Dr Balloch and Partners

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

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Overall summary

We inspected Dr Balloch & Partners on 2 October 2014, as part of our new, comprehensive inspection programme. The practice had not previously been inspected.

The overall rating for this practice is good. We found the practice to be effective, caring, responsive to people's needs and well-led. The quality of care experienced by older people, by people with long-term conditions, families, children and young people was good. Working age people (including the recently retired and students), those in vulnerable circumstances and people experiencing poor mental health also received good quality care.

Our key findings were as follows:

- The practice was a friendly, caring and responsive practice that addressed patients' needs and worked in partnership with other health and social care services to deliver individualised care.
- There was a good range of appointments available for patients through extended opening hours, visits to local care homes and appointments at home for other patients who were unable to travel to the practice.
- The practice ensured learning from incidents and events through discussion, analysis and the cascading of the findings to the appropriate staff.
- Staff were supported to do their jobs through a system of regular appraisal and supervision. GP trainees were well supported to develop their practice.
- The practice was visibly clean and regularly audited to ensure the risks of the spread of infection were minimised.
- The practice actively participated in the local safeguarding children board and the lead GP attended meetings set up under the statutory framework for reviewing serious child protection cases.
- There was a clear culture of learning, improvement and innovation amongst staff who were supported by the open door policy operated throughout the practice.

We saw several areas of outstanding practice:

- Whenever GPs at the practice referred patients onwards for specialist treatment, every referral was subject of a peer-to-peer discussion with another doctor to ensure that the treatment pathway was appropriate to the particular patient's needs.

Summary of findings

Thereafter the outcome of the referral was considered in the same way by both the requesting and reviewing doctor to ensure that the patient's needs had been met and to take any mutual learning from it.

- The practice took a proactive approach to identifying potential safeguarding concerns regarding children. Notes for new patients and those attending accident and emergency, out of hours and urgent care services were scrutinised for any suggestion of safeguarding issues. If children failed to attend hospital appointments and parents declined an offer to rebook the GP would review the circumstances and make a safeguarding referral if they judged it appropriate to do so.
- The practice shared its learning and innovation with other practices in the CCG local area. This included the nurse-led review of COPD medication which resulted in positive outcomes for patients and significant cost savings for the practice. The nurse safeguarding lead was also accessible to other practices in order to share knowledge, expertise and provide support. An information sheet designed by a GP partner to be included in the personal child health record gave information on how to use health services appropriately when a child is unwell, such as calling a pharmacist or the GP instead of visiting accident and emergency. Subsequently the local CCG funded production of the sheets and recommended their use across the whole CCG area.

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 safe. There were extremely robust systems in place for identifying patients at risk of abuse and escalating those concerns through the appropriate channels. Medicines were managed safely in order to optimise safe care for patients who were prescribed medicines for long term conditions. There were very effective arrangements in place for managing the shared care medicines prescribed to patients following hospital consultations. The structure of meetings ensured that staff were informed about risks and decision making. There were incident and significant event reporting procedures in place that encouraged learning and action was taken to prevent recurrence of incidents when required. Cleanliness, equipment and medication were monitored and maintained and all staff trained in infection control procedures, including the cleaning staff who were employed by an external contractor.

Are services effective?

Good

The practice is rated as good for effective. The practice provided specialist nurse-led clinics to initiate insulin to patients newly diagnosed with diabetes in order to reduce hospital referrals. Staff were encouraged to bring their learning from external training into the practice and carried out work which increased the effectiveness of the practice and enhanced patient care and experiences. The practice took a collaborative approach to working with other health providers and there was multi-disciplinary working at the practice. Innovation and learning from within the practice was shared within both the local and wider CCG areas. GP trainees received a high level of support and access to a range of experiences in order to refine their skills and knowledge. Whenever GPs at the practice referred patients onwards for specialist treatment, every referral was subject of a peer-to-peer discussion with another doctor to ensure that the treatment pathway was appropriate to the particular patient's needs.

Are services caring?

Good

The practice is rated as good for caring. On the day of the inspection, we saw staff interacting with patients in reception and outside consulting rooms in a respectful and friendly manner. There were a number of arrangements in place to promote patients' involvement

Summary of findings

in their care. Patients told us they felt listened to and included in decisions about their care. Health and other relevant information was clear and easily accessible to help patients understand the care available to them.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. Services were targeted at those most at risk such as older people, those with long term conditions and those reporting mental health concerns. The patients reported good access to the practice. Appointments were available, including those required out of normal working hours or in an emergency. A number of appropriate methods were available for patients to leave feedback about their experiences. The practice demonstrated it responded to patients' comments and complaints and, where possible, took action to improve the patient experience.

Are services well-led?

Good

The practice is rated as good for well-led. Staff were aware of individual accountabilities and responsibilities and understood their own roles and objectives. Staff felt engaged in a culture of openness and consultation. An appropriate management and meeting structure ensured that staff were aware of how decisions were reached and of their roles in implementing them. Staff were supported by management and a system of policies and procedures that governed activity. The management structure ensured that risks to patient care were anticipated, monitored, reviewed and acted upon. The practice sought feedback from patients and staff and listened to representatives of the patient population.

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 The practice is rated as good for the population group of older people. The practice offered personalised care to meet the needs of older people in its population. Older patients had access to a named GP, a multi-disciplinary team approach to their care and received targeted vaccinations. A range of enhanced services were provided such as those for dementia and end of life care. The practice was responsive to the needs of older people offering home visits including the provision of flu vaccinations.	Good
People with long term conditions The practice is rated as good for the population group of people with long term conditions. Innovative work had been carried out to offer patients with diabetes extensive support with learning to administer insulin meaning those patients no longer needed to be referred to hospital for this help. Patients with COPD had been reviewed and their medication changed when it was identified that the number of patients with the condition who were on triple inhaler therapy was higher than the national average. A robust system was in place to closely monitor and review patients in receipt of shared care medicines. The practice provided patients with long term conditions with an annual review to check their health and medication needs were being met. They had access to a named GP and targeted immunisations such as the flu vaccine. The Practice had named staff to lead on a range of long term conditions such as asthma, diabetes and epilepsy. Nurse practitioners had multiple specialisms so patients with multiple conditions were scheduled for appointments in order to manage all of their needs in one visit.	Good
Families, children and young people The practice is rated as good for the population group of families, children and young people. The practice took a very proactive approach to identifying potential safeguarding concerns regarding children. Notes for new patients and those attending accident and emergency, out of hours and urgent care services were scrutinised for any suggestion of safeguarding issues. If children failed to attend hospital appointments and parents declined an offer to rebook the GP would review the circumstances and make a safeguarding referral if they judged it appropriate to do so. Programmes of cervical screening for women over the age of 25 and childhood immunisations were used to respond to the needs of this patient group. Catch up appointments for cervical screening and flu vaccinations were available on Saturdays and evenings for patients	Good

unable to attend during normal surgery hours. Information for parents on the most appropriate health advice for their children was incorporated in the personal child health record (known as the ‘red book’) and regularly brought to the attention of parents during routine appointments.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of working age people (including those recently retired and students). The practice offered online services such as appointment booking and repeat prescriptions. The practice responded to the needs of working age patients with extended opening times every weekday evening. The practice was proactive in offering a short term programme of extended clinics to enable patients unable to attend flu vaccinations during weekdays could attend at weekends. Saturday morning clinics were also available for smear tests.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice noted patients living in vulnerable circumstances including those with learning disabilities. Patients with learning disabilities were offered annual health checks. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Vulnerable patients were sign-posted to various support groups. Staff knew how to recognise signs of abuse in vulnerable adults and were aware of their responsibilities in raising safeguarding concerns.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). There was a GP lead for mental health at the practice. The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health including those with dementia. Dedicated sessions were held by the GPs to review the physical health of patients living with dementia in local care homes.

Summary of findings

What people who use the service say

During the inspection, we spoke with four patients, reviewed 23 comment cards completed by patients and gathered views of the patient reference group (PRG). The PRG is a group of patients who work with the practice to discuss and develop the services provided. Patients told us that the care they received at the practice was very good. They said they felt staff were respectful and friendly. They told us the practice was accessible and they were able to get the appointments they wanted.

The results of the last patient survey, completed during 2014, showed that 70% of the 230 respondents felt availability of appointments was good or very good. Overall, 95% rated their experience of the practice as very satisfied or fairly satisfied.

Outstanding practice

We saw several areas of outstanding practice:

- Whenever GPs at the practice referred patients onwards for specialist treatment, every referral was subject of a peer-to-peer discussion with another doctor to ensure that the treatment pathway was appropriate to the particular patient's needs. Thereafter the outcome of the referral was considered in the same way by both the requesting and reviewing doctor to ensure that the patient's needs had been met and to take any mutual learning from it.
- The practice took a very proactive approach to identifying potential safeguarding concerns regarding children. Notes for new patients and those attending accident and emergency, out of hours and urgent care services were scrutinised for any suggestion of safeguarding issues. If children failed to attend hospital appointments and parents declined an offer to rebook the GP would review the circumstances and make a safeguarding referral if they judged it appropriate to do so.
- The practice shared its learning and innovation with other practices in the CCG local area. This included the nurse-led review of COPD medication which resulted in positive outcomes for patients and significant cost savings for the practice. The nurse safeguarding lead was also accessible to other practices in order to share knowledge, expertise and provide support. an information sheet designed by a GP partner to be included in the personal child health record gave information on how to use health services appropriately when a child is unwell, such as calling a pharmacist or the GP instead of visiting accident and emergency. Subsequently the local CCG funded production of the sheets and recommended their use across the whole CCG area.

Dr Balloch and Partners

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 second CQC inspector and a GP as specialist advisor.

Background to Dr Balloch and Partners

Dr Balloch & Partners provides a range of primary medical services from a purpose built facility at Prospect House, 121 Lower Street, Kettering, NN16 8DN. The practice serves a population of approximately 16,500. The area served has a lower than average deprivation rate compared to England as a whole. The full clinical staff team includes eight GP partners, two trainee GPs, seven practice nurses and one healthcare assistant. The team is supported by a practice manager, a medical secretary and reception and administration staff.

Why we carried out this inspection

We inspected this practice as part of our new comprehensive inspection programme.

We carried out a comprehensive inspection of this practice 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). We also planned the inspection to look at the overall quality of the service and to provide a rating for the practice under the Care Act (2014).

This provider had not been inspected before and that was why we included them.

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

How we carried out this inspection

Before our inspection visit, we reviewed a range of information we held about the practice and asked other organisations to share what they knew about the practice. We carried out an announced inspection visit on 02 October 2014.

During our inspection we spoke with a range of staff including the GPs, nurses, the reception team and the practice manager. We spoke with four patients and gathered views from the (virtual) patient reference group (PRG). The PRG is a group of patients who work with the practice to discuss and develop the services provided). We observed how patients interacted with staff. We reviewed the practice's own patient survey and 23 CQC comment cards left for us by patients to share their views and experiences of the practice with us.

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

- Is it safe?
- Is it effective?

Detailed findings

- 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
- The working-age population and those recently retired (including students)
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

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 to were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last two years. 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. Significant event analysis is used by practices to reflect on individual cases and where necessary, make changes to improve the quality and safety of care. The minutes of the partners' meetings available at the practice demonstrated that all incidents and near misses were discussed. The meetings included discussion on how the incidents could be learned from and any action necessary to reduce the risk of recurrence. An annual significant event analysis was completed by the practice manager. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. We saw evidence of action taken as a result such as reminders set up on staff calendars to ensure frequent checking of rejected referrals to other services. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated through tasks allocated to staff on the practice's computerised records management system to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at staff team meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems & processes including safeguarding

We found that there was a very robust approach to safeguarding children and vulnerable adults. We spoke with both clinical and non-clinical staff members who showed us the policies and procedures in use at the practice. We noted that these had been updated in July 2014 and that they were accessible to all staff. All staff received annual training in safeguarding children and vulnerable adults and were aware of their responsibilities if they suspected patients were at risk of abuse.

The practice had two separate safeguarding lead clinicians for children and vulnerable adults to whom staff passed their concerns about particular patients as well as two designated lead nurses. There was also a dedicated safeguarding administrator. We saw that this system enabled concerns to be passed on and reviewed straight away by the relevant GP or by a doctor on duty on the same day if the GP lead was not available. This also enabled referrals to be made to the local authority without delay where this was appropriate. The safeguarding leads were given dedicated time in order to meet regularly.

The practice actively participated in the local safeguarding children board and the lead GP attended meetings set up under the statutory framework for reviewing serious child protection cases. In one such case, the practice had cause to review the way it recorded information about young adult patients that had previous involvement with the local authority. This resulted in the practice being able to improve the way it managed this information and thereby its ability to understand the risks posed to individual patients or their families.

The practice took a proactive approach to ensuring they were aware of safeguarding issues relating to children. When new patients registered with the practice they completed a questionnaire in which they were asked if they had previous contact with social services. Where the response was 'yes' the notes for the whole family were fast-tracked. Upon receipt each family member's notes were analysed in order to ensure any previous concerns were identified and added to the practice's records. This was to ensure that safeguarding issues were flagged and practice staff made aware. Summaries of patient notes were carried out by a member of the practice's administrative staff who had received specific training for that task. Those summaries were regularly audited by the GP with the lead for safeguarding to ensure accuracy and that appropriate actions had been taken. Where children had attended accident and emergency, out of hours or urgent care services the lead GP analysed the notes received for those children to identify any safeguarding issues and then take appropriate action. If the practice were notified of children failing to attend hospital appointments administrative staff would contact their parents and offer to re-book the appointments. If this offer was declined the issue would be referred to the lead GP for safeguarding who would review the circumstances and make a safeguarding referral if they judged it appropriate to do so.

Medicines Management

There were robust systems in place for managing medicines safely. The GP lead for medicines management described the system the practice used to manage patients of shared care medicines. These are medicines which are initiated by hospital consultants then at an agreed time, the prescribing and monitoring is taken over by primary care. Patients were clearly labelled and all repeat prescriptions managed by one GP. The specific protocol for the medicine being taken by each patient was flagged on the practice's computerised records system. This system was to provide assurance that patients already taking other medicines which might conflict with the shared care medicine could be safely managed and alternative medicines prescribed. A pharmacist employed by the practice one day per week carried out regular audits of the prescriptions for these patients.

We spoke with one of the nursing team who was designated as the lead for the management of medicines used at the practice. We saw that all medicines that were in general use were all securely stored in locked cupboards or fridges as appropriate. This included medicines used for managing pain, vaccines and local anaesthetics used during minor surgery.

We saw records that showed that all medicines were subject to a monthly check to ensure they remained within their expiry dates and to monitor the stock levels of medicines that were regularly used. There was a system in place for ordering medicines one month in advance of their expiry date. The practice did not maintain a stock of controlled drugs.

Temperature sensitive medicines, such as vaccines for flu and for those travelling abroad, were kept in locked fridges from the time they arrived and were checked in. We noted that there was a vaccine rotation system in place that ensured the vaccines were used in date order. The fridge temperatures were monitored to ensure the vaccines were stored safely and remained fit for use.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, following revised guidance from the Medicines and Healthcare Regulatory Agency (MHRA) changes were made to the types of cholesterol lowing medication prescribed to patients at risk of developing heart disease. The MHRA regulates the prescribing of medicines in the United Kingdom in order to protect patients' safety.

Cleanliness and Infection Control

We looked at the practice's cleaning schedules. We saw that the practice was cleaned by an independent contractor and that the quality of this was monitored by virtue of wall-mounted checklists in each room or area. There was a cleaning trolley designated for each floor and we noted that equipment and materials conformed to the guidance on cleaning primary medical care settings issued by the Department of Health. There were also effective arrangements for the regular collection of clinical waste and the disposal of used sharp instruments. The buildings administrator, who was employed jointly by the two practices situated in the building, carried out regular spot checks with the cleaning provider.

All surfaces in clinical areas were cleaned by the nursing team either after each use or in accordance with a dedicated start-up and close-down procedure for each area. This ensured that the risk of patients acquiring a healthcare associated infection through contaminated treatment areas was minimised.

The practice employed a dedicated infection control lead nurse whose role included regularly updating the infection control policy and carrying out infection control checks. Staff were trained annually in infection prevention and control and we noted that there were numerous posters bearing information about hand-cleanliness. This was supported by the use of appropriate hand-wash dispensers by each sink. Further barriers to infection were also evident, such as alcohol gel dispensers for patients and staff and the use of dated, disposable curtains in treatment rooms. The practice also provided annual infection control training to the cleaners employed by the external contractors in order to provide assurance that the cleaners had the appropriate knowledge.

We saw that a hand cleanliness audit had been carried out in October 2013 by the infection control lead nurse. The audit measured the compliance of staff with relevant instructions such as the bare-arms policy and the policy prohibiting the wearing of stoned hand jewellery. The findings of that audit had been discussed at one of the monthly primary health-care team meetings to ensure clinical staff were aware of the need for adherence to the policy. The audit was due to be followed up during the month following our inspection to determine whether it had been effective. This demonstrated a diligent approach by the practice to assessing whether they had safe systems for reducing the risks of cross-infection.

In each clinical room a checklist was displayed on which records of equipment used and cleaned was displayed. Monthly audits of these checklists were carried out and required actions identified and followed up.

A Legionella risk assessment had been completed at the practice in May 2014. The certificate of conformity was available and up to date.

Equipment

The practice was located within a modern building that was purpose built for use as a health centre. As such, all of the fixtures and fittings, such as lighting and electrical connections were relatively new and well maintained. All portable appliances were tested for electrical safety.

We also saw that clinical areas were properly equipped with appropriate, clean and well maintained equipment, such as hand washing sinks, examination couches and storage cabinets.

The practice had a designated area between the reception and the consultation rooms, known as a ‘health zone’ for patients to measure their own blood pressure and body mass index. This area was also clean, clutter free and had equipment that was properly maintained and validated. All mechanical equipment was calibrated and validated according to a schedule that was maintained by a member of the administration staff.

Staffing & Recruitment

We spoke with the practice manager who explained the way that staffing levels were organised and we looked at staff rotas. Staff levels were considered well in advance and recruitment processes were initiated when it was anticipated that levels would drop. For example, the practice manager had used a staff level calculation tool to review staffing levels against an increasing patient list size. This had resulted in evidence being made available for a business case to recruit additional staff and this had been agreed by the partnership.

Staff rotas were made up two months in advance with new appointments being released six weeks ahead. This meant that appointments were set according to the availability of the clinical team. The practice manager also had authority to call upon locum GPs for cover well in advance although we learned that these occasions had been few owing to the GPs generally being able to cover colleagues’ absences between them.

We saw that there was a policy that limited the number of skilled nurses who could be on leave at any one time. The staff we spoke with confirmed that nurses were happy to work occasional extra sessions to cover for colleagues who might be absent through sickness. This showed that there were sufficient nurses available to provide skilled coverage for all of the services and clinics provided at the practice.

Monitoring Safety & Responding to Risk

We saw that the staff had access to medicines for use in a medical emergency, including those medicines used for treating patients who experienced anaphylactic shock, a severe allergic reaction to vaccinations. These were checked every week to ensure they were within their expiry dates and replacements ordered when required. The practice also had access to oxygen and an automated electronic defibrillator. We looked at staff training records and saw that training in basic life support was provided annually to ensure staff could provide cardio pulmonary resuscitation if this was required.

Identified risks were assessed and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, a patient had been identified as presenting a risk to staff in a one to one situation and it had been agreed that staff should not see that patient without another member of staff being present.

Arrangements to deal with emergencies and major incidents

We saw that every computer screen had a green button that alerted staff in the rest of the building to a potential emergency or serious incident that required immediate support or attention. Staff told us of several occasions when this had been used effectively, for example, where patients had experienced anaphylactic shock or when staff had been at risk from aggressive patients.

A business continuity plan (called the contingency and disaster plan) was in place to deal with a range of emergencies that may 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 carried out a fire risk assessment that included actions required to maintain fire safety. Staff were up to date with fire training and that they practised regular fire drills. The practice had adopted a system to assist with swift and efficient checking of the building during an evacuation or drill. Yellow hangers were hung on doors by the last person to leave or by the fire marshal who checked rooms were empty.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice reviewed, discussed and acted upon best practice guidelines and information to improve the patient experience. A system was in place for National Institute for Health and Care Excellence (NICE) quality standards to be distributed and reviewed by clinical staff. The practice participated in recognised clinical quality and effectiveness schemes such as the national Quality and Outcomes Framework (QOF). QOF is a national data management tool that provides performance information about primary medical services.

We saw that the practice had used this information to improve services for patients with asthma. By completing a review of all patients with asthma, the practice identified that those experiencing fewer chronic symptoms were less likely to attend for their annual reviews. In response, the practice provided an online questionnaire and sent a text message to all those patients with a request to complete it. Reminders were also placed on the inhaler prescriptions for those patients to attend for their annual reviews.

All emergency admissions and attendances at accident and emergency were reviewed monthly. Patients were contacted with 72 hours of discharge from hospital with an offer of a follow up appointment. These reviews were discussed at monthly partners meetings.

We saw that the practice had carried out a review of referrals to hospital outpatient departments for the year 2013 to 2014. A number of areas had been identified for improvements to decision-making by GPs. These included referrals of patients with nose bleeds. The action identified for those patients was that GPs should persist with treatment in the practice before referring patients to specialist secondary care.

Management, monitoring and improving outcomes for people

Practice nurses with specialist training led the management of care for people with long term conditions including asthma, dementia and diabetes. Three nurses with a specialism in diabetes had received additional training to initiate insulin administration for patients with a recent diagnosis of diabetes. They had worked with specialist nurses at the local hospital to reduce referrals to hospital for such patients. Patients were trained to administer insulin and received on-going support including open access to the practice nurses during the initial period. The practice told us that hospital referrals for this type of patient had completely stopped as a result of the introduction of the clinics at the practice.

Following a training event outside the practice the lead nurse for patients with chronic obstructive pulmonary disease (COPD) conducted an audit of patients who were receiving triple inhaler therapy to manage their condition. The results of the audit showed that the number of patients receiving this treatment was higher than the national average. A review of each patient was carried out and where appropriate the treatment for those patients was adjusted. The patients attended follow up appointments to check their progress with their new therapy and all were found to be responding positively.

The practice had a system in place for completing clinical audit. Clinical audit is a way of identifying if healthcare is provided in line with recommended standards, if it is effective and where improvements could be made. We saw evidence of how the practice had used clinical audit in this way.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the QOF.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. The protocol gave step by step guidance to staff to ensure that the processing guidance was consistently applied.

Dedicated sessions were held by the GPs to review the physical health of patients living with dementia in local care homes.

Effective staffing

The practice employed staff that were appropriately qualified and competent, with the right skills and experience. Newly employed staff received a structured induction programme that provided them with appropriate skills and introduced them to tasks associated with their role under the supervision of an experienced staff member acting as mentor. We also noted that the practice used staff recruitment processes that provided them with reassurances that any risks of employing staff that might be unsafe were minimised. These processes included appropriate criminal records checks for clinical staff whilst the need to carry out similar checks for non-clinical staff was subject of a risk assessment. All new staff were only employed when checks with previous employers had been carried out.

The practice also took steps to ensure that staff maintained their skills by holding monthly sessions known as protected learning time (PLT). During PLT sessions staff received updates and refresher training in topics that the practice designated as being key to their role. Such topics included basic life support, safeguarding, information governance and infection prevention and control.

We saw that the doctors were revalidated according to the standards set down by their professional body. In the case of nursing staff, the practice also ensured that they had access to knowledge, material and training – known as continuing professional development (CPD) – to enable them to maintain their professional registration. For example, the three advanced nurse practitioners (qualified nurses with additional levels of responsibility such as prescribing medicines) received 20 minutes clinical supervision every week built into their work timetable. This supervision was provided by one of the doctors when issues arising from their work were discussed.

The practice was a training practice for GP trainees. We spoke with a GP registrar who confirmed they had received excellent levels of support and guidance throughout their placement at the practice. We also consulted Health Education England who had surveyed the experience of GP registrars at the practice between 2012 and 2014. Their data demonstrated that trainees found the practice supportive of their professional development through offering them a broad range of experiences and support. Most trainees surveyed gave their experience at the practice the highest rating.

All staff received annual appraisals that examined their performance in the preceding year and identified any training needs or career development opportunities. Staff told us they felt supported by both the appraisal system and by the management team's 'open door' policy. In this way the management team were available at any time and whenever such support might be sought.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. We saw that a system was in place for such things as patient pathology results and radiology reports to be received electronically and allocated to the GPs. The process included a system of alerts for patients who required a follow up. All the staff we spoke with understood how the system was used. A system was also in place for all patients over 75 to have their hospital discharge letters reviewed by a practice nurse. Home visits would be arranged for those patients requiring post discharge follow up.

The practice held multi-disciplinary team meetings approximately every six weeks to discuss the needs of complex patients. This included those with end of life care needs or children who were subject of a child protection plan. These meetings were attended by district nurses, health visitors and the community mental health team among others. We saw that the issues discussed and actions agreed for each patient were documented. Also, all clinicians at the practice met daily for more frequent, smaller scale discussions. There were additional weekly multi-disciplinary meetings attended by the district nurses and GP partners. The staff we spoke with felt the system worked well and remarked on the usefulness of such forums as a means of sharing important information.

Whenever GPs at the practice referred patients onwards for specialist treatment, every referral was subject of a peer-to-peer discussion with another doctor to ensure that the treatment pathway was appropriate to the particular patient's needs. Thereafter the outcome of the referral was considered in the same way by both the requesting and reviewing doctor to ensure that the patient's needs had been met and to take any mutual learning from it.

The practice shared its learning and innovation with other practices in the CCG local area. This included the nurse-led review of COPD medication which resulted in positive outcomes for patients and significant cost savings for the practice. The nurse safeguarding lead was also accessible to other practices in order to share knowledge, expertise and provide support. One of the partners had designed an information sheet which was included in the personal child health record (known as the 'red book'). This sheet gave information on how to use health services appropriately when a child was unwell, such as calling a pharmacist or the GP instead of visiting accident and emergency. Clinical staff at the practice referred to the sheet at routine appointments with parents and children. Subsequently the local CCG funded production of the sheets and recommended their use across the whole CCG area.

Information Sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hours provider to enable patient data to be shared in a secure and timely manner. An electronic system was also in place for making referrals through the Choose and Book system. The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital.

The practice had systems in place to provide staff with the information they needed. An electronic patient record (SystmOne) was used by all staff to coordinate, document and manage patients' care. We spoke with staff who told us they were trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

From our conversations with staff and our review of training documentation we saw that staff at the practice had received Mental Capacity Act 2005 (MCA) training. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity. MCA guidance was available on the practice intranet.

The staff we spoke with demonstrated an understanding of the MCA and its implications for patients at the practice. Staff were also aware of the Gillick competency test (a process to assess whether children under 16 years old are able to consent to their medical treatment, without the need for parental permission or knowledge). The staff we spoke with gave examples of its use in the practice.

Health Promotion & Prevention

As well as effective staffing arrangements, the facilities and equipment at the practice also had a positive impact on outcomes for patients. For example, the 'health zone' at the entrance to the consultation room corridor allowed patients to measure their own blood pressure, height, weight and body mass index. This screened off area provided some privacy for patients who made use of it and contained a range of information in poster and leaflet form about issues affecting their health such as diet and lifestyle. Moreover, the facility enabled them to maintain an element of personal control over the way their health was assessed. Where patients were concerned about the results of the monitoring the receptionists held a protocol written by a GP which facilitated appropriate action by the practice for the patient, including instant access to a GP if needed.

The practice carried out a range of national vaccination programmes such as seasonal flu for eligible patients, shingles for older patients and childhood immunisations. The practice also took part in the cervical screening programme.

Patients with long term conditions such as coronary heart disease, diabetes, respiratory conditions and chronic kidney disease were regularly recalled for health monitoring. The practice had well established clinics for chronic lung disorders and used spirometry, a lung capacity test, as part of its service to assess the evolving needs of this group of patients. The practice also promoted independence and encouraged self-care for these patients through the provision of a range of printed information about healthy living and the opportunity to monitor the own blood pressure and body mass index in the 'health zone'.

Patients with learning disabilities and mental ill-health were offered an annual physical health check. This was a proactive process managed by a member of staff designated as recall clerk and supervised by one of the management team. This enabled the practice to be assured they had given such patients every opportunity to have their health monitored.

The evolving needs of every patient receiving care at the end of their lives were discussed at monthly primary health-care team meetings. At such meetings the needs of the relatives of terminally ill patients was also considered.

We also noted that patients who were caring for others were identified at the point of their registration as new patients and provided with information about other local services. The practice also ensured that patients identified as carers were given the opportunity of receiving the seasonal flu vaccine.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

A total of 23 patients completed CQC comment cards to provide us with feedback on the practice. The cards, which included comments about staff, were all positive. They said staff treated them with dignity and respect. We also reviewed data from the national patient survey which showed the practice was rated in line with other practices in England for patients who rated the practice as good or very good. The practice was also equal to the national average for its satisfaction scores on consultations with doctors and nurses with 84% of practice respondents describing their overall experience of the practice as fairly good or very good and 89% saying the GP treated them with care and concern.

We spoke with four patients on the day of our inspection, all of whom were positive about staff behaviours and the excellent service they received. We spoke with one patient who arrived with an interpreter. They were able to tell us that the GPs were respectful towards them.

During our inspection we saw that staff behaviours were polite and professional. We saw examples of patients receiving respectful treatment from the practice reception staff. We saw the clinical staff interacting with patients in the waiting area and outside clinical and consulting rooms in a friendly and caring manner. All staff spoke quietly with patients to protect their confidentiality as much as possible in public areas.

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

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 national patient survey showed 83% of practice respondents said the GP involved them in care decisions and 87% felt that nurses were good or very good at involving them in planning and making decisions.. Both these results were in line with the national average

The practice had made suitable arrangements to ensure that patients were involved in, and able to participate in decisions about their care. The patients we spoke with said they felt listened to and had a communicative relationship with the GPs and nurses. They said their questions were answered by the clinical staff and any concerns they had were discussed. We also read comments left for us by 23 patients. Of those who commented on how involved they felt in their care and the explanations they received about their care, all of the responses were positive.

Patient/carer support to cope emotionally with care and treatment

We saw that a process was in place at the practice for recently bereaved patients to be highlighted on the electronic patient records system. The staff we spoke with told us the GPs would make appropriate contact with bereaved patients and such patients were discussed at the weekly partners' meeting.

Patients in a carer role were identified where possible at the point of new patient registration. From our conversations with staff and our review of documentation we saw the practice maintained a register of patients who were identified as carers. Regular checks were completed on the register to ensure it was accurate and up-to-date at all times.

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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 people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS 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.

Tackling inequity and promoting equality

Two of the nursing staff we spoke with told us that patients were supported to understand their needs by involving interpreters in the discussion of their care and treatment. Interpreters were requested from a local interpreting service in advance of the patient's appointment. During our inspection we saw evidence of this taking place. On those occasions when an interpreter was not available, such as for an emergency consultation, a telephone language service was used.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

The practice understood the needs of the different population groups it served. For example, the practice had a system to identify patients with learning disabilities or who were experiencing mental ill-health. All such patients were offered an annual, physical health check. The practice also maintained a record of patients that were caring for others in order to provide help, support and signposting to other support services as required.

Where patients had communication difficulties, the practice contacted them by text rather than by phone if this was the patient's preferred mode of communication.

Access to the service

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. 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 provided to patients.

Patients with long term conditions, language or other communication barriers and those adapting to new courses of treatment such as insulin administration were offered longer appointments. Those patients were flagged on the practice's computerised records management system to ensure that administrative staff and receptionists were aware. This also included appointments with a named GP or nurse. Home visits were made to eight local care homes and to those patients who were unable to attend the practice.

Patients were generally satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to and they could see another GP if there was a wait to see the GP of their choice. Patients had access to GPs all day if required either by making appointments or telephoning for a call back from a GP.

In response to the practice's own patient survey carried out during 2014 the practice planned to extend the number of appointments which could be made online and release them at 7.00 am in order that more working patients could make the appointments before leaving home.

The practice's extended opening hours on Monday to Friday evenings was particularly useful to patients with work commitments and any other patients unable to attend during the daytime. Catch up smear clinics were offered on Saturdays to increase access for working patients. Flu vaccinations were also offered on two evenings and two Saturdays during 2014-15.

Concerns and Complaints

There was an effective and robust system in place for recording, investigating and responding to complaints and comments in line with their contractual obligations for GPs in England. We looked at the practice complaints policy and at the 'complaints and comments' leaflet supplied to patients, which was available in alternative languages. We

Good

Are services responsive to people's needs?

(for example, to feedback?)

noted that patients who wished to complain were also given information about how to access an independent complaints advocacy service to support them in making their complaint.

We also reviewed a summary of the complaints received for this year to date and looked specifically at several individual complaints files. There was evidence that the practice was receptive to all comments and feedback received and that concerns were dealt with at the appropriate level. For example, we noted that one particular complaint about the timeliness of a patient's consultation was discussed in detail at a multi-disciplinary team meeting and that a number of separate learning points had been identified. We saw that the patient had been informed and that they had responded that they had been satisfied with the outcome.

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

From speaking with staff and our review of the documentation, we found the practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice vision and values were detailed in a patient charter which stated the practice aims of delivering care to achieve the best possible outcomes, whilst maintaining patient privacy and dignity. The practice told us they had made a conscious decision not to have a formalised business plan in place. There were certain fixed areas such as succession planning for the retirement of partners but the vision and values of the practice were well communicated to all who worked there through meetings and informal discussion.

Staff told us they felt highly valued and supported and involved in developing the strategy and direction of the practice.

Governance Arrangements

The practice had decision making processes in place. Staff at the practice were clear on the governance structure. They understood that the GP partners worked as the overall decision making collective supported by the practice manager. All staff both contributed to and learned from practice processes and issues from clinical and practice staff meetings and events.

The practice had a comprehensive system of policies and procedures in place to govern activity and these were available to all staff through the intranet. All of the policies and procedures we looked at during our inspection were regularly reviewed and up to date.

The practice had arrangements for identifying, recording and managing risks. The practice's partners' meeting was used for senior staff to review and take action on all reported incidents, events and complaints. We looked at minutes of the meetings that demonstrated this happened as and when required. Details of any discussions and decisions made in those meetings were made available to all staff through a range of staff meetings and the practice's intranet.

Leadership, openness and transparency

There was a clear leadership structure at the practice which had named members of staff in lead roles. We saw there were nominated GP leads for safeguarding, the care management of patients over 75, patients experiencing mental health issues and those with cancer. There were nurse leads for such areas as infection control, COPD and patients with diabetes. The leads showed a good understanding of their roles and responsibilities and all staff knew who the relevant leads were. The staff we spoke with were clear about their own roles and responsibilities. They told us they felt valued, well supported and knew who to go to in the practice with any concerns.

From our conversations with staff and our review of documentation, we saw there was a regular schedule of meetings at the practice for individual staff groups, multi-disciplinary teams and all staff to attend.

The senior staff told us they worked hard to develop an 'open door policy'. All the staff told us there was an open culture within the practice and they had the opportunity to raise and discuss issues at the meetings. The GP registrar (a GP in training) told us that the open door policy extended to all staff grades and they felt very well supported by GPs, other clinicians, the practice manager and administrative staff

Seeking and acting on feedback from patients, public and staff

We saw that the practice had a Virtual Patient Reference Group (PRG) that was accessible through the practice web-site. A PRG is a forum of patients whose feedback is sought about areas that GP practices might need to improve upon. There was information about the PRG posted prominently on the notice board of the practice and clear information on the practice web-site about how to join the group and contribute ideas. One of the GPs at the practice had a lead responsibility for co-ordinating the activity of the PRG which meant that all feedback received had clinical oversight.

We saw that the PRG had carried out an initial survey of its members in October 2013 in order to establish what their priorities were in seeking further feedback from the practice population in general. Thereafter, in January 2014 a full practice survey was sent to all PRG members electronically with hard copy paper surveys available in reception for all other patients to complete when visiting. The survey focused primarily on the top issue that had

Are services well-led?

Good

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

been identified, which was the availability of appointments. The results of the survey were then reviewed by members of the PRG and an action plan was drawn up to improve the appointment system to be implemented over the next 12 months. Our inspection date fell within the action plan period and so the effectiveness of the action plan had not been determined. Nonetheless, this demonstrated a structured and reliable method of involving patients to improve services that was intended to take their views both online and in person.

We spoke with the practice manager who confirmed that the practice had also commissioned an independent survey organisation to implement their 'Friends and Family' test, part of the NHS' current method for obtaining patients' views. This survey was due to start in the month following our inspection.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training.

The practice offered a well-established GP training placement. We spoke with the senior GP partner who led on GP training. He told us that GP registrars were offered a comprehensive induction, full support from other clinical staff and regular appointments with himself. This was confirmed by information we received from Health Education England who oversee the training of GPs in England. We also spoke with a GP trainee who told us their experience at the practice had been very good and that the opportunities they had received, including practicing minor operations, had increased their confidence and personal development.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. GPs took responsibility for writing up and cascading the learning from these events. GP partners were also involved research projects an example of which was the impact of GP consultations on patients with back pain. The study had not concluded at the time of our inspection.

Practice nurses shared their learning from study days with the practice to encourage learning and improvement both within the practice and in the wider CCG area. One practice nurse had been nominated by the practice manager for a leadership award for a recent project which had resulted in improved outcomes for patients and financial savings for the practice.