Dr Christine Whittaker

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

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Dr Christine Whittaker (also known as Hollyoaks Medical Centre) on 5 November 2014. The inspection team was led by a CQC inspector and included a GP specialist advisor, a practice manager and an Expert by Experience. We found Dr Christine Whittaker provided a good service to patients in four of the five key areas we looked at. Improvements were needed to ensure the practice provides well led services to its patients. This applied to patients across all age ranges and to patients with varied needs due to their health or social circumstances.

Our key findings were as follows:

- The practice had some systems for monitoring and maintaining the safety of the practice and the care and treatment they provide to their patients. These needed development.
- The practice was proactive in helping people with long term conditions to manage their health and had arrangements in place to make sure their health was monitored regularly.
- The practice was clean and hygienic and had some arrangements for reducing the risks from healthcare associated infections.
- Patients felt that they were treated with dignity and respect. They felt that their GP listened to them and treated them as individuals.
- The practice had a well-established and well trained team and had expertise and experience in a wide range of health conditions.

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

Importantly the provider should:

- Develop a formal plan for the completion of clinical audit cycles. We saw examples of completed cycles and some that were shortly due to be completed, however, no organised plan of when these should be undertaken.
- Clarify its future succession planning to include how the practice will be managed when the current GP retires.

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 report incidents and near misses. The practice provided opportunities for the staff team to learn from significant events and was committed to providing a safe service. Information about safety was recorded, monitored, appropriately reviewed and addressed. The practice assessed risks to patients and managed these well. 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. Patients care and treatment took account of guidelines issued by the National Institute for Care and Health Excellence (NICE). Patients' needs were assessed and care was planned and delivered in line with current legislation. The practice was proactive in the care and treatment provided for patients with long term conditions and regularly audited areas of clinical practice. There was evidence that the practice worked in partnership with other health professionals. Staff received training appropriate to their roles and the practice supported and encouraged their continued learning and development.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients told us they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We saw that staff treated patients with kindness and respect and were aware of the importance of confidentiality. The practice provided advice, support and information to patients, particularly those with long term conditions, and to families following bereavement.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice was aware of the needs of their local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these are identified. Patients reported good access to the practice and said that urgent appointments were available the same day. The practice had good facilities and was well equipped to treat patients and meet their

Summary of findings

needs. There was a clear complaints system with evidence demonstrating that the practice responded quickly to issues raised. The practice had a positive approach to using complaints and concerns to improve the quality of the service.

Are services well-led?

Good

The practice is rated as good for providing well-led services. The practice had an open and supportive leadership and a clear vision to continue to improve the service they provided. There was a clear leadership structure and staff felt supported by management. The practice had well organised management systems and met regularly with staff to review all aspects of the delivery of care and the management of the practice. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this was acted upon. The practice had put in place plans to launch a patient participation group (PPG) in January 2015. The purpose of the PPG was to act as an advocate on behalf of patients when they wished to raise issues and to comment on the overall quality of the service. There was evidence that the practice had a culture of learning, development and improvement.

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

This practice is rated as good for the care of older people. Patients over the age of 75 had a named GP and were included on the practices 'avoiding unplanned admissions' list to alert the team to people who may be more vulnerable. The GPs carried out visits to people's homes if they were unable to travel to the practice for appointments. The practice was in the process of delivering its 'flu vaccination programme. The practice nurse was arranging to do these at people's homes if their health prevented them from attending the clinics at the surgery. The practice worked with five local care homes to provide a responsive service to the people who lived there. However, GPs told us the nursing homes generate a large volume of work that took a large amount of GP time on occasions and a plan would need to be made to reduce this workload as it could be a strain for the practice team at times.

People with long term conditions

Good

This practice is rated as good for the care of people with long term conditions, for example asthma and diabetes. 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 people 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

This practice is rated as good for the care of families, children and young people. The practice held weekly childhood vaccination clinics for babies and children. Child 'flu vaccinations were also provided. A ground floor surgery was used to make access easier for parents. A midwife came to the practice every week to see expectant mothers. Staff told us that ante-natal and post-natal appointments for mothers were usually done by the female GPs. The practice provided a family planning service.

Working age people (including those recently retired and students)

Good

This practice is rated as good for the care of working age people, recently retired people and students. The practice provided extended opening hours until 8pm on Wednesdays for people unable to visit the practice during the day. They also had

Summary of findings

arrangements for people to have telephone consultations with a GP. 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 and those with a learning disability. It had carried out annual health checks for people with a learning disability. It offered longer appointments for people with a learning disability.

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

People experiencing poor mental health (including people with dementia)

Good

This practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice had a register of people at the practice with mental health support and care needs and invited them for annual health checks. Staff described close working relationships with the local mental health team which worked with the practice to identify patients' needs and to provide patients with counselling, support and information.

Summary of findings

What people who use the service say

We gathered the views of patients from the practice by looking at 35 CQC comment cards patients had filled in and by speaking in person with eight patients. Many patients who gave us their views had been patients at the practice for many years and their comments reflected this long term experience. Data available from the NHS England GP patient survey showed that the practice scored in the middle range nationally for satisfaction with the practice.

Patients were positive about their experience of being patients at Dr Christine Whittaker. They told us that they were treated with respect and the GPs, nurses and other staff were kind, sensitive and helpful. Several patients expressed appreciation for the service they had received, some in particularly difficult circumstances. Patients said they were able to obtain appointments when needed and would always be seen in an emergency.

Areas for improvement

Action the service SHOULD take to improve

There were areas of practice where the provider needed to make improvements.

The practice should:

- Develop a formal plan for the completion of clinical audit cycles. We saw examples of completed cycles and some that were shortly due to be completed, however, no organised plan of when these should be undertaken.
- Clarify its future succession planning to include how the practice will be managed when the current GP retires.

Dr Christine Whittaker

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector. The inspection team also included two specialist advisers - a GP, a practice manager, and an Expert by Experience. An Expert by Experience is someone who has extensive experience of using a particular service, or of caring for someone who has.

Background to Dr Christine Whittaker

Dr Christine Whittaker provides primary care services at Hollyoaks Medical Centre for patients in Wythall and the surrounding area. The service is responsible for providing primary care for 4,900 patients. It is located in a rural area with a large elderly population. Twenty-nine per cent of patients are aged over 65, many of whom have long term medical conditions.

The practice is managed by a single handed GP supported by three salaried GPs, a locum GP, a practice manager, two practice nurses, a healthcare assistant, plus receptionists and other staff who provide administrative support. The lead retired since our inspection took place.

There are a total of 11 GP sessions each week and 10 sessions held by the practice nurse. The practice does not provide out of hours services to their own patients. Patients are provided with information about the local out of hours service. Patients can access this by using the NHS 111 phone number.

The practice provided medical cover to five local care homes. They contained over 200 residents.

Regulated activities are provided from Dr Christine Whittaker, Hollyoaks Medical Centre, 229 Station Rd, Wythall, Birmingham, which we visited for our inspection.

There have been no previous concerns raised with CQC about the practice.

Dr Christine Whittaker provides a range of NHS services including blood testing, chiropody, physiotherapy and anti-coagulant testing. Bereavement and mental health counselling sessions are held there.

Why we carried out this inspection

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

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the 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.

How we carried out this inspection

Before this inspection, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. These organisations included Redditch and Bromsgrove Clinical Commissioning Group (CCG), NHS England local area team and Worcestershire

Detailed findings

Healthwatch. We carried out an announced visit on 5 November 2014. During the inspection we spoke with a range of staff (GPs, nurses, practice manager, reception and administrative staff). We spoke with eight patients who used the service, one of whom was a member of the Patient Participation Group (PPG).

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People living in vulnerable circumstances
- 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 reviewed a complaint where a patient had not been correctly followed up following a blood test and saw how this had been dealt with in a timely way.

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 showed evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred and we reviewed these for the last two years. Significant events were a regular item on the practice meeting agenda and a regular agenda item was placed in clinical meetings to review actions from past significant events and complaints. These meetings were held every six weeks. There was evidence that the practice had learned from these and that the findings were shared with relevant staff, for example, a delay with following up a hospital referral. 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 and sent completed forms to the practice manager. We were shown the system used to manage and monitor incidents. We tracked five incidents, the total number from the last 12 months and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result, for example tightening the process for dealing with blood test results. 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 during practice meetings 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, for example updated prescribing information.

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.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the higher level three training to enable them to fulfil this role. All staff we spoke to were aware who these leads were and who to speak to in the practice if they had a safeguarding concern. Regular multi-disciplinary team meetings were held to discuss safeguarding concerns.

There was a system to highlight vulnerable patients on the practices' electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example patients with a learning disability, for which the practice held a register of patients.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. All nursing staff, including health care assistants, had been trained to be a chaperone. If nursing staff were not available to act as a chaperone, receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. We spoke with one patient who had recently used a chaperone who told us the system worked well and they had no concerns.

We were shown systems in place for the identification and follow up of children, young people and families living in

disadvantaged circumstances. We also saw that a system was in place for the follow up of children who persistently failed to attend appointments such as for childhood immunisations.

A system was in place which enabled the practice to review repeat medications for patients with multiple medications to ensure they remained appropriate.

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.

We saw there were Patient Group Directions (PGD) in place to support the nursing staff in the administration of vaccines. A PGD is a written instruction from a qualified and registered prescriber, such as a doctor, for a nurse or appropriately trained person to administer a medicine to groups of patients without individual prescriptions. We saw the PGDs had been signed by all the nurses who administered the vaccines and authorised by a manager. This meant that staff and managers were informed of any changes to the PGD. A member of the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

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.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice. The practice had a high prescribing level due to the large numbers of elderly people on the patient list. To review this, the practice had invited the prescribing lead from the Clinical Commissioning Group (CCG) to review this data every two weeks. The CCG were confident the practice were effectively managing this in conjunction with this additional support that was provided.

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 visibly 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 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 the lead had carried out audits and that any improvements identified for action were completed on time.

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 were also policies for needle stick injury and bodily fluid spills amongst others.

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. The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be fatal).This had been carried out in December 2013 and was due to be tested again in December 2014. We saw records that confirmed the practice was carrying out regular legionella checks in line with this policy to reduce the risk of infection to staff and patients.

Are services safe?

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, March 2013. This was due to be carried out again in March 2015. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. A recruitment checklist was used by management to ensure nothing was missed during the recruitment process.

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. We were shown how staff rotas were prepared for two months in advance. Staffing levels were then monitored weekly and adjustments made if needed due to demand.

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. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative. We were shown evidence of the last fire safety check.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at the weekly GPs meeting and within the monthly team meetings. For example, the lead GP had shared the recent findings from the monitoring of prescribing audit with the team.

We saw staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, there were emergency processes in place for patients with long-term conditions. Staff gave us examples of referrals made for patients whose health deteriorated suddenly or had been admitted to hospital in an emergency. Staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment and had made referrals to a specialist advisor.

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 and anaphylaxis, an acute allergic reaction. 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, anaphylaxis and hypoglycaemia, a deficiency of glucose in the bloodstream. 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. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified

included power failure, information technology failure, flood, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

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. We were shown the last fire safety report which had not raised any concerns.

Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the practice risk log. We saw an example of this for if there was an outbreak of influenza amongst the staff and the mitigating actions that had been put in place to manage this.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed 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, for example, changes to prescribing guidelines. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. The lead GP was responsible for the majority of lead roles and deputies were identified for lead role cover if she should be absent from the practice. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of diabetes. We were shown records to confirm this.

We were shown data from the local Clinical Commissioning Group (CCG) of the practice's performance for antibiotic prescribing, which was higher when compared to similar practices. As a result of this, the practice had invited the clinical lead from the CCG to carry out an audit of this every two weeks. During our inspection we telephoned the clinical lead and discussed this. We were told the CCG were aware the high levels of prescribing were caused by the large number (29%) of elderly patients on the patient list. This was inflated by the large number of care homes the practice provided medical cover for. GPs told us the care homes presented a large volume of work at times and could be a strain on the practice team. This would need to be examined and it was planned to do this when the current lead GP retired at the end of 2014.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital. These were audited every month.

National data showed that the practice had high referral rates to secondary and other community care services for all conditions. It was evident prescribing rates and referral rates to hospital had been increased due to the large number of elderly patients, including a large number in care homes, registered with the practice. The Clinical Commissioning Group (CCG) were aware of this. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes. All GPs we spoke with used national standards for the referral of patients identified following cervical screening.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with 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 deputy practice manager to support the practice to carry out clinical audits.

The practice showed us four clinical audits that had been undertaken in the last year. Four of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit, for example in earlier identification and treatment for patients with osteoporosis, a medical condition in which the bones become brittle and fragile from loss of tissue.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. For example, we saw an audit regarding the prescribing of medicines for diabetic patients. Following the audit, the GPs carried out medication reviews

Are services effective?

(for example, treatment is effective)

for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes. However, there was no co-ordinated plan for carrying out clinical audit cycles. Those completed had been primarily carried out for the GP's own appraisal.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, patients with diabetes had an annual medication review, and the practice met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease).

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. Clinical staff held a meeting every six weeks. 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. The GPs told us and showed us evidence about recent discussions around the number of clinical audits all staff should carry out every year. There was an understanding this was an area the practice needed to improve upon and we saw plans were in place for this to happen.

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. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary. 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 achieved and implemented the gold standards framework for end of life care. This ensured patients received well planned and well co-ordinated care. The practice had a palliative care register and had regular internal as well as multidisciplinary 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 or slightly below average to other services in the area, apart from prescribing.

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 courses such as annual basic life support and safeguarding. All 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). All staff undertook annual appraisals that identified learning needs from which action plans were documented.

Records we reviewed showed that where poor performance had been identified appropriate action would be taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. 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 practice had a policy that outlined the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. 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.

Are services effective?

(for example, treatment is effective)

We saw that the policy for actioning hospital communications was effective. The practice undertook a monthly audit of follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed.

The practice held multidisciplinary team meetings every two months 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 and remarked on the usefulness of the forum as a means of sharing important information.

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 all of its 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 to provide staff with the information they needed. Staff used an electronic patient record (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.

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. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff, for example with making do not attempt resuscitation orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

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. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. 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).

Health promotion and prevention

The practice had met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity. The primary concern mentioned by the practice was the large number of elderly patients it cared for. The practice offered well person checks, blood pressure checks, smoking cessation, dietary and exercise advice.

It was practice policy to offer a health check with the 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 smoking cessation advice to patients who smoked.

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 who were offered an annual physical health check. Mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was comparable to other practices within the CCG area. There was a policy to offer telephone reminders for patients who

Are services effective?

(for example, treatment is effective)

did not attend for cervical smears and the practice audited patients who do not attend annually. The practice nurse was 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.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a survey of 89 patients (1.8% of the patient list) undertaken by the practice. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the survey undertaken by the practice in December 2013 showed 78% of patients found it easy or very easy to get through to the practice over the telephone; 87% of patients felt the GP fully involved them in decisions about their care and 85% found the receptionists helpful or very helpful. The results were slightly below average for all practices within the Clinical Commissioning Group (CCG).

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 35 completed cards and all 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. We also spoke with eight patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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 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.

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 were no occasions where concerns had been raised.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. 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. The results from the practice's own satisfaction survey showed that 87% of patients said they were sufficiently involved in making decisions about their care.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also consistently positive and aligned with these views.

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

Comments made by patients we spoke with showed patients were positive about the emotional support provided by the practice in times of bereavement and rated it well in this area. Patients told us staff responded compassionately when they needed help and provided support when required.

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. The practice had identified 125 cares on its patient list and had offered them appropriate signposting to services for additional support. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

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. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. Changes to the appointment system had previously been made because of this. This had resulted in the availability of an increased number of same day appointments.

The practice manager told us how the practice planned to implement suggestions for improvements and make changes to the way it delivered services in response to feedback from the Patient Participation Group (PPG) after it started in January 2015. PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, the practice had access to online and telephone translation services for patients whose first language was not English. The practice provided equality and diversity training. Staff we spoke with confirmed that they had completed equality and diversity training.

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 kept a register of people living in vulnerable circumstances, and a computerised system which alerted staff to vulnerability in individual patient records.

Access to the service

Appointments were available from 8:30am to 6.30pm on weekdays with a late surgery on Wednesdays until 8pm. One patient told us this was particularly helpful for patients with work commitments. We saw that additional appointments for emergencies could be added to the end of standard surgery sessions.

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 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 in the surgery itself, in the practice information leaflet and on the practice's website.

Patients were generally satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to or they could wait to see the GP of their choice

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.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The complaints policy was in line with recognised guidance and contractual obligations for GPs in England.

We saw that information was available in the waiting room, the patient information leaflet and on the practice website to help patients understand the complaints system. Patients we spoke with were aware of the process to follow should they wish to make a complaint, but had never needed to use it.

We looked at six formal complaints received in the last 12 months and found these had been handled and resolved promptly in line with the practice's complaints policy.

Are services responsive to people's needs?

(for example, to feedback?)

The practice reviewed complaints on an on-going basis to detect themes or trends. We checked the reviews and saw that no consistent themes had been identified; however lessons learnt from individual complaints had been acted upon.

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 had a vision to deliver high quality care and promote good outcomes for patients. This was clearly stated on the practice website and within its practice leaflet as the 'provision of good quality care for all patients delivered in a clear, suitably equipped and safe environment.' At the time of our inspection, the practice needed to clarify its future succession planning on how the practice would be managed when the current GP retired. It was indicated this would take place at the end of 2014, the full details had not been finalised. This has now happened since our inspection.

We spoke with five members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. We looked at minutes of the staff meeting held in September 2014 and saw that staff had discussed and agreed that the vision and values were still current.

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. We looked at these policies and procedures and saw records to confirm they had been discussed in staff meetings.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the lead GP was the lead for safeguarding.

We spoke with five 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. This is a system for the performance management and payment of GPs. The QOF data for this practice showed it was performing slightly below national standards. It was evident prescribing rates and referral rates to hospital had been increased due to the large number of elderly patients, including a large number in care homes, registered with the practice. The Clinical Commissioning Group (CCG) were aware of this. 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 on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, we saw audits for diabetes and osteoporosis.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues, such as missed vaccinations. We saw that the risk log was regularly discussed at team meetings and updated in a timely way.

The practice held monthly governance meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

The lead GP is due to retire at the end of 2014 and we saw plans were being finalised for a replacement GP, but a formal succession plan had been finalised and not all staff we spoke with were aware of the changes..

Leadership, openness and transparency

We saw from minutes that team meetings were held monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, induction and sickness management, which were in place to support staff. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys and complaints received. We looked at the results of the latest annual patient survey which had been carried out in December 2013

and 78% of patients said it was easy or very easy to get through on the telephone. As a result of this, the practice had increased promotion of its online appointment booking facility. None of the patients we spoke with during our inspection, or comment cards we read referred to any difficulty getting through to the practice on the telephone.

Are services well-led?

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

The practice had put in place plans to launch a patient participation group (PPG) in January 2015. The initial members had been selected and it included members from various population groups. The practice planned to increase this in size at a later stage. We were told the next patient survey would be carried out in conjunction with the PPG.

The practice had gathered feedback from staff through its staff appraisals. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff and electronically on any computer within the practice.

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 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 saw that staff had protected learning time twice a year where guest speakers attended, covering topics such as information governance, data protection and confidentiality.

The practice had completed reviews of significant events, complaints and other incidents and shared the results with staff via meetings and protected learning time to ensure the practice improved outcomes for patients.