Dr RM Roope and Partners

Quality Report

The Whiteley Surgery
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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 carried out a comprehensive inspection of Dr Roope and Partners, which is based at The Whiteley Surgery, Yew Tree Drive, Whiteley, Fareham, PO15 7LB on 18 December 2014.

The practice is a training practice for GPs.

Overall we rated the practice as good for safe, effective, caring, responsive and well led.

Our key findings were as follows:

- Patients were treated with dignity and respect.
- The practice were aware of concerns related to access to appointments and were working with the patient participation group to improve this.
- The practice was visibly clean and there were systems in place to maintain an appropriate standard of cleanliness and hygiene.
- GPs and nurses received appropriate training and support to deliver care and treatment.
- Suitable systems were in place to identify and protect patients at risk of harm.

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

In the provider should:

Ensure nurses participate in the governance arrangements of the practice where this affects their roles to ensure learning and improvement is effective.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Information about safety incidents was recorded, monitored, appropriately reviewed and addressed. Lessons were learnt and areas identified for action as requiring improvement were communicated, but this did not include all relevant staff members consistently. There were sufficient numbers of staff on duty to keep patients safe. Staff demonstrated understanding of their roles and responsibility to report safeguarding concerns. Appropriate recruitment checks were carried out prior to staff commencing employment.

Are services effective?

Good

The practice is rated as good for providing effective services. Patients were treated in line with best practice and current national guidance. The practice had identified areas where action was needed to make sure reviews of patients with long term conditions were carried out and had implemented arrangements to manage and to encourage patient attendance. Staff were able to receive training appropriate to their roles and further training needs were identified and planned for through the appraisal system. Patients who had complex needs, such as those at the end of life, were discussed at multidisciplinary meetings.

Are services caring?

Good

The practice is rated as good for providing caring services. We found that patients were treated with compassion and respect and their privacy was maintained. Patients said they were involved in care and treatment decisions; however a national survey showed the practice to be lower than average regarding GPs involving patients in decisions about their care and treatment. Staff were observed treating patients with dignity and respect.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Patients reported that access to the practice could improve, but they were able to be seen on the same day if their concerns were urgent. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well led. The GPs and management team were aware of the vision and values of the practice, but these had not been cascaded to all staff who worked at the practice. Nursing staff were not routinely involved in monitoring significant events and attending clinical meetings, to improve learning and best practice where this related to their roles. Meetings were held for the specific staff teams to discuss relevant concerns, but actions from these were not routinely incorporated into the overall running of the practice. There were effective day to day working arrangements within the practice, with staff having clear roles and responsibilities.

Summary of findings

The six population groups and what we found

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

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

Good

People with long term conditions
The practice is rated as good for the care of people with long-term conditions. Longer appointments and home visits were available when needed. All these patients had a named GP and were offered a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Good

Families, children and young people
The practice is rated as good for the care of families, children and young people. The practice offered vaccinations in line with national guidance. Children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw examples of joint working with midwives, health visitors and school nurses.

Good

Working age people (including those recently retired and students)
The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services and screening that reflected the needs for this age group.

Good

People whose circumstances may make them vulnerable
The practice was rated as good for people whose circumstances may make them vulnerable. The practice had patients registered with it who were part of a settled travelling community. Flexibility in appointments was offered for this group of patients and systems were in place to follow up patients who chose not to attend appointments. The practice held a register of patients living in

Good

Summary of findings

vulnerable circumstances including those with a learning disability. It had carried out annual health checks for patients with a learning disability and these patients had received a follow-up. It offered longer appointments for people with a learning disability.

People experiencing poor mental health (including people with dementia)

Good

The practice was rated as good for people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. The practice had a contract with a local care home which specialised in dementia care and undertook a weekly ward round.

Summary of findings

What people who use the service say

We spoke with 17 patients on the day of our inspection and received four comment cards for patients who have visited the practice in the two weeks prior to our inspection.

We found that the majority of patients were satisfied with the care and treatment received, but had concerns over the availability of routine GP appointments and the opportunity to see the same GP each time. Patients said they were treated with respect and their privacy and dignity was maintained. Some patients considered the service they received was excellent.

Members of the patient participation group worked with the GPs to improve the appointment system by undertaking surveys to gather patients' views.

Areas for improvement

Action the service SHOULD take to improve

Ensure nurses participate in the governance arrangements of the practice where this affects their roles to ensure learning and improvement is effective.

Dr RM Roope and Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead Inspector and included a specialist advisor GP and specialist advisor practice manager. An expert by experience was also on the team. (Experts by Experience are members of the inspection team who have received care and experienced treatments from a similar service.)

Background to Dr RM Roope and Partners

We carried out a comprehensive inspection of Dr Roope and Partners, which is based at The Whiteley Surgery, Yew Tree Drive, Whiteley, Fareham PO15 7LB, on 18 December 2014. The practice has approximately 13,200 patients registered with it.

The practice has four GP partners, two associated GPs and a GP trainee. In addition there are two nurse practitioners, four practice nurses and two health care assistants. The clinical team are supported by a business manager, practice manager, an information technology manager and a team of receptionists and administrators and a prescriptions clerk. There are four male GPs and three are female.

The practice is open between 8am and 6.30pm Monday to Friday. Routine appointments are offered between 8.30am and 1.30pm and 2pm to 6pm.Later pre booked appointments are available on Tuesday, Wednesday and Thursday evenings. Telephone consultations are available daily when the practice is open with either a nurse or GP and also same day appointments.

The CQC intelligent monitoring placed the practice in band 1. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality and Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place. Areas of risk from the intelligence monitoring included a lower than average number of patients with high blood pressure having this monitored; a lower than average number of patients with diabetes having their blood pressure monitored; and a low number of patients being identified as having chronic obstructive pulmonary disease.

Out of hours services are provided via the 111 service.

Why we carried out this inspection

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

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.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew, such as the clinical commissioning group and Healthwatch. We carried out an announced visit on 18 December 2014. During our visit we spoke with a range of staff including GPs, nurses and administration staff and spoke with patients who used the service. We reviewed comment cards where patients and members of the public shared their views and experiences of 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 whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Good

Are services safe?

Our findings

Safe track record

The practice had a system in place for reporting, recording and monitoring significant events. The practice was able to demonstrate the process for recording incidents with the practice manager and the GPs. All serious events were discussed at GP partners meetings and practice meetings. This provided senior staff with the opportunity to discuss the incident and to record any learning points. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term. Records we viewed confirmed this.

Learning and improvement from safety incidents

We review significant event records and found that the practice had identified five incidents in the previous 12 months. Twice a year GPs met to discuss all significant incidents recorded and reviewed actions that had been put into place and to ensure risk had been minimised. Records of these meetings confirmed that changes made had been monitored and learning had been shared. The practice had recognised that information was not always shared effectively and had reviewed its meetings to ensure that all staff were made aware of areas which required improvement. A nurse practitioner said that they had not attended these meetings, but this had been planned for to commence in January 2015. Meeting schedules confirmed that this was due to commence.

An example of where practice had improved related to methotrexate prescribing (this is a medicine which can cause abnormal blood results, if not monitored closely). The practice had found that blood tests were only seen by one member of staff and blood had not always been taken prior to a particular medicine, methotrexate being prescribed. As a result of an audit the practice now ensured that all relevant groups of staff were responsible for ensuring blood was taken for testing and the results were checked to ensure appropriate action was taken.

Reliable safety systems and processes including safeguarding

Patients were protected from the risk of abuse, because the practice had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. The practice had policies on safeguarding children and adults, which included information on types of abuse, and contact details of relevant agencies. There was a specific policy on domestic abuse. Where GPs were invited to safeguarding meetings with the local authority a report was sent for other members of the meeting to consider.

Staff at the practice had received training in safeguarding children and vulnerable adults at an appropriate level for their role. One of the GP partners who took the lead in safeguarding had taken part in higher level three training in the subject. Staff we spoke with were clear about their responsibilities to report any concerns they may have. Staff were able to tell us what actions they would take if they had any concerns.

The practice manager met monthly with health visitors to review children at risk and quarterly with lead GP. An alert was placed on children's notes to identify when a plan had been put into place to safeguard the child. A children's safeguarding register was maintained by the practice and we found that there was information on discussions held and action taken to safeguard children.

A chaperone policy was available in the practice. Patients were generally offered chaperones if requested, additionally, one GP said that all female patients would have a chaperone when receiving treatment from them whether one had been requested or not. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure.) Nursing staff and health care assistants acted as chaperones.

Medicines management

Nurses and the health care assistant administered vaccinations, such as for influenza, using directions that had been produced in line with legal requirements and national guidance. The practice had designated staff to manage repeat prescription requests. Protocols were followed to ensure the medicines were still relevant and necessary. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

There were suitable systems in place for managing and monitoring medicines held within the practice. Vaccines

were stored in specialist fridges and the temperatures were monitored regularly and recorded, we found that these were within safe limits of between two and five degrees centigrade.

Cleanliness and infection control

The practice had a designated infection control lead and policies and procedures were in place for staff to adhere to minimise the risk of cross infection. Liquid soap, paper towels and hand gel were available in the practice in areas such as consulting and treatment rooms. Staff said they had sufficient personal protective equipment, such as gloves and aprons to use. We observed that treatment and consulting rooms had sharps bins for used needles and syringes. The practice had a clinical waste contract in place to dispose of any contaminated items safely.

The practice was visibly clean and tidy and there were cleaning schedules in place which were monitored regularly.

The practice had a system in place for managing the risk of Legionella (a bacteria found in water supplies which can cause serious illness).

Equipment

There was sufficient equipment for staff to carry out diagnostic examinations, such as blood pressure monitors. Equipment was maintained, tested and calibrated by an external company and records viewed confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date.

The practice had a passenger lift which was checked by an external contractor in line with Lifting of Loads and Equipment regulations.

Staffing and recruitment

The practice said that they usually had a low staff turnover, but this had increased in 2014. They were reviewing the skill mix and appointing nursing staff with difference skills to be effective at monitoring care and treatment. Applications for nursing positions were in progress at the time of our inspection.

We looked at four staff files and found that information as required in the regulations was present, such as evidence of satisfactory conduct in previous employment, proof of identity and evidence of registration with the appropriate professional body, such as the Nursing and Midwifery Council. We also found that criminal records bureau checks, undertaken through the Disclosure and Barring Service (DBS) had been made for all staff. We also noted that when a staff member had changed job role a DBS check was carried out. DBS checks been carried out on all staff.

Locum GPs employed by the practice had appropriate checks carried out prior to working at the practice. These included a check on the performer's list. The practice said that if they employed a locum GP on a long term basis then they would seek evidence of satisfactory conduct in previous employment by sending their own references. This information was gathered in addition to information supplied by the locum agency used.

Monitoring safety and responding to risk

Records confirmed that a number of risk assessments had been carried out. These included fire safety, health and safety and water quality (Legionella). Fire risk assessments were carried out annually and the latest assessments showed that there were no improvements needed.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records and staff confirmed that they had received basic life support training. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a patient's heart in an emergency). Staff were able to tell us where this equipment was located and how to use it, records confirmed that the equipment was checked regularly.

The practice computer system had an urgent assistance alarm, which could be used if needed.

Emergency medicines were held securely in the practice and all staff knew where this was. The medicines included those used for the treatment of cardiac arrest, abnormal heart rhythms and low blood sugar levels. Processes were in place to check whether emergency medicines were within their expiry date and suitable for us. All the medicines we checked were in date and fit for use.

Emergency appointments were available each day both within the practice and for home visits. Information for patients about how to access out of hours and urgent

Good

Are services safe?

treatment was provided in the practice, on the practice website and through their telephone system. The patients we spoke with told us they were able to access urgent treatment if it was required.

The practice had an emergency plan in place which detailed staff responsibilities should an incident occur, for example a power failure. There were details of emergency contacts for power supplies in the event of a power failure. Procedures were also in place to 'back up' the computer server system to ensure information was not lost in the event of a power failure.

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, and accessed guidelines from the National Institute for Health and Care Excellence and from local commissioners. Information was discussed at practice meetings and current guidance was disseminated to staff. For example, changes in guidance for treating atrial fibrillation (an abnormal heartbeat) recommended that patients were treated with warfarin (a blood thinning medicine, which helps to stop blood clots forming). One nurse was a specialist in respiratory (breathing) medicines and had educated GPs on best practice. This nurse was responsible for monitoring all patients with a respiratory condition annually. Similarly patients who had a long term condition were offered a structured annual review, for example diabetic checks to make sure they were managing their condition effectively.

The prescribing locality lead for the clinical commissioning group cascaded information via email to the practice. This was reviewed by the practice manager who ensured relevant members of staff received up to date information on best practice in prescribing.

One of the GPs who we spoke with was aware of the need to maintain their skills and keep up to date with current guidance, as they were also a GP trainer for the practice. They said they had attended a GP update course for this role. Locum GPs who worked at the practice were able to access a specific 'pack' of information on current practice.

Patients who were taking statins (a medicine to reduce blood cholesterol levels) and were 90 years of age or older had an alert on the computer systems to highlight this, so GPs could check whether this treatment needed to be continued.

Care plans for patients who were vulnerable, such as those with dementia were in place and the practice had liaised with other health professionals when needed. The practice undertook weekly ward rounds at a local care home which specialised in dementia care. GPs said that they carried out opportunistic memory checks when patients attended appointments and were able to refer those who had a poor memory to the local memory clinic.

Training for the care and treatment of patients with learning disabilities was taking place on the day of our inspection. Patients with this condition were offered annual health checks. Other health checks offered included those for patients aged over 75 years.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, managing child protection alerts and medicines management.

The practice has a system in place for completing clinical audit cycles. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool.

We looked at examples of audits with the full cycle of standard-setting, first cycle audit, a discussion with peers, agreeing changes, implementing them and then re-auditing to see whether it has made a difference or not. There was evidence of reflection at the end of the full cycle, regardless of whether the desired change was achieved not. An example seen was audits of patients' referrals to hospital were monitored to determine whether they were relevant and necessary.

The GP responsible for managing QOF performance said that they reviewed performance throughout the year and any weaknesses were addressed. An example given was treatment of hypertension. Figures showed a shortfall in following up patients with this condition for the period ending December 2014. The practice had put into place a system to recall patients via text or telephone them to come to the practice for a review. The practice was aware of another area concerned with the health reviews on patients with diabetes. The practice said they had had a low take up when patients were recalled for their annual review, but they were continuing to offer these patients a review and be flexible with appointment times.

In response to low prevalence of COPD (chronic obstructive pulmonary disease) compared to the expected prevalence the practice initiated hand held spirometry screening at

Good

Are services effective?

(for example, treatment is effective)

patients NHS checks to identify whether they had COPD. (Spirometry screening is a process whereby a patients breathing is measured prior to and after nebulisers are given to open airways).

The practice said they had piloted a letter for patients who chose not to participate in bowel screening for cancer, with the aim of increasing the number of patients tested. This had been shared with other GP practice across the clinical commissioning group area and implemented.

The IT lead responsible for QOF management had a system in place to recall patients for checks, which comprised of three letters being sent to patients, and then exempting the patient from the data set, if there was no response. Patients were able to indicate they did not wish to participate in the review.

GPs had a system in place of peer review referrals to hospitals on a monthly basis; this involved checking each other's referrals to secondary care, to see whether they had been appropriately carried out.

Patients who had received end of life care had their treatment reviewed to determine whether their support and care could have been improved and whether their place of death had been their preference. All patients who had a diagnosis of cancer were reviewed to ensure treatment and care was effective. Pregnant women, who were at risk of pre-eclampsia, were monitored closely throughout their pregnancy at intervals, such as having blood pressure readings every three days, with weekly blood tests, in accordance with their needs. (Pre-eclampsia is a complication of pregnancy in which a woman's blood pressure becomes elevated and requires monitoring and in some cases early delivery of the baby).

Patients who were experiencing poor mental health, including those with dementia had care plans in place to describe what treatment and support they needed. Some of the patients with dementia lived in a local care home, which specialised in this type of care and the practice undertook weekly routine visits, as part of a contract with the home.

GPs undertook minor surgical procedures in line with their registration and NICE guidance. Staff were appropriately trained and kept up to date. The practice regularly carried out clinical audits on minor surgical procedures undertaken and used them in their learning.

Effective staffing

The practice had a designated member of staff responsible for managing staff rotas and absences, such as annual leave and sickness. There was a GP rota in place until the end of March 2015 and were told that if needed, for example if a GP was off sick, then another GP would cover. A member of staff said that if locum GPs were used, the practice tried whenever possible to use the same locum for continuity of care.

A nurse practitioner told us they were responsible for managing some patients with minor illnesses. However, pregnant women and children under one year old were always seen by a GP.

The reception manager carried out induction for new staff which included a tour of the premises and health and safety instructions. The reception manager also coordinated shadowing opportunities for new recruits to enable them to learn about all job roles at the practice.

GPs said that information on education and learning was shared at practice meetings on Friday afternoons and that visiting hospital consultants would on occasion attend to provide education.

Working with colleagues and other services

The local midwifery team managed antenatal care for pregnant women. GPs said that when midwives were on annual leave they would provide antenatal care. The practice also worked with the community team, interim care manager and community matron to meet the needs of older patients.

The practice worked with other service providers to meet patient's care needs. Blood results, X-ray results, letters from the local hospital including discharge summaries, out of hour's providers and other services were received both electronically and by post.

The practice shared key information with the Out of Hours (OOH) service about patients nearing the end of their lives, particularly information in relation to decisions that had been made about resuscitation in a medical emergency. Likewise, patient treatment information gathered by the OOH service was shared with the practice the following morning.

Good

Are services effective?

(for example, treatment is effective)

Patient information was stored on the practice's electronic record system which was held on practice computers that were all password protected. This information was only accessible to appropriate staff.

There was a monthly meeting with district nurses and health visitors to carry out care reviews. The practice held a register of patients who were carers or being cared for by other people.

Information sharing

The practice had a computer system where all records related to patients were stored. This included scanned documents from hospitals, such as discharge summaries and care plans. The documents were also forwarded on to the most appropriate GP or nurse to deal with. The practice had recognised that use of locum GPs could result in information not being shared effectively and had put a 'buddy' system into place to manage this. For example, blood test results and urgent letters were dealt with by either the locum GP or their buddy to maintain continuity of care.

Consent to care and treatment

The practice had suitable arrangements in place to protect patients' confidentiality. Staff were aware of Gillick competence when asked about treating teenage patients. (Gillick competence is a term used in law to determine whether a patient aged under 16 is able to consent to their medical treatment, without the need for parental permission or knowledge).

The staff were aware of the best interest decision process and were able to give examples of when this process would be used. One nurse practitioner had completed training on the Mental Capacity Act 2005 in their previous employment and demonstrated effective knowledge of how to assess a patient's capacity to make a decision.

Health promotion and prevention

The practice mainly used leaflets and information links on its website to promote health and keeping well. GPs told us they routinely accessed relevant leaflets for patients to read, such as those for high blood pressure, but did not consistently discuss ways of self-management of health conditions with patients. We found practice website had links to information on other websites, such as NHS choices. Routine health checks for patients over the age of 40 years were offered in line with national guidance.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We were able to talk with 17 patients during our inspection that included members of the patient participation group. All considered they were treated with dignity and respect. Some commented that reception staff were helpful.

The most recent NHS England GP patient survey showed that the practice was below average in comparison to other nationally, in GPs treating patients with care or concern. However, patients we spoke with on the day of our inspection did not express any concerns about the care and treatment they received.

We received four comments cards which were completed by patients in the two weeks prior to our inspection. All respondents stated that they were satisfied with the care and treatment, with some commenting that it was excellent.

Care planning and involvement in decisions about care and treatment

The most recent NHS GP patient survey data showed that the practice was just below average in comparison to other nationally, regarding GPs involving patients in decisions about their care and treatment. However, patients told us that they were fully involved with the decision making process when they saw a GP. Comments received on our comment cards showed that respondents were involved in decision making. Two comments specifically mentioned the time GPs had taken to explain treatment options in detail.

One patient said that following a consultation with a nurse for a routine they changed aspects of their lifestyle as they had been given information in a clear and direct way, which outlined the risks of not making changes. Another patient commented that the GP they usually saw was direct and straightforward which they appreciated.

Patient/carer support to cope emotionally with care and treatment

The practice said that they contacted bereaved families to offer support. For patients who had care plans in place, such as those with long term conditions, practice nurses had time allocated to carry out a quarterly monitoring telephone call with patients to review their care and treatment. The practice held a register of patients who were cared for or had caring responsibilities.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, if a patient was a carer or care for an alert was placed on their medical record in order that GPs and nurses were aware of their social situation.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). This mainly concerned appointments times and availability. The PPG had gathered views of patients on the appointments system and had worked with the practice to improve access. For example, the practice user to operate a triage system, but this had been changed to open clinics with specific hourly time slots for on the day face to face appointments if needed.

Tackling inequity and promoting equality

The practice had access to online and telephone translation services for patients whose first language was not English. The main areas of the practice website were able to be translated into other languages and the size of the print magnified if needed.

The practice was fully accessible to the disabled, and all the patient areas including the waiting room, consulting rooms and toilets had wheelchair access. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

The practice had patients registered with it who were part of a settled travelling community. Flexibility in appointments was offered for this group of patients and systems were in place to follow up patients who chose not to attend appointments.

Access to the service

Patients were able to book routine appointments up to four to six weeks ahead dependant on when the appointments were released. One GP had identified a weakness in this system whereby some patients who required a routine appointment following a consultation with one of the health care assistants were unable to book a routine appointment at a suitable time. The GP had advised the health care assistant to contact them and discuss treatment options when the patient was with them, to avoid a delay in treatment.

Patients commented that it was difficult to book a routine appointment if they needed a specific time in order that tests results could be reviewed, as the routine appointments were often fully booked. Patients said that there were difficulties in obtaining a routine appointment with the same GP for continuity of care. However, if a patient required an urgent same day appointment this was facilitated. All same day appointments were booked onto a duty screen on the computer system and worked through by a duty GP and a nurse.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England. The practice manager was responsible for managing complaints. Information on how to make a complaint was displayed in the practice and on its website. We reviewed a selection of complaints the practice had received. These had been investigated and resolved as far as possible to the complainant's satisfaction.

A recurring theme was the appointment system and the practice were working with the PPG to monitor and improve access to the service. These concerns were on going due to the closure of the branch practice a couple of years ago. GPs said social media sites had been used in the past twelve months to a detrimental effect. They had offered opportunities for these patients to meet with them to discuss a way forward, but this had limited take up. GPs considered that complaints could be linked to patient expectations and lack of awareness of what services the practices provided. They recognised that patient education was important and were working with the PPG) to provide information on how practice operated.

The practice had experienced complainants addressing their concerns to other agencies rather than approaching the practice in the first instance to seek resolution. The practice felt this had a negative impact on the time the practice were able to respond to concerns and they

Good

Are services responsive to people's needs?

(for example, to feedback?)

considered that some concerns could have been addressed more speedily had complaints approached the practice first. We found that NHS choices had negative comments displayed, but the practice were unable at the time of inspection to respond, as they had sent a moderation email message to the website.

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 GPs said that they aimed to continually improve and be innovative at all times and considered there was a collaborative leadership style with staff members. Other staff felt they were supported both in terms of clinical skill and managing their daily work; however, they were not fully aware of the overarching vision and strategies of the practice. One GP considered the whole staff team were like a family and they valued the team structure. GPs were aware that at times nursing staff were disengaged from the running of the practice, by not being involved in relevant meetings, but were working to rectify this.

Governance arrangements

We saw good day to day working relationships amongst staff and an ethos of team working. Partner GPs and the practice nurses had areas of responsibility, such as, prescribing or safeguarding it was clear who had responsibility for making specific decisions and monitoring the effectiveness of specific areas of clinical practice.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed improvements were needed in some areas such as blood pressure control in diabetics and prevalence of chronic obstructive pulmonary disease (a condition which causes breathlessness). We saw that QOF data was regularly discussed at governance meetings and action plans were produced to maintain or improve outcomes.

The practice had suitable systems in place to maintain confidentiality and all confidential paper waste was shredded prior to disposal. Staff said they would lock their computers when they left consulting rooms and would lock the doors. Care was also taken not to discuss patient care or treatment in communal areas, such as the reception.

There were suitable systems in place to manage risks associated with health and safety. For example, a fire risk assessment and risk assessments for moving and handling. These were reviewed and changes made when needed to minimise risk.

Leadership, openness and transparency

We were shown a clear leadership structure which had members of staff in lead roles. For example, a GP partner was the lead for safeguarding. We spoke with ten members of staff and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns, but would appreciate more opportunities to be involved with the overall running of the practice. Nurses reported that they were not regularly involved in clinical meetings and only attended significant events meetings if they were involved in the concern.

GPs said that at present salaried GPs did not attend partners meetings, but were welcome to attend and they were invited to an away day. The practice manager encouraged GPs to take their lunch breaks in the staff room to promote staff interaction; we saw this occurred on the day of inspection.

The GP partners met regularly with the business manager and practice manager to discuss planning for the future, in terms of staff numbers, skill mix and services offered.

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

The practice had gathered feedback from patients through: patient surveys, comment cards and complaints received. The practice had an active patient participation group (PPG) which met quarterly. The practice worked with them to help improve the care services, such as monitoring and improving the appointment system. All the patients we spoke with and the comment cards patients had completed were complimentary about practice and the service they had received. Patients told us that they felt listened to and involved in the decisions about their care and treatment.

The practice held a number of meetings for staff, for example, senior manager's meetings and cascaded information from these meetings to other staff. They acknowledged that improvements could be made as staff did not consider they had sufficient opportunities to provide feedback.

Management lead through learning and improvement

The practice undertook and participated in a number of regular audits. We saw that incidents were reported promptly and analysed. We noted examples of learning from incidents and audits, and noted that where applicable practices and protocols had been amended accordingly. Findings were shared with selected staff.

Are services well-led?

Good

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

Each staff member had an annual appraisal to monitor performance and identify further learning needs. We looked at four appraisal records and found there was information about learning needs and plans were in place for the staff member to achieve their learning goals. Practice nurses said that the nurse practitioner who managed them was approachable and facilitated further learning, when asked for or required. They added that some of the GPs would conduct mini training sessions, for example management of patients with headaches and head injury.

Regular meetings were held for staff groups and covered issues relevant to their team. For example, receptionists had meetings and as a result of one of these meetings, customer care training was organised for reception staff, as this had been identified and needing improvement.

The GPs meet monthly to discuss clinical care and on occasion health visitors and other health professionals attended, to share learning and best practice.

GPs said the duty team would meet opportunistically and involved reception staff, nurse practitioners and GPs to review how systems were working and identify what was going well and what might need improving.