Dr J R Larner & Dr N S Jadoon

Quality Report

Meadows Health Centre
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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 inspected this service on 18 November 2014 as part of our new comprehensive inspection programme.

The overall rating for this service is good. We found the practice to be good in the safe, responsive caring, effective and well-led domains. We found the practice provided good care to older people, people with long term conditions, people in vulnerable circumstances, families, children and young people, working age people and people experiencing poor mental health.

Our key findings were as follows:

- Patients were kept safe because there were arrangements in place for staff to report and learn from key safety risks. The practice had a system in place for reporting, recording and monitoring significant events over time.
- The practice was responsive to the differing needs of its patient population. It had taken particular steps to encourage non English speakers to undergo bowel screening.
- The practice worked well with a home for people with learning disabilities.

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

The provider should:

- Make further efforts to collect the views of its patients.
- Ensure there is clinical supervision of the practice health care assistant.
- Improve record keeping for multi-disciplinary team meetings.
- Engage with staff through more regular formal team meetings.
- Ensure that practice recruitment policies are followed on every occasion.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from NICE and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and planned. The practice could identify appraisals for all staff. Staff worked with multi-disciplinary teams.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

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

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available, easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Summary of findings

Are services well-led?

Good

The practice is rated as requires improvement for being well-led. It had an unwritten vision, but not all staff were aware of this and their responsibilities in relation to it. There was no documented leadership structure but staff felt supported by management. There was no formal strategy but the partners had discussed future plans for the practice. The practice had a number of policies and procedures to govern activity, but some of these were overdue a review. Governance meetings were held every six months. The practice had not held a patient survey for over a year and did not have an active patient participation group (PPG). Both partner GPs took leading roles in activities beyond their own practice.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people.

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

People with long term conditions

Good

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

There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

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

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations compared with other practices. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students).

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

People whose circumstances may make them vulnerable

Good

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

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

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. The practice informed vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Staff at a local care home for people with a learning disability were very complimentary about the GPs at the practice. Staff at the home told us that the GPs were particularly good at checking that consent was as informed as possible.

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 patients experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE. It had a system in place to

Summary of findings

follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for patients with mental health needs and dementia.

Summary of findings

What people who use the service say

We collected 40 Care Quality Commission comment cards from a box left at the surgery in the week before our visit. The comments on the cards were overwhelmingly positive. Four patients commented that it could sometimes be difficult to get an appointment.

Patients who responded to the national GP survey were particularly complimentary about the GPs and staff at the practice. Patients responding to the national GP survey were less satisfied with their experience of making an appointment at the practice. Staff at a local care home for people with a learning disability were very complimentary about the doctors at the practice. They told us that the doctors were very understanding and supportive.

Areas for improvement

Action the service SHOULD take to improve

- Make further efforts to collect the views of its patients.
- Ensure there is clinical supervision of the practice health care assistant.
- Improve record keeping for multidisciplinary team meetings.
- Engage with staff through more regular formal team meetings.

Dr J R Larner & Dr N S Jadoon

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector. The team included a GP, a practice nurse and a practice manager.

Background to Dr J R Larner & Dr N S Jadoon

Dr J R Larner & Dr N S Jadoon provide a range of primary medical services to just over 3,500 patients from purpose built premises, known as Meadows Health Centre, situated at 1 Bridgeway Centre, in Nottingham. The practice shares its premises with another, unrelated practice.

There are currently two GP partners at the practice. There is a part time practice nurse and a health care assistant based at the surgery. There are a total of 14 GP sessions each week and two sessions held by the practice nurse.

The practice has opted out of providing out-of-hours services to their own patients. Out of hours care is provided by a separate organisation. The practice has a general medical services (GMS) contract with the local Clinical Commissioning Group (CCG).

Why we carried out this inspection

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

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, we reviewed a range of information we hold about the practice and asked other organisations such as the local Clinical Commissioning Group and NHS England to share what they knew. We carried out an announced inspection on 18 November 2014. During our inspection we spoke with a range of staff and spoke with patients who used the practice. We reviewed comment cards where patients and members of the public shared their views and experiences of the practice.

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. These groups are:

- Older people

Detailed findings

- 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)

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, we saw that there had recently been a discussion about the risks associated with accepting unlabelled sample bottles from patients. The lessons from this were shared with all staff.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. This showed the practice had managed these consistently over time and 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 events were a standing item on the practice meeting agenda. Any new incidents were discussed at a weekly meeting. There was evidence that the practice had learned from previous incidents and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. She showed us the system she used to manage and monitor incidents. For example, we saw evidence that all staff had received additional training after a serious safeguarding incident at the practice.

National patient safety alerts were received and disseminated by the assistant practice manager. 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 weekly meetings.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible. Staff had received updated safeguarding training following an incident at the practice last year.

The practice had appointed a dedicated GP as the lead in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

There was a chaperone policy, which was visible on consulting room doors. The nurse and the health care assistant had been trained to be a chaperone.

The GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults, and records demonstrated good liaison with partner agencies such as the police and social services.

The clinical staff were alert to the possibility of their patients being the victims of domestic violence. There was guidance available to help staff support any patient who might be affected.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a

clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

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

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

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead member of staff for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that an infection control audit had most recently been carried out in September 2014 and that any improvements identified for action were being addressed. Minutes of practice meetings showed that the findings of the audits were discussed.

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

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence that the weighing scales and the blood oxygen measuring equipment in the practice had been calibrated regularly.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Most staff had worked at the practice for many years. The most recently appointed member of staff to be recruited had also previously worked at the practice. Because the person was already known to the practice, it did not follow every aspect of its own recruitment policy in this instance.

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

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

Are services safe?

We noticed that the health care assistant (HCA) had not been in receipt of any formal clinical supervision. However, a doctor told us that they constantly monitored the HCA's performance.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. The practice rented the building it occupied. The building manager carried out annual and monthly checks of the building and the environment. The practice had a health and safety policy. Health and safety information was displayed for staff to see.

The practice did not have its own record of risk assessments. The building manager shared health and safety risk assessments with the practice.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest and anaphylaxis. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. 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. Records showed that staff were up to date with fire training and that they practised regular fire drills. There was a fire drill during our inspection. The practice staff managed the drill effectively.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and had ready access to guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. We found from our discussions with the GPs that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurse supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, the GPs told us that they regularly discussed specific patients at their weekly meetings.

The practice showed us their performance data for antibiotic prescribing, which was comparable to similar practices. The practice had also taken steps to improve the care of patients with diabetes following information from the local Clinical Commissioning Group (CCG) that their performance was below the regional average. The practice used computerised tools to identify patients with complex needs who had multi-disciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. BothGPs we spoke with used national standards for the referral of patients with suspected cancers to be referred and seen within two weeks.

Interviews with the GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and assistant practice manager to support the practice to carry out clinical audits.

The practice showed us three clinical audits that had been undertaken in the last two years. One of these was a completed audit where the practice was able to demonstrate the changes resulting since the initial audit. An audit had shown that the practice needed to encourage more patients to have bowel screening. Patients were written to in their own language to explain the importance of the screening. One of the doctors was able to telephone patients from the Asian community and speak with them in their own language. As a result, patient uptake on bowel screening increased significantly. The practice also audited its prescriptions of benzodiazepine tablets (used to treat anxiety). The result was fewer patients on the medicine and a new protocol for the practice and its locum doctors to use.

The practice also used the information collected for the Quality Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. QOF is a national performance measurement tool. For example, the percentage of patients aged over 6 months to under 65 years, in the defined influenza clinical risk groups, that received the seasonal influenza vaccination was well above average compared with other practices in the area. This practice was not an outlier for any QOF (or other national) clinical targets.

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

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. They also checked that all routine

health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had a palliative care register and had regular internal as well as multi-disciplinary meetings to discuss the care and support needs of patients and their families.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. In some areas, such as attendance at accident and emergency, the practice was performing better than the local average.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the GPs with one having additional qualifications in gynaecology. Both the GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

We were told that staff undertook annual appraisals that identified learning needs from which action plans were documented. We were only able to see the most recent appraisals for each member of staff as we were told appraisals from previous years had been destroyed. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses such as diversity training. Most training was carried out on line so we were not able to see individual certificates of completion. The practice manager told us that they monitored completion rates for all staff.

There was only one part time nurse working at the practice and they were not at work on the day of our inspection. We were not able to review any training the nurse had received.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and support people with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries that were not followed up appropriately.

The practice had not taken up the enhanced payment on offer to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). However, the practice was reviewing all patients who had attended the local accident and emergency department and was providing many of them with written guidance about alternative ways to be treated.

The practice held formal multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made most of its referrals last year 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 to provide staff with the information they needed. Staff used an electronic patient

Are services effective?

(for example, treatment is effective)

record, known as EMIS, to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. The practice provided care to several people with learning disabilities in a local care home. Staff at the care home told us that the GPs were particularly good at checking that consent was as informed as possible.

All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

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

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18-25 and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40-75. Practice data showed that 48% of patients in this age group took up the offer of the health check. A GP showed us how patients were followed up if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and all of them were offered an annual physical health check. Practice records showed 60% had received a check up in the last 12 months. The practice had also identified the smoking status of 97% of patients over the age of 16 and actively offered smoking cessation clinics to 73% of these patients. The smoking cessation clinics were run by a separate organisation. Patients could be referred by the practice or could self-refer to this separate organisation.

The practice's performance for cervical smear uptake was 82%. There was a policy to send recorded delivery reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend. There was a named person responsible for following up patients who did not attend screening.

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

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This was primarily information from the 2014 national patient survey. The evidence from this source showed patients were reasonably satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was average for patients who rated the practice as good or very good. The practice was also about average for its satisfaction scores on consultations with doctors and nurses.

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 40 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Four comments were less positive with the most common theme being difficulty in getting through to the practice to make an appointment.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. However, we did witness two members of staff discussing a patient's attitude in a way that could have been overheard by another patient. We immediately drew this to the attention of the practice manager who dealt with it appropriately.

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

There was a clearly visible notice in the patient reception area stating the practice had zero tolerance for abusive behaviour. The receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 73% of practice respondents said the GP involved them in care decisions and 84% felt the GP was good at explaining treatment and results. Both these results were about average compared to other practices in the local area

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area.

Notices in the patient waiting room and on the patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

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

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs.

The local 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.

There had been very little turnover of staff during the last three years which enabled good continuity of care and accessibility to appointments with a GP of choice. Longer appointments were available for patients who needed them and those with long term conditions. This also included appointments with a named GP or nurse.

We were shown an action plan for addressing concerns expressed by patients in the national GP patient survey. The practice had introduced a second phone line for patients in order to increase capacity. The practice had also introduced online booking of appointments in response to patient demand.

Tackling inequity and promoting equality

The practice had access to online and telephone translation services. One of the GPs spoke several Asian languages. The practice also used interpreters who accompanied patients during consultations when necessary. The practice had contacted patients in their own language when encouraging a greater take up of a bowel screening programme.

The practice provided equality and diversity training via e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training.

The premises were suitable for the needs of patients with disabilities. The practice was all on one level and there was a ramp at the entrance.

Access to the service

Appointments were available from 9am to 11:30am and from 4pm to 6.30pm on weekdays except on Thursday afternoons when the practice was closed. We did not receive any negative comments from patients about the practice being closed on Thursday afternoons.

Comprehensive information was available to patients about appointments on the practice website and in the practice leaflet. This included how to arrange urgent appointments and home visits and how to book routine appointments. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

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 if there was a wait to see the GP of their choice they could see the other GP at the practice. Home visits and longer appointments were available when needed.

Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

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.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. This was set out in the practice leaflet and on the web site.

The practice manager told us that the practice rarely received formal complaints. Informal complaints were not recorded. We looked at how two more serious complaints

Are services responsive to people's needs?

(for example, to feedback?)

had been handled. We found that the complaints had been fully investigated and responded to. We also saw evidence that the practice had discussed the learning from the complaints at internal meetings.

Are services well-led?

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

Our findings

Vision and strategy

The practice did not have a formal vision, mission and values statement. The GP we spoke with articulated a clear vision to deliver high quality care and promote good outcomes for patients. We spoke with four members of staff and they were not all familiar with the vision.

There was no formal strategy or business plan, although the practice had given thought to how it would respond if its patient numbers increased to a level where it could no longer cope within its existing facilities.

The practice had not taken any new enhanced service options as they regarded them as providing insufficient benefit to patients compared to the work involved.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. Staff told us that they knew where to find the policies. We could not tell how recently the policies had been reviewed.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead for infection control and a partner was the lead for safeguarding. We spoke with four members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example the practice had audited its use of cholesterol lowering medicines. The result was a better understanding by the GPs and improved prescribing practices in line with national recommendations.

The practice did not keep a formal record of corporate risks. The partners were aware that they might run out of space in the building and were actively considering their options in response to this. The partners were also aware that they were heavily reliant on the practice manager for the smooth running of the practice. The practice manager was considering steps to ensure that the practice could function effectively if she was unexpectedly absent for a prolonged period.

Leadership, openness and transparency

Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues with the practice manager or the GPs. Staff told us that team meetings were irregular and were not recorded in detail.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example disciplinary procedures and induction policy which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice used the most recent national GP patient survey to understand the views of its patients. The most common complaint made by patients completing the survey was about difficulties in contacting the practice to make an appointment. The practice had responded by installing an additional telephone line and by introducing an online appointment booking system.

The practice had not carried out its own patient survey for over 18 months. The practice told us that they had been unable to form a patient participation group (PPG) because of a lack of interest locally. A PPG is a group of patients who work with the practice to discuss and develop the services provided. There was a poster in the waiting room and an advert in the practice leaflet inviting patients to join the PPG.

There was a suggestions box in the waiting room. The staff told us that it was rarely used.

Management lead through learning and improvement

Are services well-led?

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

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at three 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. We noticed that the health care assistant was not in receipt of any formal clinical supervision.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings. For example, following the loss of a pad of prescriptions during a home visit, doctors now only carried a single prescription when visiting patients in their own homes.

One of the partners was training to become a practice adviser with the local clinical commissioning group. They had also taken a lead role in developing gynaecology guidelines for use in primary care. One partner was also involved in developing a holistic approach to the treatment of cancer.