Dr Paul Downie

Quality Report

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Romney Marsh,
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Website: none

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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?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of Dr Paul Downie on 26 February 2015. During the inspection we gathered information from a variety of sources. For example we spoke with patients, interviewed staff of all levels and checked the right systems and processes were in place.

Overall the practice is rated as good. This is because we found the practice to be good for providing effective, caring, responsive and well-led services. We found we found the practice to require improvement for providing safe services. It was good for providing services for the patient population groups of; older people, people with long-term conditions, families, children and young people, working age people (including those recently retired and students), people whose circumstances may make them vulnerable and people experiencing poor mental health (including people with dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents. Information about safety was recorded, monitored, reviewed and addressed. However there were areas such as infection control and recording of significant incidents where improvements are needed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and additional training planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- 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.

Summary of findings

- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

Importantly the provider should

- Ensure that all staff understand that they should consider reporting incidents that have the potential to be significant events.
- Review patient specific directions to help ensure that the time they are valid for was clear to staff.
- Complete the actions identified in their own infection control audit and in particular review: the use carpets throughout the practice, the use of fabric covered chairs in clinical rooms and the storage of clinical waste.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents though they were less clear about reporting near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, reviewed and addressed. However there were areas such as infection control and recording of significant incidents where improvements are needed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was 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 England Area Team and the local 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

Summary of findings

needs. Information about how to complain was available, easy to understand and evidence showed that the practice responded quickly to issues raised. There was evidence of learning from complaints.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. Staff had received inductions, regular performance reviews and attended staff meetings.

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 above average 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. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. 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 people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Historically immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw examples of joint working with midwives, health visitors and school nurses.

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 help to ensure these were accessible, flexible and provided continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

Summary of findings

People whose circumstances may make them vulnerable

Good

he 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 those with a learning disability. It had carried out annual health checks for people with a learning disability and all 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 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

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

Summary of findings

What people who use the service say

We spoke with five patients. We received three completed comment cards. All the patients were pleased with the quality of the care they had received. They all said it had been easy to make appointments with a GP and that they were seen at, or close to, the time of their appointment. They said that the practice was clean, safe and that staff were caring.

There is a survey of GP practices carried on behalf of the NHS twice a year. In this survey the practice results are compared with those of other practices. A total of 256 survey forms were sent out and 137 were returned. The main results from that survey were:

What the practice does best

• Patients find it easy to get through to this practice by phone.

• Patients with a preferred GP usually get to see or speak to that GP.

• Patients described their experience of making an appointment as good.

There were no areas where the patients' replies to questions were significantly below the national results.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that all staff understand that they should consider reporting incidents that have the potential to be significant events.
- Review patient specific directions to ensure that the time they were valid for was clear to staff.
- Complete the actions identified in their own infection control audit and in particular review: the use carpets throughout the practice, the use of fabric covered chairs in clinical rooms and the storage of clinical waste.

Dr Paul Downie

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector and included a GP specialist advisor and a practice manager specialist advisor.

Background to Dr Paul Downie

Doctor Paul Downie is a GP practice located in the centre of the small town of Lydd, Kent. It provides care for approximately 3,900 patients. The practice's population of patients between 65 and 85 years of age is a third higher than the national average. Levels of deprivation are somewhat higher than nationally. The number of nursing home patients is two and a half times the national average.

There is one male GP who is the principal and a female salaried GP. The principal was due to retire at the end of March 2015 and the salaried GP due to take over from that date. Both work full time. There are 15 GP clinical sessions each week, one session being half a day. There is currently no practice nurse, as the position is vacant. There are two healthcare assistants (HCA) providing about 14 sessions weekly. The practice has a general medical services (GMS) contract with NHS England for delivering primary care services to local communities.

Services are delivered from:

Bleak Road,

Lydd,

Romney Marsh,

Kent.

TN29 9AE.

Telephone: 01797 320307

The practice has opted out of providing out-of-hours services to their own patients. There is information available to patients on how to access out of hours care. Out of hours care is provided by Integrated Care 24.

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 visiting, we reviewed a range of information we hold about the practice. This included demographic data, results of surveys and data from the Quality and Outcomes Framework (QOF). QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice.

Detailed findings

We asked the local clinical commissioning group (CCG), NHS England and the local Healthwatch to share what they knew about the service.

The visit was announced and we placed comment cards in the practice reception so that patients could share their views and experiences of the service before and during the inspection visit. We carried out an announced visit on 26 February 2015. During our visit we spoke with a range of staff including the salaried GP, healthcare assistants, the practice manager, receptionists and administrators. We spoke with patients who used the service.

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)

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality regarding patient safety. For example they considered reported incidents and accidents, national patient safety alerts as well as comments and complaints received. This was a small practice and staff we spoke with felt confident that they could raise any safety issues with the GPs and nursing staff.

There was a process for dealing with safety alerts. These were received by the practice manager. We looked at safety alerts over the previous year and saw that they had been received, recorded and circulated to the staff affected by the alert.

Learning and improvement from safety incidents

The practice had a system for reporting, recording and monitoring significant events, incidents and accidents. The staff were aware of their responsibilities to raise concerns and knew how to report incidents but were less sure about the action to take with near misses.

The events that had been reported had been thoroughly investigated. The patients who were involved were included in the subsequent learning where possible. For example one event had involved a child and initially one parent was involved in the discussions, later the second parent was also involved. Records demonstrated the action taken by the practice and the individual learning that stemmed from it.

However, there were other occurrences that could have been classified as significant events. Staff did not recognise that they were significant events although, on discussion with the inspection team, saw that they had the "potential" to be significant events. For example, there were incidents where some patients had stated that they had not received some important items or medicines when staff believed they had. This was discussed and a system brought in where by patients sign to evidence that they have received certain things. However neither the incidents nor the learning from it were recorded.

Reliable safety systems and processes including safeguarding

Patients said that they felt safe at the practice. The practice offered a chaperone option where a member of staff was available to accompany patients during intimate examinations at their request (or at the instigation of the clinician involved). There were notices in the waiting area and in consultation rooms informing patients about chaperone services.

The practice had systems and policies to safeguard vulnerable adults and children that were up to date. There were also other documents readily available to staff that contained protocols for them to follow in order to recognise potential abuse and report it to the relevant safeguarding bodies. The GPs had been trained in safeguarding children to the required level (level 3) and all other staff had been trained to the levels appropriate to their roles. All staff had been trained to recognise signs of abuse in vulnerable adults and older people, and they knew how to report it.

Staff told the inspection team of instances where child safeguarding alerts had been raised, referred to the local safeguarding authority and investigated using the approved procedures.

Medicines management

There was a comprehensive policy for repeat prescribing. We spoke with the GP who confirmed that the practice had a system for checking that repeat prescriptions were issued with reference to the medicine review date for each patient. Repeat prescriptions were handed into the reception staff. They were not accepted over the telephone. The repeat prescriptions were checked by staff and were always checked by a GP before issue. If medication reviews were indicated before a repeat prescription was to be issued staff made the appointment for this. In any cases of doubt staff referred the matter to a GP. The patient record system flagged up relevant medicines alerts when the GP was prescribing medicines.

Medicines stored in the treatment rooms and medicine refrigerators were secure and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures. However the practice had not consistently followed this. There was a book for recording refrigerator temperatures. This had been completed properly over the last five weeks, before then entries were erratic and some were crossed through without explanation. We checked expiry dates of the medicines in the refrigerator and they were all in date.

Requires improvement

Are services safe?

The practice undertook minor surgery such as joint injections and details of any medicines used, such as the batch number of the local anaesthetic, were detailed in the patient's record.

The patterns of hypnotics, sedatives and anti-psychotic prescribing were within the range that would be expected for such a practice. There was no practice nurse in post at the time of the inspection. The health care assistants administered vaccines using patient specific directions that had been produced in line with legal requirements and national guidance. However the manner in which the directions were completed meant that staff could be confused over the time frame that the direction was valid for. There was evidence that the health care assistants had received appropriate training to administer vaccines.

Cleanliness and infection control

The premises were generally clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns regarding cleanliness or infection control.

The practice had infection control policies that contained procedures for staff to refer to in order to help them follow the Code of Practice for the Prevention and Control of Health Care Associated Infections. The code sets out the standards and criteria to guide NHS organisations in planning and implementing control of infection. The practice had an identified infection control lead. Staff told us they were up to date with infection control training and records confirmed this.

The treatment and consulting rooms were clean, tidy and uncluttered. However, there were chairs in the treatment and consulting rooms that were cloth covered and stained. Staff said that they were regularly cleaned but, as the material was porous cleaning would not always be effective. The cloth on some of the chairs was torn. Some clinical areas were carpeted, for example, a nurse's room, where invasive procedures such as taking blood were carried out. This did not comply with Department of Health guidance and no risk assessments had been carried out. The practice had carried out audits that had identified many of the issues but had not rectified them.

There was a system for safely handling, storing and disposing of clinical waste. This was carried out in a way that reduced the risk of cross contamination. Clinical waste was stored in a dedicated area in the practice building but it was not in secure containers. It was collected by a registered waste disposal company.

We spoke with the GP who will be the registered provider from 1 April 2015. They had an action plan prepared to remedy the failings that had been identified in the infection control standards and we were assured that this would commence as soon as the change to registered provider had been completed.

The practice had a system for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). A legionella risk assessment had been carried and, as a result, the practice had imminent arrangements, with an expert contractor, for the submission water samples for analysis.

Equipment

Staff told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly. There were stickers on the equipment certifying when it had been checked and calibrated as well as when it was due to be retested.

Staffing and recruitment

Personnel records we looked at contained evidence that appropriate checks had been undertaken prior to employment. For example, proof of identification, references and criminal record checks through the Disclosure and Barring Service. There were records to show that the professional registration checks for staff with the National Midwifery Council or the General Medical Council had been completed.

The practice comprised a small staff team and the manager monitored staff leave to help ensure that staff covered for each other's absences. There was a recruitment policy that set out the standards it followed when recruiting any staff. There was a rota system for all the different staffing groups to help ensure that enough staff were on duty. 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.

Monitoring safety and responding to risk

There was a duty GP to handle emergencies and urgent appointments. If the receptionists received a call that was

Requires improvement

Are services safe?

urgent or pressing and the appointments were all taken they took the details and passed the matter to a GP who called the patient back. The GP then decided whether the matter needed an appointment, a home visit or a further referral. The consultation hours were extended, If necessary, to accommodate any urgent work.

The practice had a health and safety policy to help keep patients, staff and visitors safe. Health and safety information was displayed for staff to see. There was a system governing security of the practice. For example, visitors were required to sign in and out using the dedicated book in reception.

Arrangements to deal with emergencies and major incidents

Most of the staff were up to date with basic life support (BLS) training and there was training planned for those who were not. Emergency medicines and emergency equipment were available including medical oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). These had been checked regularly and checks recorded in a log book. Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included medicines for the treatment of cardiac arrest, anaphylaxis, and hypoglycaemia. All the medicines and emergency equipment we checked were in date and fit for use.

There were contingency plans to deal with a range of emergencies such as power failure, unplanned sickness, failure of the patient record system and loss of access to the building. The documents contained relevant contact details for staff to refer to in the event they needed to take further action. The building was a purpose built single story surgery and complied with the current fire safety regulations. A fire risk assessment had been undertaken that included the actions required in order to maintain fire safety. Fire extinguishers were located at designated points and had been regularly serviced. Staff had completed fire safety training. There were regular fire evacuation drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance. They accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. For example the practice used ambulatory blood pressure in diagnosing certain heart conditions. Ambulatory blood pressure monitoring is a non-invasive method of obtaining blood pressure readings over a 24-hour period, whilst the patient is in their own environment, representing a true reflection of their blood pressure. It is recommended by NICE guidance.

The GPs led in specialist clinical areas for example in chronic obstructive pulmonary disease (COPD), diabetes and family planning. This this allowed the practice to focus on specific conditions. There had been a range of nurse appointments available to patients. This had included chronic disease management such as diabetes, asthma, heart disease and chronic obstructive pulmonary disease (COPD). The practice nurse had left shortly before the inspection and the practice was in the process of engaging an agency nurse prior to recruiting to the post. There were two healthcare assistants who were carrying out the routine health checks for patients with long-term conditions and referring patients to the GPs where appropriate

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

Management, monitoring and improving outcomes for people

The practice had a system for completing clinical audit cycles. We looked at two clinical audits that had been completed in the previous year. One had concerned the use of a medicine used to treat hypertension (high blood pressure). The second for the use of a medicine used to lower the patient's cholesterol. Both audits had resulted in changes to or reviews of patient's treatment. In both these cases there had been re-audits to check that the changes had been implemented and improvements made. A third audit was focussed on preventing infections in patients who had had conditions of the spleen. One cycle of this audit had been completed and a second cycle of the audit was planned for the following year.

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 voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, there was an audit regarding the prescribing of a medicine used in the control of nausea after a medicines safety alert.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. There is a range of these indicators across commonly found long-term conditions. The practice's performance in this respect was considerably above that of other practices nationally. For example 95 per cent of patients with dementia or with mental health problems had had face-to-face reviews in the preceding 12 months and 91 per cent of diabetic patients had been reviewed. For patients with rheumatoid arthritis, chronic obstructive pulmonary disease (COPD), coronary heart disease, atrial fibrillation (to assess the risk of patients having a stroke), chronic kidney disease and hypertension the figure was 100 per cent. QOF results are capable of different interpretations, and these figures relate to the year ending March 2014, but the practice's results were often 10 or even 15 per cent better than those achieved nationally.

Effective staffing

There were two GPs both of whom were appraised annually. All GPs were up to date with their yearly continuing professional development requirements and all had either 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).

The practice nurse, who had left, had been appraised by the GP. Administrative staff were appraised annually. There had been no appraisal in the current year as there were plans to reform the appraisal process from 1 April 2015. All

Good

Are services effective?

(for example, treatment is effective)

the staff we spoke with about their appraisal said that they had found the process useful. It had helped to identify training needs and provided an opportunity for staff to discuss problems with the manager. However this was not reflected in the records of appraisal where the sections for learning and other annual objective were sometimes not completed.

We reviewed a case of poor performance within the practice. It had been identified at an early stage and appropriate action had been taken to manage it.

Working with colleagues and other services

The practice worked with other professionals such as, district nurses, social services, GPs and other specialists. There were regular meetings with the palliative care service. These meetings discussed the medical needs of patients and included social, spiritual and family needs. The district nurse met with the healthcare assistants at the practice every week to discuss specific patients' needs.

The practice received test results and information from other services electronically and by post. There were policies setting out how these were dealt with and staff were aware of them. Items in letters and reports were highlighted for GPs to check and returned to the reception staff for action and filing. There were no reported instances within the last year of any results or discharge summaries that were not followed up appropriately. There was no significant backlog of results awaiting action.

The practice was commissioned for a new enhanced service and had a process to follow up on patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). There was a system for following up on patients admitted to hospital which was working well. These patients received priority appointments. They were asked to telephone and speak to a GP if their condition changed to the point that they thought they needed to be admitted to hospital.

Information sharing

All information about patients received from outside of the practice was captured electronically in the patients' records. For example, letters received were scanned and saved into the patients' records by the practice. Information from the out-of-hours service (OOH) was received by fax or by e-mail and was scanned into patients' notes.

There was a system for referring patients to secondary care. Referrals were dealt with swiftly, often on the same day. They were typed by the medical secretary and checked and signed by the GP before being sent. Referrals were traceable through the patients' record and staff checked to help ensure documents were correctly scanned and actioned within the system. For rapid access referrals (14 day cancer referrals) the practice had a separate folder which the staff monitored and followed up if it appeared that the patient would not receive the referral within the time..

Consent to care and treatment

The practice had a consent policy that governed the process of patient consent and guided staff. The policy described the various ways patients were able to give their consent to examination, care and treatment, such as implied consent. The policy stated how consent should be recorded. Consent was specifically recorded for any invasive procedures and a proforma document was used for this. Staff we spoke with understood the consent and decision-making requirements of legislation and guidance.

The GP we spoke with had received formal training in the Mental Capacity Act 2005 (MCA) and was aware of the implications of the Act. Reception staff had not had formal training in the Act but were aware of the need to identify patients who might not be able to make decisions for themselves and to bring this to notice.

Health promotion and prevention

All new patients were offered a health check. This followed a standard format that included blood pressure, weight, height and other measurements recommended by best practice. Anonymised records showed that these were completed to a high standard. Where the healthcare staff identified health issues such as, patients who were on repeat medicines, they referred them to the GP for further consultation.

There was a range of leaflets available to inform patients on health care issues. These included smoking cessation, diet and healthy living. There was more detailed information about long-term conditions including mental health, cancer and asthma. There were details of organisations that were available to help patients suffering from these, and other, conditions.

Good

Are services effective?

(for example, treatment is effective)

The practice also offered NHS Health Checks to all its patients aged 40-75. Staff told us of several instances in the last year when these checks had led to the early diagnosis of conditions for example high blood pressure.

The practice undertook other health prevention activity. In the previous year it had identified and offered assistance to all patients with specific chronic diseases who were smokers. The practice's results in offering smoking cessation help to young people and those with chronic diseases were amongst the best in the country.

The practice offered a full range of immunisations for children and influenza vaccinations in line with current national guidance. Over the longer term the performance for child immunisations was comparable to or exceeded the averages locally. During the last year this had fallen to approximately two thirds of the local average. We were told that because of the lack of a practice nurse patients were receiving their immunisations elsewhere.

The practice provided influenza vaccinations to the elderly and patients with long-term conditions achieving results that were in line with the clinical commissioning group (CCG) and national performance.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available from the national patient survey. This showed that patients felt they were treated with dignity and respect. Patients said that the GPs and nurse listened to them, explained tests as well as results and treated them with care and concern.

The patient survey information showed patients responded fairly positively to questions about their being treated with care and concern. For example, the data showed 98 per cent of respondents said the nurse treated them with care and concern and 77 per cent said the same of GPs. The national figures were 90 and 85 per cent respectively.

Patient confidentiality was respected. There was a reception area with ample seating. The reception staff were pleasant and respectful to the patients. This was small practice and staff knew the regular patients well. Although the layout of the reception area made it difficult to keep conversations confidential, staff were aware of this and took time and trouble to maintain confidentiality. There was a private area where patients could talk with staff if they wished. There was a notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

All consultations and treatments were carried out in the privacy of a consulting or treatment room. We saw that staff always knocked and waited for a reply before entering any of the rooms. All the consulting rooms had substantial doors and it was not possible for conversations to be overheard. The rooms were, if necessary, fitted with window blinds. The consulting couches had curtains and patients said that the doctors and nurses closed them when this was necessary.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded quite positively to questions about their involvement in planning and making decisions concerning their care and treatment. For example, data from the national patient survey showed 95 per cent of practice respondents said the nurse involved them in care decisions and 78 per cent said the same of GPs. The national figures were 85 and 82 per cent respectively.

Patients said that the GPs and the healthcare assistants (HCAs) discussed their health with them and they felt involved in decision making about the care and treatment they chose to receive. For example, we saw that 20 out of 21 mental health patients had a care plan which had been discussed and agreed with them, and their relatives or carers where appropriate. Patients said staff explained the care and treatment that was being provided and what options were available. Patients also received appropriate information and support regarding their care or treatment through a range of informative leaflets. The patient record system used by the practice enabled GPs to print out relevant information for the patient at the time of the consultation, for example where a patient received a new diagnosis.

Patients' comment cards and the patients we spoke with reported that they felt listened to. Although this was a very small proportion of the patient population they said that the care was very good. They said that they were treated as individuals by staff who knew them well. We had some comments about how quickly problems and referrals were acted on.

Patient/carer support to cope emotionally with care and treatment

There was support and information for patients and their carers to help them cope emotionally with their care, treatment or condition. We heard reception staff explaining to patients and their carers how to obtain access to services such as those related to specific disabilities or conditions. There was written information available for carers to help ensure they understood the various avenues of support available to them. There were notices in the waiting room informing patients how to access a number of support groups and organisations.

The GPs carried out home visits to patients who were housebound or receiving end of life care. There were end of life care plans. There was a policy to follow up with families who had suffered bereavement. This took the form of a telephone call to the family and the offer of consultation, at a flexible time and location to meet the family's needs, and advice on how to find any support services. There was information displayed, privately, so that staff were aware when a family had suffered a bereavement and could provide a sympathetic response.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to patients' needs and had systems to maintain the level of service provided. The needs of the practice population were understood and there were systems to address identified needs in the way services were delivered. We heard staff making appointments. They were pleasant and respectful to the patients. They tried to accommodate the times that the patients asked for, however when they could not they talked with the patients to identify other suitable times. Patients had the choice of a male or female GP, though this was dependent on the working patterns of the GPs.

The practice did not have a patient participation group (PPG). It had tried to generate interest in a group but had not been successful. There were NHS family and friends survey leaflets available that patients had completed but it was too early to draw any definite conclusions from the results. (The NHS friends and family test is an opportunity for patients to provide feedback on the services that provide care and treatment). The practice took into account the views and comments of patients for example, it had improved wheelchair access after patients said that some types of chairs stuck on the entry ramp. Patients suggested that, as it was not possible to securely leave pushchairs outside, they should be permitted inside and this was taken up.

Tackling inequity and promoting equality

Disabled patients could access the practice. There was a ramp leading to the front door so that patients in wheel chairs could use it. The waiting area was large enough to accommodate patients with wheelchairs as well as 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.

There were translation services available for patients who did not have English as a first language, though staff said that they rarely had to use them. There was no hearing loop at the reception. Patient confidentiality made this impractical. From our observations it was clear that staff knew the patients who had hearing, or sight, difficulties and took steps to meet their needs.

There was a lowered area of the reception counter so patients in wheelchairs could talk with staff at their own level.

All patients who had a diagnosis of dementia were flagged on the practice's computer system. This helped staff to identify the patients so that they could provide the relevant support. There was a register of patients with a diagnosis of dementia and the practice reviewed the care and treatment of these patients with their carer, when there was a carer available. Of these patients 17 out of 18 had had their care reviewed over the preceding 12 months. This placed the practice in the top three quarters of practices in the country and they had consistently maintained this position over the last three years.

The practice told us that when they had cared for homeless patients they had done so by using the practice's address for registration purposes. They told us one occasion where they had been able to encourage the patient to attend and receive some important investigations and treatment before the patient had left the area. They said that the patient had told them they had been able to achieve this because they were open, friendly and not judgemental.

Access to the service

The practice was open from 8am to 6.30pm and reception area staffed during all of this period. The switchboard was also open during this time. The practice saw most patients within 48 hours of the request for an appointment except where a specific GP was requested and the GPs' work patterns prevented this. There were book on the day appointments, but patients could book several weeks in advance. Comprehensive information was available to patients about appointments in the practice leaflet. There were also arrangements to help ensure patients received urgent medical assistance when the practice was closed. If patients telephoned the practice when it was closed, an answerphone message gave the contact details of other relevant out- of- hours services.

Patients were generally satisfied with the appointments system. In surveys, more than 84 per cent rated their experience of making an appointment as good or very good compared with 75 per cent for practices in the locality. Patients told us they could see a GP on the same day if they needed to. Patients also said that the reception staff understood their needs, for example, booking appointments to fit with school collection times. Older patients requiring urgent care were seen on that day either

Good

Are services responsive to people's needs?

(for example, to feedback?)

as an emergency appointment or in a home visit if the person was housebound, in a care home or too unwell to attend. Children who called with urgent matters were seen as soon as possible and, in any event, on the day they called. There were telephone consultations available, on the day, for patients where this was appropriate.

Longer appointments were available for patients who needed them and those with long-term conditions or for mental health and substance misuse consultations.

Listening and learning from concerns and complaints

There was a complaints policy that included timescales by which a complainant could expect to receive a reply. The practice manager was designated to manage all complaints. The complaints log was comprehensive and showed that matters were investigated in a thorough and timely way. Timescales for the responses to patients were laid out and adhered to. Responses were articulate, detailed and polite. The responses included the details of the Parliamentary and Health Service Ombudsman (PHSO) for those patients who wished to take the matter further. There had been learning from complaints. For example a complaint had led to a review of the practice's complaints policy, processes and the forms used so that they were closely aligned to the patients' needs and to regulatory requirements.

Are services well-led?

Good

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

Our findings

Vision and strategy

The staff we spoke with told us that they felt well led and described a practice that was open and transparent. Staff consistently said that they understood what the practice stood for, for example trying to ensure that patients saw their own (preferred) GP whenever possible and trying to respond to patients needs to the best of their ability at all times. The GP and the practice manager said that they advocated an "open door" policy and all staff told us that the GPs and practice manager were approachable.

The principal GP was due to retire on 31 March and there was a plan for another GP to take over the practice. Some parts of the plans of the new GP were well advanced however many of the aspirations for the future of the practice had yet to be converted into detailed plans.

Governance arrangements

There was a range of mechanisms to manage governance of the practice. There were regular meetings amongst staff at lunch times when the practice was closed to patients. There were no minutes of these but we were told that at these meetings day to day problems were resolved informally. There were formal practice meetings monthly. We looked at the minutes for the last three meetings and saw that staff were informed about changes to practice and had the opportunity to contribute to the safe running of the practice. For example changes were made to the way that families were booked in for new patient checks to help ensure the most effective use of the practice nurse's time.

Staff were also kept informed of the changes to the leadership in the practice.

The practice had carried out some reviews and audits. There had been reviews of the time lost when patients did not attend (DNA) their appointments. As a result there was a weekly check of DNAs and patients were contacted to ascertain the reasons. There had been a review of referrals to help ensure that urgent referrals were not left on staff members' desks, where they might get mislaid, but were given to individuals so that they were dealt with quickly.

Leadership, openness and transparency

Staff felt able to speak out regarding concerns and comments about the practice. Receptionists we spoke with said that they would interrupt a consultation if they had an urgent concern and GPs supported this. All the staff we spoke with said they felt valued by the practice and able to contribute to the systems that delivered patient care. Staff had job descriptions that clearly defined their roles and tasks at the practice. There were plans for the new GP (taking over on 1 April) to interview staff to find out about their individual roles and aspirations.

Practice seeks and acts on feedback from its patients, the public and staff

Staff we spoke with felt that the practice listened to staff suggestions. We saw examples where staff had influenced how the practice was run such as coming to agreement on how to provide extra cover to deal with the high volume of telephones calls at certain times of the day and how to reduce the number of patients coming to the practice, in person, just to get results of tests. Records showed that GPs stayed for some parts of staff meetings but were happy to leave so that staff were empowered to resolve other issues between themselves.

Management lead through learning and improvement

Staff told us that they felt well supported by the practice and there was regular training. The practice had recently carried out a training needs assessment where each staff member had completed a questionnaire. There were plans to provide training to meet the needs that had been identified. There were plans for administration staff to manage more of their own meetings. The managers felt that this would lead to staff being more involved in how the practice was run.

The practice had completed reviews of significant events and other incidents and shared these with relevant staff at meetings to help ensure the practice improved outcomes for patients. Records of discussions between the GPs and practice nurse about an incident demonstrated they had reviewed a similar case in medical literature and identified learning points including how to recognise particular signs of increased risk in the condition concerned.