Dronfield Medical Practice

Quality Report

Dronfield Medical Centre, High Street, Dronfield,
Derbyshire S18 1PY
Tel: 01246 412242
Website: www.dronfieldhealth.co.uk

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected this practice on 21 October 2014, as part of our new comprehensive inspection programme. The practice had not previously been inspected. We found the practice to be good in all the key areas we inspected; the overall rating is good.

Our key findings were as follows:

- Patients expressed a high level of satisfaction about the way the services were provided. Patients were asked for their views, and their feedback was acted on to improve the service.
- Robust systems have been put in place to help keep patients safe and to protect them from harm.
- Staff worked well together as a team, and received appropriate support, training and an appraisal to enable them to carry out their work effectively.
- Patients were treated with kindness, dignity and respect.
- The appointment system was flexible and enabled patients to access care and treatment when they needed it.
- There was a commitment to improving the quality of care and services for patients. The governance systems have been strengthened to ensure that the practice is providing high standards of service.

The provider should:

Ensure that the recruitment policy is followed to provide assurances that new staff are suitable to carry out the work they are employed to undertake.

Provide comment slips and complaint forms to enable people to use the suggestion and comments box.

Ensure that completed appraisal forms detail all aspects of staff performance and learning and development needs.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for safe. There were enough staff to keep people safe. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Significant events were reviewed and lessons were learnt and communicated widely to minimise further incidents. Robust systems have been put in place to help keep patients safe and to protect them from harm.

Are services effective?

Good

The practice is rated as good for effective. The practice had an established staff team, which ensured continuity of care and services. Staff worked with partner health and social care services to meet patients' needs. Patients' needs were assessed and their care and treatment was delivered in line with evidence based practice. Patients were regularly reviewed to assess the effectiveness of their care and treatment. Completed clinical audits were carried out to monitor and improve the care and outcomes for patients.

Are services caring?

Good

The practice is rated as good for caring. Patients described the staff as friendly and caring, and said that they felt that they treated them with respect. Patients were involved in decisions about their health and treatment, and their wishes were respected. Staff supported patients to cope emotionally with their health and condition. Patients were supported to manage their own health and care and to maintain their independence, where able. Patients' privacy, dignity and confidentially were maintained; staff were respectful and polite towards patients.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The appointment system was flexible and was regularly reviewed to enable people to access care and treatment when they needed it.

The practice was well equipped to treat and meet patients' needs. A daily clinical meeting was held, which provided peer support and effective communications, to ensure that patients' received consistent care and appropriate treatment. Patients concerns and complaints were listened to and used to improve the service. The complaints procedure had been made accessible to patients to ensure they know how to raise concerns.

Summary of findings

Are services well-led?

Good

The practice is rated as good for well-led. Patients were asked for their views, and their feedback was acted on to improve the service. A clinical audit programme was in place to monitor the quality of care provided. The governance systems have been strengthening to provide assurances that the practice is providing high standards of service. Staff felt supported and valued. There was strong teamwork and a commitment to improving the quality of care and services for patients. All staff had clear roles and responsibilities to ensure that the practice was well led.

Summary of findings

What people who use the service say

During our inspection we spoke with nine patients including six members of the Patient Participation Group (PPG). The PPG included representatives from various population groups, who work with staff to improve and the quality of care and services. We also received comment cards from 38 patients. We also spoke with senior staff at a care home and an enhanced care unit where patients were registered with the practice.

Patients and representatives expressed a high level of satisfaction about the way the services were provided.

Patients told us that the premises were clean, and that the facilities were accessible and appropriate for their needs. Patients described the staff as friendly and caring, and felt that they treated them with dignity and respect. They also said that they felt listened to, and able to raise any concerns with staff if they were unhappy with the care or the service.

Patients said that they promptly received test results and were referred to other services, where appropriate. They also said they were involved in decisions about their treatment, and were satisfied with the care and service they received. However, several patients said that they did not find it easy to get through to the practice by phone or access appointments at times. In response to feedback, records showed that the practice had made changes to the telephone and the appointment system to improve access for patients.

Two care homes we spoke with praised the support staff received from the practice, and the care and service patients received. They said that patients were promptly seen and their needs were regularly reviewed.

Representatives of the PPG told us they worked well with the practice to further improve the service. Patients were asked for their views, and their feedback was acted on to improve the service. A patient survey was carried out in September 2014, which over 400 patients completed. 78% of people said they would recommend the practice to their friends and family. The PPG had agreed the action points from the survey to improve the service.

We looked at the 2014 national GP survey, which 133 patients completed. The findings were compared to the regional average for other practices in the local Clinical Commissioning Group (CCG). A CCG is an NHS organisation that brings together GPs and health professionals to take on commissioning responsibilities for local health services. Areas where the practice scored highest included patients had confidence and trust in staff, they were good at listening and patients usually waited 15 minutes or less after their appointment time to be seen. Areas for improvement included access to appointments, getting through to the practice by phone and being able to get to see or speak to a preferred GP.

Areas for improvement

Action the service SHOULD take to improve

Ensure that the recruitment policy is followed to provide assurances that new staff are suitable to carry out the work.

Ensure that the minutes of clinical meetings include changes to practice and National Institute for Health and Care Excellence (NICE) guidelines discussed.

Provide comment slips and complaint forms to enable people to use the suggestion and comments box.

Ensure that completed appraisal forms detail all aspects of staff performance and learning and development needs.

Dronfield Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Dronfield Medical Practice

Dronfield Medical Practice provides primary medical services to approximately 9,700 patients in the Dronfield, Unstone, Barlow and Holmesfield area of Derbyshire. The services include minor surgery, the treatment of minor injuries, family planning, maternity care, blood testing, vaccinations and various clinics for patients with long term conditions.

The practice is managed by Dronfield Medical Practice. It employs 14.40 whole time equivalent staff, including nine administrative staff, a practice manager, three partners and three salaried GPs, a nurse practitioner, two practice nurses and a health care assistant. Two of the GPs are males. It is a training practice for nurses and doctors in training. The practice opted out of providing the out-of-hours service.

The practice holds the Personal Medical Services (PMS) contract with the NHS to provide personal medical services.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008, as part of our regulatory functions. The practice had not previously been inspected and that was why we included them. This inspection was planned to check whether the provider was 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.

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

How we carried out this inspection

Prior to our inspection we reviewed information about the practice and asked other organisations to share what they knew about the service. We also spoke with four partner health and social care services who worked closely with the practice.

We carried out an announced visit on 21October 2014. During our visit we checked the premises and the practice's records. We spoke with a practice nurse, the nurse practitioner, a health care assistant, five GP's, reception and clerical staff, and the practice manager. We also received comment cards we had left for patients to complete and spoke with patients and representatives who used the service.

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

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

Detailed findings

- Is it well-led?

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Good

Are services safe?

Our findings

Safe Track Record

Patients told us they felt safe when using the service. Records showed that safety incidents and concerns were appropriately dealt with. Risks to patients were assessed and appropriately managed. A system was in place to ensure that staff were aware of national patient safety alerts and relevant safety issues, and where action needed to be taken.

The practice used a range of information to identify risks and to improve patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. We reviewed incident reports and minutes of meetings where incidents were discussed from the last 18 months**.** This showed the practice had managed incidents consistently over time, and so could evidence a safe track record.

Staff we spoke to were aware of their responsibilities to raise concerns, and how to report incidents and near misses. For example, a staff member had reported a concern about medication a patient had been given. Additional checks had been put in place to prevent further errors.

Learning and improvement from safety incidents

Staff told us that the practice was open and transparent when things went wrong. We saw that a system was in place for reporting, investigating and monitoring incidents, accidents and significant events. Records were kept of incidents and events that had occurred during the last 10 years.

We looked at six recent significant events. These were completed in a comprehensive and timely way, and included action taken. Records of significant events showed that appropriate learning and improvements had taken place, and that the findings were communicated widely. For example, it was identified that a hospital letter had been coded incorrectly on a patient's records, resulting in required action not being taken. This was reported, investigated and followed up with relevant staff to address the error and prevent further incidents.

Reliable safety systems and processes including safeguarding

Systems were in place to manage and review risks to vulnerable children, young people and adults. All staff we spoke with said that they had received safeguarding training specific to their role. For example, all GPs had completed level 3 training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities to share information, record safeguarding concerns and how to contact the relevant agencies. Following the inspection, we received assurances that all staff had received the above training.

A system was in place to highlight vulnerable patients on the practice's electronic records, including children and young people who were looked after, or on a child protection plan. The alert system ensured they were clearly identified and reviewed, and that staff were aware of any relevant issues when patients attended appointments or contacted the practice.

One of the GPs was the designated lead for safeguarding. As part of their role they attended regular meetings with relevant professionals to discuss patients who were vulnerable, at risk of abuse or on a child protection plan. Essential information was recorded in patient's records.

A chaperone policy was in place, and was visible in the waiting area and consulting rooms. Discussions with staff and records showed that staff who acted as chaperones had undertaken relevant training. Staff understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Patient's individual records were managed in a way to keep people safe. Records were kept on EMIS electronic system, which held all information about the patient including scanned copies of results and communications from other health and social care services. This ensured that staff had access to essential information about patients.

Medicines Management

Several patients and representatives told us that the system in place for obtaining repeat prescriptions generally worked well to enable them to obtain further supplies of medicines.

Arrangements were in place to enable patients to collect their dispensed prescriptions directly from a community pharmacy. Local pharmacies also delivered medicines to housebound patients.

Good

Are services safe?

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. 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, to ensure they were kept secure. A system was in place relating to the management of high risk medicines, which included regular monitoring in line with national guidance.

We saw that most medicines including vaccines were stored appropriately and securely. However, a supply of two medicines were stored in an unlocked cupboard in one of the treatment rooms, and the emergency medicines were not secure. All rooms were locked when unoccupied by staff. However, all staff had access to the areas where the above medicines were kept, including non-clinical staff that were not authorized to handle them. Following the inspection, we received assurances that the above medicines were stored safely; a risk assessment had been completed in regards to access to the emergency medicines, to ensure they were secure. We were unable to independently verify this.

Policies and processes were in place to protect patients against the risks associated with the unsafe use of medicines. For example, staff carried out regular checks to ensure that medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Staff agreed to put a new list in place for checking the emergency medicines as the one in use required replacing. Expired and unwanted medicines were disposed of in line with waste regulations.

Records showed that the medicine fridge temperatures were being recorded regularly in line with the provider's protocol, to ensure that the medicines were stored appropriately. The cold chain protocol did not state what action staff should take if the fridge fell out of the recommended temperature range. Following the inspection, we received a copy of the updated cold chain protocol, which included further key information. We were assured that relevant staff would be made aware of the changes.

Cleanliness & Infection Control

We observed the premises to be clean and tidy; we did not identify any issues in regards to the cleanliness. Patients we spoke with told us they always found the practice to be clean.

The practice manager confirmed that the cleaning provider carried out regular checks to monitor the standard of cleanliness, and ensure that appropriate practices were being followed. However, the practice did not see the reports. Following the inspection, we received written assurances that the practice now received the reports, and that the cleaning provider had put work sheets in place, to show that the staff had completed the cleaning tasks at the practice. We were unable to independently verify this.

The nurse practitioner was the lead for infection control. Staff we spoke with said that they had received some training on infection control and hand washing. They also had access to the infection control policy, to ensure that they followed appropriate practices. The infection control lead was booked on training at the end of October 2014, with a view to providing further training to all staff. Following the inspection, we were assured that all staff had received recent training on infection control. We were unable to independently verify this.

The infection control policy stated that a yearly hand hygiene audit was completed. Records were not available to show that a hand hygiene or infection control audit had been completed recently, to ensure that policies and practices were being followed.

The practice manager told us that senior staff carried out regular checks to ensure that the premises were clean and hygienic, although this was not recorded. Following the inspection, the lead nurse completed an infection control audit; we received a copy of this. The audit showed that the practice was compliant in all relevant areas assessed. The practice manager confirmed that the infection control policy had been updated, to state that an audit would be completed every six months.

A policy was in place relating to the immunisation of staff at risk of the exposure to Hepatitis B infection, which could be acquired through their work. An external occupational health team checked staff's immune status, and provided vaccinations as necessary. The records did not show that all relevant staff were protected from Hepatitis B infection. Following the inspection, we received written confirmation that all relevant staff were up to date with their vaccinations, and had received a 5 yearly booster, where required**.** The occupational health team notified the employee and the practice of staff's immunisation status.

Equipment

Good

Are services safe?

Staff we spoke with confirmed that all equipment was safe to use, and that they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Records showed that equipment was regularly tested and maintained, including items requiring calibration such as weighing scales and blood pressure machines.

Staffing & Recruitment

The recruitment policy detailed the various stages of the process and information obtained when recruiting new staff. We checked the files of two staff employed in the last twelve months, and a locum GP who was working at the practice on a 12 month contract. All three staff members were well known to the practice prior to their employment, having previously worked there, or as a partner health worker in their previous job.

We found that the provider's recruitment policy was not consistently followed in practice to ensure that staff were suitable to carry out the work they were employed to do. New staff were required to provide a copy of their curriculum vitae (CV). These contained varying levels of information to support the recruitment process, and a person's suitability to carry out the work.

One staff file we checked contained appropriate recruitment checks, whilst two files did not contain all the required information. For example, one person's file did not include a full employment history. The practice manager took immediate action to request and obtain this information.

Two staff files did not include evidence of the staff member's conduct in their previous health care employment, which involved working with children or vulnerable adults. The practice manager confirmed that in view of their previous position and involvement with the practice, a risk assessment was completed and a decision was made not to request references. However, this was not recorded. Following the inspection, we received assurances that both staff files had been updated to include the above information. We were unable to independently verify this.

We saw that a system was in place to oversee that the practice nurses and GPs remained fit to practice with their relevant professional body, prior to their employment and on an annual basis.

The practice had an established staff team and patients received care from regular staff that they knew. Staff told us about the arrangements for ensuring sufficient numbers and skill mix of staff were available to meet patients' needs. Members of staff covered each other's annual leave and absence.

Staff said that there was usually enough staff on duty to ensure patients were kept safe, and to maintain the smooth running of the practice. One of the partner's was planning to retire in the next year or so. Succession plans were in place to replace to maintain the partnership and GP skill mix.

Monitoring Safety and Responding to Risk

The practice had various systems and policies in place to identify, manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the equipment and the management of medicines. Action plans were in place to reduce and manage any risks. These were discussed at GP partners' and team meetings. The practice had a health and safety policy, which staff had access to. The practice manager was the lead member of staff on health and safety issues.

We saw that staff were able to identify and respond to risks to patients including deteriorating health and well-being or medical emergencies. For example:

Emergency processes were in place for patients with long term conditions. Staff gave us examples of referrals made for patients that had a sudden deterioration in health.

The practice monitored repeat prescribing for patients receiving high risk medicines.

There were emergency processes in place for identifying acutely ill children and young people.

Emergency processes were in place for acute pregnancy complications.

Staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to deal with emergencies. Records showed that staff had received training in basic life support. Emergency equipment was

Good

Are services safe?

available including access to oxygen and an automated defibrillator (used to attempt to restart a person's heart in an emergency). Records showed that the emergency equipment and medicines were regularly checked to ensure they were fit to use and within their expiry date. All the medicines we checked were in date and suitable to use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the day to day running of the practice. Risks identified included power failure, adverse weather, access to the building and staff changes. Actions were recorded to reduce and manage the risks.

A fire safety risk assessment had been completed, which included actions required to maintain fire safety. Records showed that staff had received recent fire safety training and that fire drills were carried out annually, to ensure they knew how to evacuate the premises and what to do in the event of a fire.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinical staff told us that they received updates relating to current best practice and the National Institute for Health and Care Excellence (NICE) guidelines electronically. The aim of the guidelines is to improve health outcomes for patients. Staff said that changes to practice and NICE guidelines were discussed at clinical meetings. We did not see evidence of this in the minutes of meetings we looked at.

The practice knew the needs of their patient population well. The GPs and nurses had lead clinical roles relevant to their skills and knowledge, which enabled them to focus on specific conditions and to help drive improvements. We found that patient needs were assessed and that they received effective care and treatment to meet their needs.

A system was in place to recall older people, those in vulnerable circumstances, with long term conditions and experiencing poor mental for an annual health review. Records showed that regular multi-disciplinary meetings were held to review the health needs and care plans of patients who had complex needs, and were receiving end of life care. Patients were referred appropriately to secondary and other community care services on the basis of need.

Patients over 75 years had a named GP to ensure continuity of care and oversee that their needs were being met. The practice had signed up to the enhanced service to help avoid unplanned hospital admissions. Enhanced services are additional services provided by GPs to meet the needs of their patients. The practice worked closely with partner health and social care services to support elderly patients, people at high risk or with complex needs to remain in their own home or local care home to improve outcomes for patients.

Representatives from a care home and an enhanced care unit we spoke with praised the support patients received from the practice.

Patients with a learning disability were offered an annual health check, including a review of their medicines. At the end of the review the patient was provided with a health action plan in an easy read form to meet their needs.

Clinical staff worked closely with the local learning disability and mental health teams to ensure that patients with learning disabilities, or experiencing poor mental health received appropriate care and treatment.

The practice provided ante natal and post natal checks. There were systems in place that ensured babies received a new born and six week development assessment in line with the Healthy Child Programme.

Management, monitoring and improving outcomes for people

Staff across the practice had clear roles in monitoring and improving outcomes for patients. The GPs told us clinical audits were often linked to the management of medicines, significant events or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool.

The practice held the Quality Practice Award from the Royal College of General Practitioners, which reflected work done in achieving high standards of care. The team made use of audit tools, clinical supervision and staff meetings to assess the performance of clinical staff.

We saw that a system was in place for completing clinical audit cycles to provide assurances as to the quality of care, and to improve the outcomes for patients. Various audits and reviews had been completed in the last two years, and the practice was able to demonstrate the changes resulting from these. For example, an audit cycle was completed on the management of people with acne, resulting in improved recording of the condition and effective treatment. We were informed that an audit to monitor the outcomes of minor surgical procedures, had not been completed in the last two years. The practice planned to undertake this.

Discussions with staff and records showed that the outcome of audits was communicated through the team and clinical meetings. The meetings enabled the staff to discuss clinical issues and peer review each other's practice, driving improvements in care.

Effective staffing

Staff we spoke with said that that they had received an appropriate induction to enable them to carry out their work. We saw that a detailed induction programme was in place, which was relevant to specific roles to ensure that staff received essential information to carry out their work.

Good

Are services effective?

(for example, treatment is effective)

Staff told us they worked well together as a team. The practice had an established staff team with appropriate knowledge and skills to enable them to carry out their roles effectively. This ensured continuity of care and services.

Staff were supported to maintain and develop their skills and knowledge. For example, a practice nurse was undertaking a nurse practitioner course, and a GP was completing a certificate in Medical Education to enable them to be an approved trainer to support doctors in training. The practice closed for half a day each month to enable all staff to receive time for learning. Further training was planned.

Records showed that staff received supervision through peer support and regular team meetings they attended. They also received an annual appraisal to review their performance and learning and development needs. We looked at two completed appraisals. Parts of the forms required further detail to show that a robust appraisal had been completed, as some sections contained brief information. Also, the form did not include a section at the end for the appraiser/s and the employee to record any overall comments relating to the review.

GPs told us that they were up to date with their professional development requirements, and had either been revalidated or had a date for revalidation. Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis, that they are up to date with current best practice and remain fit to practice.

The practice was a training practice. Doctors who were in training to be qualified as GPs received extended appointment times, and had access to a senior GP throughout the day for support. One of the GPs we spoke with had not long ago completed their training to be a GP at the practice. They praised the level of support they received during their training.

Working with colleagues and other services

Staff worked closely with partner health and social care services to meet patients' needs. They held regular meetings with the Macmillan and end of life care team, midwife and health visitor. The practice held regular multidisciplinary team (MDT) meetings to discuss patients with complex needs, at risk or in vulnerable circumstances. These meetings were attended by a district nurse, physiotherapist, social worker, community psychiatric nurse and a care co-ordinator. Staff said they felt that the community care co-ordinator's role was beneficial in supporting integrated care, and provided a valuable point of contact for sharing information.

The practice had signed up to the enhanced service to help avoid unnecessary admissions and to follow up patients discharged from hospital. Enhanced services are additional services provided by GPs to meet the needs of their patients. Data from the area Clinical Commissioning Group (CCG) showed that there had been a decrease last year in the number of unplanned admissions to hospital for people aged 75 years and over.

Discussions with staff and records we looked at showed that people were supported to remain in their own home. For example, the practice worked closely with the out-of-hours service to ensure that staff providing emergency cover, had access to essential information about patients' needs, including end of life wishes and specific health issues to help avoid unnecessary admissions.

The practice was also involved in a local 'falls' initiative, which enabled patients who had fallen at home and had been taken to hospital for assessment, to be promptly returned home by ambulance on discharge.

Information Sharing

A shared system was in place with the local out-of-hours provider to enable essential information about patients to be shared in a secure and timely manner. The practice used EMIS web electronic system to coordinate records and manage patients' care. All staff were trained to use the system, which enabled scanned paper communications, such as those from hospital, to be saved for future reference.

For patients who needed to go to hospital, from the practice, as an emergency, GPs provided a printed summary record for the patient to take with them to A&E or hospital, where possible. The practice had also signed up to the electronic Summary Care Record. Summary Care Records provide healthcare staff treating patients in an emergency or out-of-hours with faster access to key information.

Electronic systems were also in place for making referrals. The GPs used a dictation system, which enabled them to

Good

Are services effective?

(for example, treatment is effective)

dictate and send referrals easily. Patients had access to the Choose and Book system, which enabled them to choose which hospital they wished to be seen in, and to book their own outpatient appointments.

Health Promotion & Prevention

We saw that various health promotion information was available to patients and carers on the practice's website, and the noticeboards in the waiting area. Some information displayed was not themed or grouped together to aid ease of reference for patients.

New patients completed a form, which provided some essential information about their health. It was policy to offer new patients registering with the practice an initial health check. This ensured that staff had access to essential information about people's health needs, and that any tests or reviews they needed were up-to-date.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The 2013/14 data for immunisations showed that the practice was above average for the area CCG, and there was a system in place for following up patients who did not attend.

The practice offered NHS Health Checks to all patients aged 40 to 75 years. Patients were also encouraged to attend relevant screening programmes including bowel, breast and cervical smears. A recall system was in place for following-up patients who did not attend screening.

All patients with a learning disability, poor mental health, long standing conditions or aged 75 years and over were offered an annual health check, including a review of their medication.

The practice had strong links with the local community and supported various health and social groups including a cardio-vascular club and a retirement group, which were held in an adjoining building.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Patients we received feedback from described the staff as friendly and caring, and felt they treated them with dignity and respect. They also said that they felt listened to and that their views and wishes were respected.

Representatives of a care home and an enhanced care unit we spoke with where patients were registered with the practice also said that they felt the staff were caring and treated patients with respect. Staff and patients told us that all consultations and treatments were carried out in the privacy of a suitable room.

The 2013/2014 national GP survey showed that 72% of patients surveyed were satisfied with the level of privacy when speaking to receptionists at the practice. The survey also showed that 75% of people said that the last GP they saw or spoke to, was good at involving them in decisions about their care, 84% felt the GP was good at explaining treatment and results, 94% felt that they were good at listening to them and 83% said that they were good at treating them with care and concern. 86% also said that the last nurse they saw or spoke to was good at treating them with care and concern. These results were above the Clinical Commissioning Group (CCG) regional average for GP practices in the area.

A sign was displayed in the reception area informing patients that they could speak privately with staff, if required. We observed that patients were treated with dignity, respect and kindness during interactions with staff. Patients privacy and confidentially was also maintained. Staff told us that if they observed any instances of discriminatory or disrespectful behaviour they would raise this with the practice manager.

Care planning and involvement in decisions about care and treatment

Patients we received feedback from said that they felt listened to, and were supported to make decisions about their care and treatment.

The practice had signed up to the enhanced service to help avoid unnecessary hospital admissions. Enhanced services are additional services provided by GPs to meet the needs of their patients.

Clinical staff told us that patients at high risk of being admitted to hospital, including elderly patients and patients with complex needs, or in vulnerable circumstances, had a care plan in place to help avoid this. The care plans included patient's wishes, including decisions about resuscitation and end of life care. This information was available to the out-of -hours service, ambulance staff and local hospitals. The practice used an alert system to ensure that the out-of-hours service were aware of the needs of these patients when the surgery was closed.

Staff told us that patients with long term conditions, learning disabilities, poor mental health and over 75 years of age were offered an annual health review, including a review of their medication. We saw that an appropriate health check form and care plan was used for patients with a learning disability. This was in an easy read form so that patients understood it.

Staff told us that some patients attending the practice required support to make decisions about their care and treatment, including people who had dementia or a learning disability. Citizen's advice held a weekly surgery at the practice, which patients and carers had access to.

Patient/carer support to cope emotionally with care and treatment

Patients we received comments from said that they received support and information to cope emotionally with their condition, care or treatment. They described the staff as caring and understanding. Where able, they were supported to manage their own care and health needs, and to maintain their independence.

The computer system identified patients who had carer responsibilities to enable the staff to offer them support. We found that importance was given to supporting carers to care for relatives, including patients receiving end of life care. Bereaved carers known to the practice were supported by way of a personal visit or phone call from a GP, to determine whether they needed any practical or emotional support. The practice also sent a letter of condolence to the carer.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice provided a wide range of services to meet patients' needs, and enable them to be treated locally. The services were flexible, and were planned and delivered in a way that met the needs of the local population, with involvement of other local services.

We spoke with senior staff at a care home and an enhanced care unit where patients were registered with the practice. They told us that patients were promptly seen when required and their needs were regularly reviewed. Both services had named GPs, which provided continuity of care and treatment. The GPs held regular surgeries at the care services, for patients who were unable to attend the practice. This pro-active approach meant that patients were regularly seen and reviewed, to help prevent health issues from becoming more serious.

The GPs and nurse practitioner attended a formal daily clinical meeting to discuss patients' needs. The meeting we observed was exemplary as it was robustly chaired, well focused and professional with all clinicians actively contributing. On questioning clinical staff, it was evident that this was a typical meeting and it was always this structured. The meetings ensured that patients received consistent care and appropriate treatment.

Antenatal care and support to younger children was provided by the designated midwife and health visitor, who worked closely with the practice. Regular multidisciplinary meetings were also held to discuss patients with complex needs or at risk, including people with poor mental health, learning disabilities or receiving end of life care. This helped to ensure that patients and families received coordinated care and support, which took account of their needs and wishes.

The practice had an established staff team, providing continuity of care and access to appointments. We saw that systems were in place to ensure that test results, information from the out-of-hours provider and letters from the local hospital including discharge summaries were promptly seen, correctly coded and followed up by a GP, where required.

Systems were also in place to ensure that patients were promptly referred to other services, where required. GPs used a dictation system, which enabled them to send referrals quickly.

The practice worked in partnership with the Patient Participation Group (PPG) and responded to information to meet patients' needs. The PPG included representatives from various population groups, who work with staff to improve and the quality of care and services. The PPG was reviewing the usefulness of the patient information screen in the waiting area.

Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services, and worked with partner health and social care services to understand the diverse needs of patients. Staff informed us they operated an open list culture, accepting patients who lived within their practice boundary.

Home visits and longer appointments were available for patients who needed them, including people in vulnerable circumstances, experiencing poor mental health, with complex needs or long term conditions.

The premises and services available met the needs of people with disabilities. The facilities were accessible and spacious for people in a wheelchair, and mothers with young children in a pushchair.

Access to the service

Patients told us they were able to get an appointment or were offered a telephone consultation, where needed. However, several patients reported difficulty in booking an appointment at times. The 2013/2014 national GP survey showed that 86% of people surveyed, were able to get an appointment to see or speak to a clinician the last time they tried. However, 52% said that they had not found it easy to get through to the practice by phone.

Records showed that the appointment system and telephone response times were regularly checked, to ensure that the practice responded to patients' needs.

Patients were able to book an appointment in person, by telephone or on line. The practice opened from 8am until 6:30pm on Monday, Tuesday, Wednesday and on Friday. Extended opening hours were available from 8am until

Good

Are services responsive to people's needs?

(for example, to feedback?)

8pm on Thursdays. This enabled children and young people to attend appointments after school hours. It also enabled working age patients and those unable to attend during the day, to attend in the evening.

We saw that systems were in place to prioritise emergency and home visit appointments, or phone consultations for patients who were not well enough to attend the practice. One person arrived at the practice in the afternoon requesting an urgent appointment, by which time the day's appointments were booked. The person was advised to wait in the surgery, and they would be seen at the earliest opportunity.

Records showed that the appointment system and telephone response times were regularly checked, to ensure that the practice responded to patients' needs. For example, in response to recent concerns about access, the practice had made more appointments bookable a month in advance. Information about the appointment system, opening times and the out-of-hours service was available in the reception area and on the practice's website.

The practice population is predominantly white British. Staff we spoke with were aware that they could access a translator for patients attending the practice, whose first language was not English. We saw that information in different languages was available in the reception area, informing people that a translator service was available, if required.

The premises were purpose built to a high standard. We found that the facilities and the premises were accessible and appropriate for the services being delivered. Patient facilities are on two floors, which are accessed by stairs and a lift.

Listening and learning from concerns and complaints

Patients we spoke with said that they felt listened to and able to raise concerns about the practice. They were aware of the process to follow should they wish to make a complaint, but they had not had cause to do so.

We saw that patients had access to a suggestion and comments box, although comment slips and complaint forms were not at hand to encourage people to use this. Also, the complaints procedure was not clearly visible to patients on the practice's website or at the surgery. Following the inspection, we received written assurances that the complaints procedure was available to patients. The complaints policy had also been updated in line with recognised guidance and contractual obligations for GPs.

A system was in place for handling complaints and concerns. During the inspection, the practice manager and a GP dealt with a new complaint they had received. Appropriate action was taken and the concerns were promptly resolved. We looked at the records of complaints received in the last 12 months. These showed that concerns had been acknowledged, investigated and responded to in line with the practice's policy. People had been informed of the outcome of their complaint and were offered an apology, where appropriate.

Complaints were reviewed to identify any patterns, and to ensure they had been responded to properly. Staff told us that there was a culture of openness and that they were encouraged to raise concerns. They also said that complaints were shared with staff at team meetings, and were acted on to improve the service for patients. Records of meetings supported this. For example, in response to concerns about the approach of certain staff, all staff had received training on customer service. The practice had received no further concerns about staff attitudes.

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

There was a clear vision and strategy to deliver high quality care and promote good outcomes for patients, which was shared by the staff team. Staff we spoke with understood the vision and values of the practice, and were committed to achieving these. A business plan was in place, which set out the plans for future development. Regular meetings were held to review this. Staff were involved in reviewing the vision and plans for the service.

Governance Arrangements

The practice had a wide range of policies and procedures in place to govern the practice, and to ensure that the service was well run. These were available to staff electronically. A system was in place to ensure that the policies were regularly reviewed and were up-to-date, and that these were shared with staff.

An internal peer review process was in place to help ensure consistency in clinical practice. The practice used performance data to measure their service against others and identify areas for improvement. This included the use of Quality and Outcomes Framework (QOF) to measure their performance; and clinical audits to identify and manage risks. QOF is a national performance tool designed to reward good practice.

Records showed that QOF data was regularly discussed at team meetings, and action plans were produced to maintain or improve outcomes. The practice maintained high QOF scores with the most recent data showing a total of 99.8%, which was above the practice average across England.

We saw that various systems were in place to monitor the service, including complaints, incidents, safeguarding, medicines management and the appointment system. We highlighted some areas where the systems required strengthening such as cleanliness and infection control. Following the inspection, we received assurances that the monitoring arrangements had been strengthened to oversee all aspects of the service.

Leadership, openness and transparency

We were shown a clear leadership structure, which included three GP partners, three salaried GPs, a practice manager, nurse practitioner and two practice nurses. All senior staff held lead roles linked with patient outcomes, and to ensure that the service was well led. For example, one of the partners was the lead for clinical governance, finance and clinical audit, and one of the salaried GPs was the lead for safeguarding and teaching of medical students.

Staff we spoke with were clear about their roles and responsibilities, and felt that the practice was well led. They also said that they felt valued, well supported, and involved in decisions about the practice. Staff described the culture of the organisation as supportive and open, and felt able to raise any issues with senior managers as they were approachable. The practice manager had an 'open door' policy to discuss any concerns or suggestions.

A whistleblowing policy was in place and staff were aware of this, but they had not had cause to use it. Records showed that regular team meetings and away days were held, which enabled staff to share information and to raise any issues. There were high levels of staff satisfaction.

Practice seeks and acts on feedback from users, public and staff

The practice obtained feedback from patients through patient surveys and complaints. The practice had a Patient Participation Group (PPG), which included representatives from various population groups, who work with staff to improve the quality of care and services for patients.

We spoke with two members of the PRG. They told us that the group had tried to enlist a member to represent younger people; however no one had expressed an interest. They also said that the practice valued their role, and asked for their views to improve the service. For example, when the reception area was being refurbished they were consulted about purchasing chairs, automatic doors, noticeboards, and floor coverings.

The PRG carried out an annual patient survey. The results and actions agreed from recent surveys were available on the surgery's web site and at the practice. This provided assurances that patients were asked for their views, and their feedback was acted on to improve the service.

Discussions with staff and records reviewed showed that the practice obtained feedback from staff through away

Are services well-led?

Good

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

days, team meetings and appraisals. Staff said that they felt involved in decisions about the practice, and were asked for their views about the service to improve outcomes for patients and staff.

Management lead through learning & improvement

Staff said that they were supported to maintain and develop their skills and knowledge. Records showed that staff received on-going training and development and an annual appraisal to enable them to carry out their work effectively.

Records showed that accidents, incidents and significant events were reviewed to identify any patterns or issues, and that appropriate actions were taken to minimise further occurrences. Minutes of practice meeting showed that appropriate learning and improvements had taken place, and that the findings were communicated widely.