

Dr IR Serrell's Practice

Quality Report

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Date of inspection visit: 7 October 2014
Date of publication: 16/04/2015

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We inspected this service on 7 October 2014 as part of our new comprehensive inspection programme. The overall rating for this service is good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. We found the practice provided good care to older people, people with long term conditions and people in vulnerable circumstances. They provided good care to families, children and young people, working age people and people experiencing poor mental health.

Our key findings were as follows:

- Patients were kept safe because there were arrangements in place for staff to report and learn from key safety risks. The practice had a system in place for reporting, recording and monitoring significant events over time.
- The practice responded to the recent practice survey carried out by the Patient Participation Group (PPG) and as a result had implemented suggestions for improvements and made changes to the way it

delivered services in response to feedback from them. These were to: update leaflets/patient brochures, update Wheatbridge PPG website (WPPG), update the practice website and add a list of Pharmacists to WPPG website.

- There were systems in place to keep patients safe from the risk and spread of infection. Systems were in place to monitor and make any required improvements.
- Evidence we reviewed demonstrated that the majority of patients were satisfied with how they were treated and that this was with compassion, dignity and respect. It demonstrated that the GPs were good at listening to patients and gave them enough time.

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

The provider should:

- Display appropriate warning sign on rooms containing oxygen.

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?

The practice is rated as good for providing safe services.

Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients.

Good



Are services effective?

The practice is rated as good for providing effective services.

Staff referred to guidance from NICE (National Institute for Health and Care Excellence) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and planned. The practice could identify all appraisals and the personal development plans for all staff. Staff worked with multidisciplinary teams.

Good



Are services caring?

The practice is rated as good for providing caring services.

Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We saw that staff treated patients with kindness and respect, and maintained confidentiality.

We found the practice provided good care to older people, people with long term conditions and people in vulnerable circumstances. They provided good care to families, children and young people, working age people and people experiencing poor mental health.

Good



Are services responsive to people's needs?

GOOD

The practice is rated as good for providing responsive services.

Good



Summary of findings

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

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

Are services well-led?

The practice is rated as good for being well-led.

It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Good



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.

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

Visits were made to two care homes providing specialist care for older people living with mental health problems by means of proactive ward rounds. Those visits were done on a weekly basis on Tuesdays, by a named GP and to those patients who needed one.

Good



People with long term conditions

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

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

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Practice nurses with extended roles such as those seeing patients with long-term conditions like asthma, COPD, diabetes and coronary heart disease were able to demonstrate that they had appropriate training to fulfil these roles.

Good



Families, children and young people

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

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all

Good



Summary of findings

standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

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 as well as a full range of health promotion and screening that reflects the needs for this age group.

Good



People whose circumstances may make them vulnerable

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

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

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

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

Good



Summary of findings

100% of people experiencing poor mental health had received an annual physical health check. 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.

Visits were made to two care homes providing specialist care for older people living with mental health problems by means of proactive ward rounds that were done on a weekly basis by a named GP and to those patients who needed one.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE both of which are national charitable mental health support agencies. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with 19 patients in the reception and waiting areas of the practice including patients from a number of different practice population groups.

The majority of the patients we spoke with were very happy with the service they received. They told us that the GPs and the nurses were caring, patient, kind and treated them with respect. Some patients however were unhappy with the long waiting time for an appointment.

Patients had completed CQC comment cards to tell us what they thought about the practice. We received 34 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Five comments were less positive but there were no common themes to these.

In the latest National GP patient survey results on this practice 264 surveys were sent out and 119 were returned, of those 96% of respondents said the last GP they saw or spoke to was good at listening to them, 94% of respondents said the last GP they saw or spoke to was good at treating them with care and concern and 93% of respondents said the last GP they saw or spoke to was good at giving them enough time. These results were all above the CCG average. However only 52% of respondents with a preferred GP said they usually got to see or speak to that GP and only 66% of respondents described their experience of making an appointment as good. 68% of respondents said they found it easy to get through to the practice by phone. These results were all below the CCG average.

Areas for improvement

Action the service **SHOULD** take to improve

Display appropriate warning sign on rooms containing oxygen

Dr IR Serrell's Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP and an Expert by Experience. (Experts by Experience are people who have experience of using care services).

Background to Dr IR Serrell's Practice

Dr IR Serrell's Practice delivers primary care under a Personal Medical Services (PMS) contract with NHS England.

They are responsible for a patient population of 15,678 within Chesterfield and surrounding villages. Nearly 18% of the practice population are over the age of 65. The largest population group the practice serves are between the ages of 17 and 65.

There are five partner GPs (three male and two female) and six salaried GPs (four female and two male) who provide 76 sessions between Monday and Friday. There is an all-female nursing team consisting of a nurse manager, seven practice nurses, one health care assistant and a phlebotomist.

The doctors are able to carry out a number of minor surgery procedures.

The practice provides a number of clinics including family planning, cervical smears, antenatal, postnatal, children's immunisations and child health surveillance. Along with

these they also included travel and yellow fever vaccinations, well person checks, over 75's, flu and pneumococcal vaccinations, blood pressure, hypertension, asthma and more complex chronic disease management.

The practice is open from 7am - 8pm on Mondays and from 7am - 6:30pm Tuesday to Fridays. The clinical sessions of individual doctors and nurses vary within these hours.

The practice GPs do not provide an out-of-hours service to their own patients and patients are signposted to the local out-of-hours service when the practice is closed at the weekends. This service is provided by Derbyshire Health United.

The practice is located in a purpose built medical centre constructed in 2008 over two floors. The premises are shared with local community services such as physiotherapists, district nurses, health visitors and midwives. This enables easier access to those services for the practice's patients in most circumstances and facilitates communication about patients.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. We carried out the inspection under Section 60 of the Health and Social Care Act as part of our regulatory functions. 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.

This practice had not been inspected before and that was why they were included as part of the North Derbyshire Clinical Commissioning Group.

Detailed findings

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

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?
- Is it well-led?

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

- 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)

Before our inspection we reviewed a range of information we held about the practice and asked other organisations to share what they knew. We asked North Derbyshire clinical commissioning group (CCG) and the local Healthwatch to tell us what they knew about the practice and the service provided. We reviewed some policies and procedures and other information received from the practice prior to the inspection. The information reviewed did not highlight any areas of risk.

We carried out an announced inspection on 7 October 2014. During our inspection we spoke with all the staff available on the day. This included two of the GP partners, two nurses, a visiting physiotherapist, the practice manager, four administration staff and two members of reception. We spoke with 19 patients who used the service and one member of the patient participation group. We reviewed comments from 34 CQC comments cards which had been completed. We observed interaction between staff and patients in the waiting room.

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last five years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held monthly to review actions significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system they used to manage and monitor incidents. We tracked three incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked

members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

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

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

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

There was a chaperone policy, which was visible on the waiting room noticeboard however these were missing in consulting rooms. All nursing staff, including health care assistants, had been trained to be a chaperone if nursing staff were not available to act as a chaperone.

Medicines management

There were policies in place to govern the management of medicines.

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

Are services safe?

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

The nurses and the health care assistant administered vaccines using directions which had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines. Prescribing was carried out by appropriately qualified clinical staff who received regular supervision and support in their role.

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.

The practice did not hold stocks of controlled drugs.

Cleanliness and infection control

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

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits for each of the last three years and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

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

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

The practice had a policy for the management, testing and investigation of legionella (bacteria found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

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

Staffing and recruitment

Records we looked at contained evidence to demonstrate that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty.

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

Monitoring safety and responding to risk

Are services safe?

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. However there was no warning notice displayed outside the room that contained the oxygen to alert staff, patients and fire and rescue teams to its location and potential risks in the event of fire.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis (a serious allergic reaction that is rapid in onset and may cause death) and hypoglycaemia (a medical emergency that involves an abnormally low content of glucose in the blood).

Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use except for the case of Atropine which was two months out of date. Injections of atropine are used in the treatment of bradycardia (an extremely low heart rate). On pointing this out the practice immediately removed the Atropine and replaced it with one that was within its expiry date.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document contained relevant contact details for staff to refer to. For example, in the case of loss of electricity supply contact details of NHS Estates including telephone numbers.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Risks associated with service and staffing changes were included on the practice risk log. For example planning and training sessions were implemented and reviewed during appraisals. Key monthly dates were held in the practice calendar to which all staff had access. Practice insurance provided payment for the absence of key personnel.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support.

The practice had completed a review of case notes for patients with high blood pressure which showed they were all receiving treatment and regular review. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed by their GP according to need.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients with suspected cancers who were referred and seen within two weeks. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and saw that improvements to practice were shared with all clinical staff.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

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

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. For example, we saw an audit regarding the management of patients with acne (a long term skin condition). Following the audit, it was noted that the recording of the severity of the condition was poor with this being present in only 75% of notes. Following the audit we saw evidence which demonstrated the GPs recorded this in 100% of cases.

GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice used the information collected for QOF and performance against national screening programmes to monitor outcomes for patients. For example, 97.5% of patients with diabetes had received an annual medicines review, and the practice met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease). This practice was not an outlier (a GP practice being an outlier means that it is performing significantly better or worse than the standards expected of it) for any QOF (or other national) clinical targets.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke told us they reflected on the outcomes being achieved for patients and areas where this could be improved as a group. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

Are services effective?

(for example, treatment is effective)

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used.

The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had achieved and implemented the GSF gold standards framework for end of life care (GSF is about giving the right person the right care, in the right place at the right time, every time). It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of such patients and their families.

The practice participated in local benchmarking schemes run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses developed by the practice such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant

courses, for example in children and vulnerable adult safeguarding. As the practice was a training practice, doctors who were training to be qualified as GPs had access to a senior GP throughout the day for support.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles such as those seeing patients with long-term conditions like asthma, COPD, diabetes and coronary heart disease were able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries that were not followed up appropriately.

The practice held multidisciplinary team meetings every eight weeks to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

The practice used a "buddy" system whereby GPs were paired up to ensure all clinical letters/results were medically screened and actioned in the event of them being absent.

The practice shared premises with other services provided by a number of organisations including; sexual health

Are services effective?

(for example, treatment is effective)

services, special care dental surgery, pharmacist, The Alzheimer's Society and deaf and hearing support. This meant that patients could be signposted to these services if appropriate.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner.

Electronic systems were in place for making referrals, and the practice made 3807 referrals last year through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. One GP showed us how straightforward this task was using the electronic patient record system, and highlighted the importance of this communication with A&E. The practice has signed up to the electronic Summary Care Record and this was fully operational. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record called the Egton Medical Information Systems (EMIS) to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

Staff were aware of the legislation regarding the consent to care and treatment and were able to describe how they implemented this in their practice. The practice had drawn up a policy to help staff, by providing specific scenarios

where patients may lack capacity to consent. For example in making do not attempt cardio-pulmonary resuscitation orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

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

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant / practice nurse. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing.

The practice offered NHS Health Checks to all its patients aged 40-75.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients (49) with a learning disability. Practice records showed all had received a health check up

Are services effective?

(for example, treatment is effective)

in the last 12 months. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 84.2%, which was better than others in the CCG area. There was a policy to offer telephone reminders for patients who

did not attend for cervical smears and the practice audited patients who do not attend annually. There was a named nurse responsible for following up patients who did not attend screening.

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

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey, a survey of 140 patients undertaken by the practice's patient participation group (PPG) and patient satisfaction questionnaires sent out to patients by each of the practice's partners. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect.

For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was above average for its satisfaction scores on consultations with doctors and nurses with 87% of practice respondents saying the GP was good at listening to them and 86% saying the GP gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 34 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Five comments were less positive but there were no common themes to these.

We spoke with 19 patients in the reception and waiting areas of the practice including patients from a number of different practice population groups. The majority of the patients we spoke with were very happy with the service they received. All of the patients we spoke with told us that the GPs and the nurses were caring, patient, kind and treated them with respect. Some patients told us they were unhappy with the long waiting time for an appointment.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk in a separate office and therefore keeping patient information private. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected; they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff. We were shown an example of a report on a recent incident that showed the actions taken had been robust. There was evidence of learning taking place as staff meeting minutes showed this has been discussed.

The practice liaised with other appropriate agencies and signposted patients via the website, leaflets or advertisements on the screens in the waiting room.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 74% of practice respondents said the GP involved them in care decisions which was slightly lower than the CCG as a whole but slightly better than the national average and 81% felt the GP was good at explaining treatment and results, again this was slightly lower than the CCG as a whole but slightly better than the national average.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment

Are services caring?

they received. They told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was positive and aligned with these views.

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

Patient/carer support to cope emotionally with care and treatment

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

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The NHS Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

The GPs attended meetings of the patient participation group (PPG) and as a result had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from them.

These were to: update leaflets/patient brochures, update Wheatbridge PPG website (WPPG), update the practice website and add a list of Pharmacists to WPPG website.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. This included services for the vulnerable housebound, those with a learning disability, patients with mental health issues and the practice provided links to the Derbyshire Carers Association for carers of vulnerable patients.

The practice had access to online and telephone translation services.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed they had completed the equality and diversity training in the last 12 months and that issues regarding equality and diversity were regularly discussed at staff appraisals and team events.

The practice was situated on the first and second floors of the building with most services for patients on the first floor. There was lift access to the first and second floors. The practice had provided turning circles in the wide corridors for patients with mobility scooters. This made movement around the practice easier and helped to maintain patients' independence.

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 majority of patients within practice were English speaking though it could cater for other different languages through translation services.

Access to the service

Appointments were available from 7am to 8pm on Mondays and from 7am to 6:30pm Tuesday to Friday. The clinical sessions of individual doctors and nurses varied within these hours. While the practice was open from 7am, patients could not contact the practice by phone until 8am. The practice offered additional pre-bookable appointments Monday to Friday from 7am to 8am and on Mondays only from 6:30pm to 8pm.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring for support. Information on the out-of-hours service was provided to patients.

Longer appointments were available for patients who needed them and those with long-term conditions. This included appointments with a named GP or nurse. Visits were made to two care homes providing specialist care for older people living with mental health problems by means of proactive ward rounds that were done on a weekly basis on a Tuesdays, by a named GP and to those patients who needed one. The practice provided a service to a centre for people with a learning disability with inpatient facilities and they carried out daily visits.

The practice operated directly bookable appointments by the GPs to monitor patients. This controlled access for routine care patients, saved blocking same day/routine appointments and improved continuity of care.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice.

Are services responsive to people's needs?

(for example, to feedback?)

Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. In the latest patient survey results on this practice 264 surveys were sent out and 119 were returned, of those 92% said the last appointment they got was convenient, 85% described their overall experience of this surgery as good and 69% usually waited 15 minutes or less after their appointment time to be seen. These results were in line with the CCG and slightly better than national results. However only 52% of respondents with a preferred GP said they usually got to see or speak to that GP and only 66% of respondents described their experience of making an appointment as good. 68% of respondents said they found it easy to get through to the practice by phone. These results were all below the CCG average.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system with posters displayed in the reception and waiting areas. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at 38 complaints received in the last 12 months which showed that concerns had been

acknowledged, investigated and responded to in line with the practice's policy. Complaints received were reviewed to identify any patterns, and to ensure they had been responded to in a timely way.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on.

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 practice had a clear vision to deliver high quality care and promote good outcomes for patients.

All staff we interviewed or observed exhibited behaviours and attitudes that illustrated a caring, compassionate nature towards patients.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at 10 of these policies and procedures and most staff had completed a cover sheet to confirm that they had read the policy and when. All 10 policies and procedures we looked at had been reviewed annually and were up to date.

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

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

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example an audited pathology blood tests ordered from 2012 to 2013, a C Difficile audit in January 2014 and a Winter Pressures audit 2013/14.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues, such as an assessment of legionella risk at the practice. We saw that the risk log was regularly

discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

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

Leadership, openness and transparency

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

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

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys and complaints received. We looked at the results of the annual patient survey and patients agreed telephone consultations would be useful. 12% of the 140 surveyed in 2013 said they were not able to receive telephone calls when the practice was open. A further 25% said it was inconvenient for them to do so. As a result of this survey arrangements were made to use some of the extended hour times between 7am and 8am each day and 6:30 – 8:00 pm on Monday evenings for telephone consultations.

The practice had an active patient participation group (PPG) which has steadily increased in size. The PPG had carried out annual surveys and met every quarter. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the PPG website.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any

Are services well-led?

Good 

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

concerns or issues with colleagues and management. One member of staff told us that they had asked for specific training around chaperoning at the staff away day and this had happened. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

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

Management lead through learning and improvement

Performance data was regularly reviewed, reported, disseminated and used as a basis to change or develop services. For example housebound patients were now visited and monitored for long term conditions by practice nurses and/or GPs.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training.

The practice was a GP training practice. (A GP Registrar or GP trainee is a qualified doctor

who is training to become a GP through a period of working and training in a practice).

We saw that Registrars were allocated between 10 and 20 minutes to consult with patients. The practice manager told us that they were initially closely supervised by a GP until they had demonstrated their competence. Before they qualify as GPs, they will have had to undertake further examinations and demonstrate to the practice that they are able to practice to an excellent standard.

Patients had the right to decline in helping with assessment & training.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients.