clinical staff were kept up to date via clinical and educational meetings.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). The 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. The results are published annually. The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients.

The latest publicly available data from 2014/15 showed the practice had achieved 98.4% of the total number of points available to them, with a clinical exception reporting rate of 9.4%. The QOF score achieved by the practice in 2014/15 was above the England average of 94.8% and the local clinical commissioning group (CCG) average of 94.4%. The clinical exception rate at 9.4% was comparable to the England average of 9.2% and the CCG average of 9.5%. Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects.

The data showed:

- Performance for asthma related indicators was above the national average. For example, the percentage of patients on the asthma register who had an asthma review within the preceding 12 months that included an assessment of asthma control was 77.1%; the national average was 75.4%.
- Performance for diabetes related indicators was comparable to the national average. For example, the percentage of patients on the diabetes register who had an influenza immunisation was 94.5%, compared to the national average of 94.5%.
- Performance for chronic obstructive pulmonary disease (COPD) related indicators were comparable to the national average. For example, the percentage of patients with COPD who had a review undertaken including an assessment of breathlessness in the preceding twelve months was 89.1% the national average was 89.9%.
- Performance for mental health related indicators was comparable to the national average. For example, 88.4% of patients with schizophrenia, bipolar affective disorder and other psychosis had a comprehensive agreed care plan documented within the preceding 12 months. The national average was 88.5%.
- Performance for dementia indicators was slightly above the national average. The percentage of patients diagnosed with dementia whose care was reviewed in a face-to-face review within the preceding 12 months was 84.5; the national average was 84%.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes. We saw examples of audits which had been carried out the last three years, which included, audits of new cancer diagnosis, preferred place of death, asthma admissions, inflammatory bowel disease, minor surgery and various prescribing audits.

We saw two examples of two cycle audits which had been carried out in the last year. One was in relation to atrial fibrillation which demonstrated significant improvement in care in line with new NICE guidance, the practice was particularly proud of this audit. The practice had risk assessed 86% of the patients with atrial fibrillation and they had received a 'CHADS'score, which helps estimate stroke risk in patients by prescribing anticoagulants. The target was to identify 100% of these patients which the practice achieved, if anticoagulants were not prescribed a review was carried out and the reasons for this identified. The other was in relation to COPD showing improvements in case finding and demonstrated prevalence increasing from 2.7% (2014) to 3.45% (2016).

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

Good

Are services effective?

(for example, treatment is effective)

- The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as fire safety, health and safety and responsibilities of their job role. There was also an up to date locum induction pack at the practice.
- The learning needs of non-clinical staff were identified through a system of appraisals and informal meetings. Staff had access to appropriate training to meet those learning needs and to cover the scope of their work. Non-clinical staff had received an appraisal within the last twelve months. They told us they felt fully supported in carrying out their duties.
- The nurse practitioner appraised practice nurses with the practice manager. There were monthly in-house nurse meetings which were minuted and the nurses attended a local CCG education meeting every month. The nurse practitioner was appraised and supported by one of the GP partners.
- Both GPs in the practice had received their revalidation (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list.) They both attended monthly education sessions to update their skills.
- Staff received training that included: fire procedures, health and safety, basic life support and information governance awareness. All staff had received safeguarding children training, however some administration staff had not received safeguarding adults training. Clinicians and practice nurses had completed training relevant to their role.

Coordinating patient care and information sharing

The practice had effective and well established systems in place to plan and deliver care and treatment. Information was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and test results. All relevant information was shared with other services in a timely way, for example when people were referred to other services.

However, not all hospital discharge letters or letters informing the practice that a patient had attended out of hours services were seen by the GPs. The secretaries or reception staff triaged the letters and decided which letters were seen by the GPs. There were no clear protocols in place to support the secretaries or reception staff in triaging hospital letters. There was no audit in place of the letters which had not been seen by the GPs. We asked the practice to review their processes in relation to this to ensure that it was a fail-safe system. Following the inspection the practice sent us an email to re-assure us that all hospital discharge and out of hours services letters were seen by a GP.

Staff worked together and with other health and social care services. Multi-disciplinary team meetings took place monthly where the district nurse and community matron attended. At this meeting there was a review of deaths of patients registered with the practice, palliative care and new cancer diagnoses. At these meetings data and knowledge of patients was used to identify high risk patients who were in need of care plans or follow up contact.

The practice had a palliative care register and used a traffic light system used to identify the most vulnerable and in need patients on the register in order to manager their treatment and support.

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements, including the Mental Capacity Act (MCA) 2005. All clinicians had received recent training in MCA and were able to articulate how this had improved the way in which they assessed patients. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. This included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were then signposted to the relevant service.

Good

Are services effective?

(for example, treatment is effective)

Childhood immunisation rates for the vaccinations given were in line with CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 95% to 98%, compared to the CCG averages of 85% to 99% and for five year olds from 88% to 100%, compared to CCG averages of 92% to 100%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients with the healthcare assistant or the GP or nurse if appropriate. There were also over 40 and older persons health checks. Follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed throughout the inspection that members of staff were courteous and very helpful to patients; both attending at the reception desk and on the telephone. Curtains were provided in 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 reviewed 22 CQC comment cards completed by patients prior to the inspection. Patients who completed the comment cards were generally satisfied with the service they received. Common words used to describe the practice included, caring, helpful, excellent, good and nice.

All of the patients we spoke with were satisfied with the care they received from the practice. Words used to describe the practice included good and very caring. They told us staff were friendly and helpful and they received a good service.

Results from the National GP Patient Survey in January 2016 showed patients were happy with how they were treated and that this was with compassion, dignity and respect. The practice was variable for its satisfaction scores on consultations with doctors and nurses. For example, of those who responded:

- 91% said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 100% said they had confidence and trust in the last nurse they saw compared to the CCG average of 98% and the national average of 97%.
- 88% said they found the receptionists at the practice helpful compared to the CCG average of 89% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

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

Results from the National GP Patient Survey we reviewed showed patients responses were variable about their involvement in planning and making decisions about their care and treatment when compared to local and national averages. For example, of those who responded:

- 87% said the GP was good at listening to them compared to the CCG average of 91% and the national average of 89%.
- 91% said the GP gave them enough time compared to the CCG average of 89% and the national average of 87%.
- 82% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88% and the national average of 86%.
- 95% said the last nurse they spoke to was good listening to them compared to the CCG average of 92% and the national average of 91%.
- 93% said the nurse gave them enough time compared to the CCG average of 94% and the national average of 92%.

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

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations. This included information regarding how to cope with stress and carers services.

The practice's computer system alerted GPs if a patient was a carer. There were 203 patients recorded on the practice's computer system as a carer which is 4% of the practice population. The practice said this was an area they wanted to co-ordinate better. They felt they were under recording the help they were giving to carers. Written information was available for carers to ensure they understood the various avenues of support available to them in the waiting area of the practice.

Staff told us that if families had suffered bereavement, depending upon the families wishes the GP would telephone or visit to offer support.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood the different needs of the population and acted on these needs in the planning and delivery of its services. Many of the staff had worked there for many years and the practice was small which enabled good continuity of care. The practice had close links with the local community through the different multi-disciplinary meetings and groups the practice attended.

The practice worked with the local clinical commissioning group (CCG); they were part of the CCG initiative of Better Outcomes, the project aims were to improve the quality of patient care by delivering identification of high risk patients and providing care plans. The practice had two nominated residential care homes for elderly patients; care plans were in place for the patients who lived there and the nurse practitioner visited the homes weekly.

We found the practice was responsive to people's needs. They participated in a CCG initiative 'change makers' to see if they were 'young person friendly' in 2015. Young people completed a questionnaire which resulted in changes being made in the practice. Subsequent action taken included ensuring information was made available for young people in the waiting room and sending a young person's information leaflet on the practice to them on their 14th birthday.

Services were planned and delivered to take into account the needs of different patient groups and to help to provide flexibility, choice and continuity of care. For example;

- The practice offered extended opening hours on a Monday evening until 7:15pm.
- Telephone consultations were available if required.
- Booking appointments with GPs and requesting repeat prescriptions were available online.
- Home visits were available for housebound patients or those who could not attend the surgery.
- All patients had a named GP to ensure continuity of care as far as possible.
- Clinicians would see a patient for more than one problem per appointment and clinics would be adjusted accordingly.
- Specialist clinics were provided including minor surgery, and travel vaccinations which included yellow fever.
- There were disabled facilities and translation services available; however there was no hearing loop available.
- All patient services were accessible to patients with physical disabilities. Other reasonable adjustments were made and action was taken to remove barriers when people find it hard to use or access services. There were electronic doors at the entrance to the building and there were baby change facilities in the public toilets.
- Antenatal clinics were ran by the attached midwife. Child immunisations were carried out by making an appointment with the practice nurse.

Access to the service

The practice was open weekdays from 8:30am until 6pm Tuesday to Friday. There were extended opening hours on a Monday evening when the practice was open until 7:15pm.

Consulting times with the GPs and nurses ranged from 8:30am – 11am and from 2pm every afternoon. Consulting times ran to; Monday 7:10pm, Tuesday 5:40pm, Wednesday 4pm, Thursday 5:10pm (the nurse practitioner had appointments to 6pm) and Friday 4.30pm.

Patients we spoke with said they did not have difficulty obtaining an appointment to see a GP, however four of the 22 patients who completed the CQC comment cards said that sometimes it could be difficult to obtain an appointment.

We looked at the practice's appointments system in real-time on the afternoon of the inspection. There were routine appointments to see a GP in two working days and appointments with the nurse practitioner in one working day.

Results from the National GP Patient Survey showed that patient's satisfaction with how they could access care and treatment was higher than local and national averages. For example, of those who responded;

- 83% of patients were satisfied with the practice's opening hours compared to the local CCG average of 81% and national average of 76%.
- 86% patients said they could get through easily to the surgery by phone compared to the local CCG average of 79% and national average of 73%.
- 77% patients described their experience of making an appointment as good compared to the local CCG average of 77% and national average of 73%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice had devised an action plan for the coming year to further improve access for patients. This included better training for staff to sign post patients to appropriate services which could help such as the chemist and expanding the role of the practice nurse and healthcare assistant. The practice had introduced telephone reviews for chronic disease management.

Listening and learning from concerns and complaints

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

We saw the practice had received four formal complaints in the last 12 months and these had been investigated in line with their complaints procedure. Where mistakes had been made, it was noted the practice had apologised formally to patients and taken action to ensure they were not repeated. Complaints and lessons to be learned from them were discussed at practice meetings.

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's mission statement was to provide the best possible quality primary care service for patients within a confidential and safe environment by working together. Staff we spoke with talked about patients being their main priority.

The practice had a business development plan for 2016-2021. This set out aims for service development. Included was quality improvement of outcomes for patients such as quality in prescribing. There were plans in place to improve information technology in the practice, streamlining processes and improving document workflow.

The staff we spoke with, including clinical and non-clinical staff, all knew the provision of high quality care for patients was the practice's main priority. They also knew what their responsibilities were in relation to this and how they played their part in delivering this for patients.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care.

- There was a clear staffing structure and staff were aware of their own roles and responsibilities, the GP partners were involved in the day to day running of the practice.
- There were clinical leads for areas such as safeguarding.
- Practice specific policies were implemented and were available to all staff.
- Managers had an understanding of the performance of the practice.
- A programme of continuous clinical audit was used to monitor quality and to make improvements.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care. The partners were visible in the practice. Staff told us that they were approachable and always took the time to listen to all members of staff as did the practice manager.

We saw that there was a strong culture of team working in the practice. An example of this was where the whole practice team were involved in the management of long term conditions.

The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents.

There were clinical meetings held every month which the nurses also attended and there were monthly practice meetings which all staff attended. The nurses held their own monthly meetings The partners held monthly meetings with the practice manager. Multi-disciplinary meetings were held. We saw minutes from all of these meetings.

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

The practice encouraged and valued feedback from patients. They had gathered feedback from patients through a patient survey, although this was from 2014, and from formal and informal complaints received and the practice participation group (PPG).

The practice had an established patient participation group (PPG) with between eight and 12 members who met quarterly, we saw agenda and minutes from these meetings. Various members of the practice team attended the meetings which also included GPs and nurses. The PPG members we spoke with told us the practice was very open to suggestions made by them. They had assisted with questions for past practice surveys. They had made suggestions for improvements which the practice had adopted. This included a TV screen to call patients into consultations, new seating in the waiting area and notice boards being reorganised in reception.

The practice had also gathered feedback from staff. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Opportunities for individual training were identified at appraisal. All staff were encouraged to identify opportunities for future improvements on how the practice was run. There were regular staff social events.

Continuous improvement

The practice took part, in early 2016, in supporting undergraduate students studying pharmacy at a local

Are services well-led?

Good

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

university to spend time in the practice to experience first-hand experience of general practice. Due to excellent feedback this was to be recommended for the following year.

The practice had devised an action plan for the coming year to further improve access for patients. This included better training for staff to sign post patients to appropriate services which could help such as the chemist and expanding the role of the practice nurse and healthcare assistant.

There was a focus on continuous learning and improvement within the practice. The practice had protected learning times once a month both at the practice and at CCG organised events.