Dr Isaacs & Partners

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This was a comprehensive inspection of the Dr Isaacs & Partners, which is also known as Jenner House Surgery and was carried out on 15 October 2014. At the time of the inspection the registered manager had retired and the practice was identifying a new manager to register with the Care Quality Commission. Overall, we found the practice was providing a good service. We found good practice in the way the practice responded to the needs of older patients', children and families, and patients with long term conditions, providing them with effective care and treatment. The practice had responded to some of the needs of working patients and those patients who had problems accessing GP services.

Our key findings were as follows:

- Patients found the practice accessible with a recently reviewed and changed appointments system.
- The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs.
- Patients were complimentary about the care and support they received from staff.
- Staff told us they were committed to providing a service that put patients first.

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

Importantly, the provider must:

- The practice should ensure they have evidence of written references to satisfy themselves of the suitability of locum GPs to work with vulnerable adults and children.

In addition the provider should:

- The practice should ensure patients who use wheelchairs can access a toilet facility.
- The practice should make sure they act on the findings of their infection control audit to ensure patients are cared for in a hygienic environment.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

The practice is rated as requires improvement for safe. This is because improvement is needed for the recruitment records of locum GPs.

The safeguarding arrangements for children showed the practice had taken a proactive approach to ensure that children at risk and children who may be at risk of harm were known about and safeguarded.

Staff understood and fulfilled their responsibilities to raise concerns, and 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 people safe.

Are services effective?

Good 

The practice is rated as good for effective.

Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence guidance was referenced and used routinely.

Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health.

Staff had received training appropriate to their roles and further training needs had been identified and planned.

The practice could identify all appraisals and the personal development plans for all staff. Multidisciplinary working was evidenced.

Are services caring?

Good 

The practice is rated as good for caring.

Data showed patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions.

Summary of findings

We observed a patient centred culture and found strong evidence that staff were motivated and inspired to offer compassionate care and worked to overcome obstacles to achieving this. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team and clinical commissioning group to secure service improvements where these were identified.

Patients reported good access to the practice and a named GP and 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.

There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for well-led.

Staff were clear about the aims of the practice to provide high quality compassionate care 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 regular governance meeting had taken place. There were systems in place to monitor and improve quality and identify risk.

The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group.

Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst 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 by operating a personalised GP patient list, and by ensuring that patients over the age of 75 saw their own GP wherever possible.

The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs.

The practice had systems in place to ensure patients end of life care and treatment wishes were known and respected. All the GPs we spoke with told us about how they supported patients, and how they shared information within the practice. Essential information was shared with external agencies to ensure patient's end of life wishes were known and adhered to.

We reviewed the practice's policies and procedures on safeguarding vulnerable adults. We found there were appropriate systems in place to respond to any concerns relating to older patients. GPs described situations where they had reported a concern to the lead safeguarding agency and told us about how this had safeguarded vulnerable adults.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions.

Emergency processes were in place for patients in this group that had a sudden deterioration in health and required referrals.

When needed longer appointments and home visits were available. All these patients had a named GP and structured annual reviews to check their health and medication needs were being met.

Summary of findings

For those people with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people The practice approached safeguarding arrangements for children to ensure that children at risk and children who may be at risk of harm were known about and safeguarded. In addition, regular meetings were held to discuss relevant children and families with the health visitor and the GPs were fully involved with child protection planning and meetings.

The practice also met the needs of families, children and young people by having specific services to meet these needs. The practice actively sought to meet childhood immunisation targets and followed up on the health of babies through post-natal checks.

The appointment system ensured young children were seen on the same day as they presented.

The practice had safeguarding children policies and procedures in place. We found there were appropriate systems in place to respond to any concerns. The practice nurses regularly met with the health visitors to ensure they offered the care and treatment families with babies and young children needed.

The practice had a range of child health clinics and these were promoted by posters and through the practices website. In addition, families, babies, children and young people had a named GP to promote the continuity of their care.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the working-age people (including those recently retired and students).

The practice had a high population of patients who were either working age or recently retired but the services available did not fully reflect the needs of this group. Although the practice offered extended opening hours for appointments during Monday to Friday, there was no online appointment booking or on-line repeat prescribing system in place, although patients could request repeat prescriptions by post, email, fax or in person.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good however there are aspects that require improvement for the population group of people whose circumstances may make them vulnerable.

The practice had a significant number of patients whose first language was not English. The practice told us they relied on patients attending appointments with family members who could act as interpreters. There was limited written information available for these patients in an alternative language.

The practice held a register of patients living in vulnerable circumstances including those with learning disabilities. The practice had carried out annual health checks for people with learning disabilities, and these patients had a nominated GP to ensure they received continuity of care from a GP they knew and felt comfortable with. However there was no information available for these patients in an accessible format such as easy read or pictorial formats.

The practice worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and voluntary organisations. Patients without a permanent address could register using the practice address and staff told us that vulnerable patients could be seen on the same day as registering if their need was urgent.

Staff knew how to recognise signs of abuse in vulnerable adults and children and were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and when the practice was closed.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of 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. The practice had in place advance care planning for patients with dementia.

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

Summary of findings

The system of personalised GP lists enabled patients who were experiencing poor mental health to receive continuity of care and build up a relationship with their named GP. GPs told us about how they sign-posted patients to community services, including a local drop in café.

The practice had accessible appointments and patients who felt anxious about waiting in the reception area could enter the practice though another door and wait in a quiet separate room.

Summary of findings

What people who use the service say

During our visit we spoke with five patients and reviewed 22 comments cards from patients who had visited the practice in the previous two weeks.

Patients were complimentary of the staff and the care and treatment they received. Patients told us that they were not rushed and staff explained their treatment options clearly. They said all the staff at the practice were helpful, caring and supportive.

The results of the 2013 National Patient Survey showed that 75% of patients who responded to the survey would recommend Jenner House surgery, and 95% of patients stated that the last time they wanted to see or speak to a GP or nurse from Jenner House surgery they were able to get an appointment. The practice was below the national average for patients reporting that they could easily access the practice on the telephone. However, the practice had changed their telephone and appointments systems in response to this, and other feedback they had received about the accessibility of the practice.

Areas for improvement

Action the service MUST take to improve

- The practice should ensure they have evidence of written references to satisfy themselves of the suitability of locum GPs to work with vulnerable adults and children.

Action the service SHOULD take to improve

- The practice should ensure patients who use wheelchairs can access a toilet facility.
- The practice should make sure they act on the findings of their infection control audit to ensure patients are cared for in a hygienic environment.

Dr Isaacs & Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector, and a GP specialist advisor. The team included a second CQC inspector and a specialist advisor in practice management.

Background to Dr Isaacs & Partners

Dr Isaacs & Partners which is also known as Jenner House Surgery is based at 159 Cove Road, Farnborough, Hampshire, GU14 0HQ and is a general practice surgery. The practice provides a service to approximately 10,300 NHS patients.

The practice has two male and three female GPs to enable patients to see a GP of their choice. The practice consists of five GP partners who are supported by three practice nurses, a phlebotomist and a Health Care Assistant. There is also a practice manager, an assistant practice manager and a team of 13 reception and administrative staff.

The location offers approximately 40 GP sessions per week.

Patient appointments are available between 8:30 am and 8:30 pm on Mondays; 8:30 am to 6:30 pm Tuesdays to Fridays and Saturday mornings between 9 and 11 am. When the practice is closed patients are able to access urgent care from an alternative Out-of-Hours service. Information about the Out-of-Hours service is available on the practice website.

Why we carried out this inspection

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. These included local organisations such as Healthwatch, NHS England and the clinical commissioning group.

We carried out an announced visit on 15 October 2014.

Detailed findings

During our visit we spoke with a range of staff including GPs, practice nurses, a phlebotomist, reception and admin staff and the practice manager and assistant practice manager.

As part of the inspection we talked with five patients and reviewed 22 comment cards from patients expressing their views about the practice.

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 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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

The demographics of the practice indicated that they had a significant population of working age patients, paediatrics and patients in vulnerable circumstances who may have poor access to primary care. Although the demographics of the practice area showed less deprivation than the UK average, the practice catchment area had higher than average deprivation than the local area.

Requires improvement

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. The practice reported incidents, monitored national patient safety alerts as well as responding to, and learning from comments and complaints received from patients. For example, we saw the practice had responded to a medication error by changing their prescribing system. GPs told us that the new system reduced the potential risk of the incident re-occurring. Staff we spoke with were aware of their responsibilities to raise concerns, and understood how to report incidents and near misses.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of accidents or incidents, and significant events that had occurred during the last 12 months and these were made available to us. A slot for significant events was on the clinical governance meeting agenda and a dedicated meeting occurred quarterly to review actions from past significant events and complaints. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff, including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible. The safeguarding arrangements for children showed the practice had taken a proactive approach to ensure that children at risk and children who may be at risk of harm were known about and safeguarded. In addition, regular meetings were held to discuss relevant children and families with the health visitor and the GPs were fully involved with child protection planning and meetings.

The practice had dedicated GP's appointed as the lead for safeguarding vulnerable adults and children who had the necessary training to enable them to fulfil this role. All staff we spoke to were aware who the 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 so staff were aware of any relevant issues when patients attended appointments; for example, when domestic violence was identified.

A chaperone policy was in place and posters were located in the waiting room and in consulting rooms. A chaperone is a person who, with their consent, accompanies another person or child during their consultation or treatment. The chaperone poster provided information on how to access the service, and an explanation of when a patient might wish to have a chaperone present. There were also guidelines and training for chaperones to ensure they understood their role and responsibilities.

Medicines Management

Arrangements were in place to manage medicines safely.

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 medicines were kept at the required temperatures. This was being followed by the practice staff, and the action to take in the event of a potential failure was described.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. Nurses told us they had received appropriate training to administer vaccines.

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.

GPs told us they had a robust system in place, including a lead GP to ensure the practice managed and monitored prescribing. This included reviewing prescribing data, for

example, checking patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice. There was also a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how changes to patients' repeat medicines were managed. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary. The practice reviewed patient medicines at least annually and had a lead prescribing GP. All the GPs told us that this had been useful in terms of ensuring prescribing guidelines were applied appropriately.

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 held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs. Practice staff undertook regular audits of controlled drug prescribing to look for unusual products, quantities, dose, formulations and strength. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

Cleanliness & Infection Control

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

The practice had a senior practice nurse who was the lead for infection control. All staff received induction training about infection control specific to their role and there after annual updates on infection control issues such as effective hand washing. We saw evidence the lead had carried out an audit in 2014 and identified actions. This had identified a number of areas such as floor coverings that required improvement to ensure patients were cared for in a clean and hygienic environment.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. 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 in order to comply with the practice's infection control policy.

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

Occupational health was outsourced through a contract with the local NHS trust and staff had been referred for pre-employment checks on immunisation and Hepatitis B status.

There were systems in place to manage patients who presented with potentially infectious illnesses including a separate treatment room.

The practice had a policy for the management, testing and investigation of legionella (a germ 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 in order to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly 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.

The practice had equipment to support patients including a blood pressure machine for patient use that was situated in the reception area. The practice also had an ECG (electrocardiogram) at the practice. This enabled patients to have their heart rhythm checked at the practice rather than having to attend the hospital. The practice told us

they had good links with the local hospital cardiology consultant to support them if they needed advice on the interpretation of test results or on the management of patients with cardiology problems.

Staffing & Recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that for permanent staff appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service. However, the practice did not have written references to satisfy themselves of the suitability of locum GPs to work with vulnerable adults and children.

The practice described how they reviewed staffing needs on an on-going basis to ensure they could keep patients safe and meet their needs through considering different demands such as winter pressures or staff annual leave requirements. GPs ensured there were sufficient GPs on duty and this was reviewed weekly. Staffing was changed to meet increasing demand for example, by increasing the numbers of GPs available on a Friday to ensure patients could access the service before the weekend. There was an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe.

Monitoring Safety & Responding to Risk

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

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing 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). All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. The document also contained relevant contact details for staff to refer to, and was also held by a neighbouring practice to ensure staff could access the plan if they were not able to enter their building.

The practice had robust systems in place to enable them to manage an emergency such as a fire. We saw records that showed staff were up to date with fire training. A fire risk assessment had been undertaken that included actions required to maintain fire safety.

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 treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. GPs explained how they used practice meetings to disseminate new guidelines, or clinical updates and talk about best practice. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, assessments of patients' needs and these were reviewed when appropriate.

The practice screened patients for long-term conditions as part of their registration as a new patient, and through clinical reviews and health promotion programmes. The practice managed patients with long-term conditions and staff were aware of procedures to follow to ensure that patients on the Quality and Outcomes Framework (QOF) disease registers were contacted and recalled at suitable intervals. The practice used QOF to improve care for example, by exploring clinical changes for conditions such as diabetes or chronic obstructive pulmonary disease (COPD).

Management, monitoring and improving outcomes for people

The practice operated a personalised patient list that ensured patients knew their GP and continuity of care was provided. GPs told us this enabled them to understand their patient's and proactively manage their healthcare needs. GPs in the practice met daily to discuss the care and treatment of their patients. This enabled them to discuss treatment options and ensured patients received care in line with national standards.

There was a system in place for completing clinical audit cycles. Examples of clinical audits included minor surgery, repeat prescribing of antibiotics, diabetes and dementia. We saw that the practice developed action plans in response to the audit findings and reviewed these to ensure the cycle of audit was completed. We saw examples of changes for instance the systems for recalling women for cervical cytology as a result of audit findings that showed they had recalled a small number of women too early. As a result of a dementia audit the practice had elected to take part in the dementia enhanced service to ensure that all patients who were seen as at risk were screened for dementia.

GPs undertook minor surgical procedures in line with their registration and NICE guidance. The staff were appropriately trained and kept up to date. They also regularly did clinical audits on their results and used that in their learning.

There was a nurse led respiratory clinic which offered in-house spirometry for patients. Spirometry is a test that can help diagnose various lung conditions, most commonly chronic obstructive pulmonary disease (COPD). The practice told us they worked to national guidance within the respiratory clinic and could seek advice from a nurse specialist for more complex cases.

Patients were able to access an anti-coagulant clinic that was run by the practice. This minimised the number of visits to the local hospital for patients and enabled GPs to assess and monitor patient's warfarin levels within the practice. The practice had ensured that nursing staff were appropriately trained to manage the clinic and could seek advice or guidance from the lead GP for the clinic. There were examples of where the practice had responded to warfarin issues to prevent a patient being admitted to hospital.

Patients were able to access a diabetic clinic run by the practice. The clinic was nurse led and managed by GP, who was the lead for diabetes in the practice. The practice nurse had appropriate training and was hoping to further develop their skills to enable the clinic to offer a service to diabetic patients with more complex needs.

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 such as annual basic life support.

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller

Good

Are services effective?

(for example, treatment is effective)

assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

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

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles for seeing patients with long-term conditions such as diabetes were also able to demonstrate they had appropriate training to fulfil these roles. Nursing staff described a learning environment where the team were actively encouraged to develop and maintain their clinical skills.

Working with colleagues and other services

The practice worked with other service providers to meet and manage patients complex care needs. Blood results, X ray results, letters from the local hospital including discharge summaries, Out of Hours providers were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. The GP seeing 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 which were not followed up appropriately.

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had in place advance care planning for patients with dementia. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs.

The practice held multidisciplinary team meetings quarterly to discuss patients with complex needs e.g. those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, and palliative care nurses. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. The practice used the gold standard framework to support patients who were receiving palliative care. They worked with other teams such as the palliative care team and supported people to choose to stay at home if that was their wish. Patients who required this support had care plans which were shared with other providers such as the Out-of-Hours service to ensure external providers understood what patients wanted to happen.

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.

Information Sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals 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.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

The practice described effective partnership working with the local authority and external healthcare providers to promote effective outcomes for older people in need of social care or secondary healthcare services.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke to understood the key parts of the legislation and

Good

Are services effective?

(for example, treatment is effective)

were able to describe how they implemented it in their practice. For example, the practice recorded consent to discuss a patient's medical care with a family member. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity. For example GPs described how they used the principles of the Mental Capacity Act 2005 when assessing a patient's capacity to make important decisions such as not wishing to be resuscitated in the event of cardiac failure. All GPs and nursing 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).

Our discussions with GPs and the practice manager demonstrated the practices commitment to protecting patient confidentiality. For instance, the practice had communicated with all their patients to explain a research project that involved releasing some patient data to an external body. They were clear that patients needed to understand the information in order to ensure their consent was informed.

The practice had not had an instance where restraint had been required in the last 3 years but staff were aware of the distinction between lawful and unlawful restraint.

Health Promotion & Prevention

The practice offered health promotion clinics including respiratory, travel, phlebotomy and minor ailments clinics. The practice had a range of child health clinics and these were promoted by posters and through the practices website.

It was practice policy to offer all new patients registering with the practice a health check with either the GP or practice nurse. GPs told us new patients could be seen on the same day if they presented with an urgent need. We noted a culture amongst the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing.

The practice referred patients to the local pharmacist / specialist service for smoking cessation support. We noted there were posters in the waiting room that provided patients with information about local smoking cessation services.

Flu vaccination was offered to all patients over the age of 65, those in at risk groups and pregnant women. The practice had an effective system to ensure that all patients who required a vaccination were offered one. Older patients were also offered the shingles vaccination.

The waiting area had general information notice boards that provided patients with health promotion information such as over 65's NHS healthcare checks, flu vaccinations, blood testing, carers support services, and information about the practice including the chaperone and complaints policy. The waiting room also contained information leaflets patients could read to gain knowledge about different health conditions, local services, national charities and voluntary organisations.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction.

The results of the 2013 National Patient Survey showed that 75% of patients who responded to the survey would recommend their GP surgery, and 95% of patients stated that the last time they wanted to see or speak to a GP or nurse from their GP surgery they were able to get an appointment. The practice was below the national average for patients reporting that they could easily access the practice on the telephone. However, the practice had changed their telephone and appointments systems in response to this, and other feedback they had received about the accessibility of the practice.

Patients completed Care Quality Commission comment cards to provide us with feedback on the practice. We received 22 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 also spoke with five other patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice switchboard was located in a separate room to the reception desk.

Care planning and involvement in decisions about care and treatment

We spoke with GPs who told us that patients were involved in deciding what care or treatment they received. They told us they achieved this by giving patients information about the types of care or treatments available and making clinical recommendations. All GPs told us that patients were treated with care and respect and involved in all decisions about their care.

Patients were able to choose the local hospital where they wished to have further treatment. GPs told us they discussed the different hospital options with patients in order to support them to make an informed decision and make choices about where they wanted to have further treatment.

All the patients we spoke with told us that GPs and other clinical staff took time to listen to them and had fully discussed their treatment options. The practice told us they used a variety of methods to ensure patients were informed about their medical needs in a way they understood. For example the practice had pre-printed information about a range of health conditions and also accessed online patient leaflets which they could print off for their patient. The practice accessed patient leaflets in other languages and also had access to an interpreting and translation service.

Patient/carer support to cope emotionally with care and treatment

There was information about carers' services available in reception, where there was also a noticeboard asking patients to tell the practice if they were acting as a carer for a friend or relative. The practice ensured that GPs were alerted by the computer system when a patient was also a carer.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The patients we spoke with during our inspection told us that they were happy with the treatment that they received. We found that the practice had listened to patient comments and taken action to improve their service. For example, the practice made significant changes to its system of arranging patient appointments as a result of feedback from patients and the patient participation group. Patients we spoke with said they were always able to get an appointment and comment cards we received confirmed patients were generally satisfied with the new appointments system.

Tackling inequity and promoting equality

The practice had an equal opportunities policy and provided equality and diversity training via e-learning.

The practice worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector organisations. Patients without a permanent address could register using the practice address and staff told us that vulnerable patients could be seen on the same day as registering if their need was urgent.

The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs.

The practice had a significant number of patients whose first language was not English. There was limited written information available for these patients in an alternative language. The practice told us they relied on patients attending appointments with family members who could act as interpreters. The practice also had access to online and telephone translation services.

The practice held a register of patients living in vulnerable circumstances including those with learning disabilities. The practice had carried out annual health checks for people with learning disabilities, and these patients had a nominated GP to ensure they received continuity of care from a GP they knew and felt comfortable with. However there was no information available for these patients in an accessible format such as easy read or pictorial.

The premises and services had been adapted, so far as possible, to meet the needs of people with disabilities. There was wheelchair access and the waiting room offered seating that was accessible to patients with restricted mobility. Treatment and consulting rooms were situated on the ground and first floor and staff told us that patients with restricted mobility were seen in consulting rooms on the ground floor. The practice did not have a wheelchair accessible toilet. The practice had applied for planning permission to extend the premises and ensure the practice environment could accommodate a variety of patient needs in the future.

It was evident through our discussions with GPs and the practice manager that the practice had a strong ethos of challenging discrimination and providing equitable services for all patients such as advocating to commissioners on patients' behalf to secure equitable funding for health projects.

Access to the service

Appointments were available between 8:30 am and 8:30 pm on Mondays; 8:30 am to 6:30 pm Tuesdays to Fridays and Saturday mornings between 9 and 11 am. These included appointments for both routine and urgent (same day) appointments.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the Out-of-Hours service was provided to patients.

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

Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. One patient we spoke with told us how they needed an urgent appointment was seen within two hours of contacting the practice. One patient wrote on a comment card that they had required an urgent appointment and

Good

Are services responsive to people's needs?

(for example, to feedback?)

were seen within 15 minutes. The practice also told us that they reserved some appointments for patients over the age of 75 to ensure that these patients could be seen by their own GP, even for urgent same day appointments.

The practice's extended opening hours on Monday evenings and Saturday mornings was useful to patients with work commitments. The practice also operated a walk-in service on Mondays and Wednesdays to enable patients to easily access routine checks should as urine or blood tests.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Their 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. These included posters in the waiting room and patient leaflets. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

We looked at the complaints the practice had received in the last twelve months and found these were satisfactorily handled and dealt with in a timely way.

The practice reviewed complaints on an annual basis to detect themes or trends. We looked at the report for the last review and no themes had been identified, however lessons learnt from individual complaints had been acted upon. Minutes of team meetings showed that complaints were discussed to ensure all staff were able to learn and contribute to determining any improvement action that might be required.

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 been through significant management changes over the year preceding the inspection. The senior partner had retired and this had been sensitively communicated to patients through a letter on the practice website. The remaining five partners described a time where they had needed to work together, and support each other to develop the practice and ensure it continued to be well-led through the transitional period. All the staff including the GPs agreed this had been managed well and that patient care had improved as a result of the changes and practice development.

Staff told us that the new leadership aims were to provide a caring patient focused practice and ensure the entire team felt involved in the development of the service. Our discussions with GPs demonstrated that they were committed to a continual cycle of learning and improvement, they also told us they discussed succession planning in all areas of the practice as part of GPs and other staff development.

Governance Arrangements

The practice explained to us the steps they had been taking to improve their approach to clinical governance which included holding quarterly governance meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed. Records we looked at and GPs we spoke with confirmed the improvements had resulted in a robust approach to clinical governance. Examples of this included the documentation of governance meetings, effective clinical auditing, responses to complaints and significant events, effective links with the wider healthcare system and a good awareness of external guidance.

We noted through our discussions with staff that there were robust management systems in place that ensured that information was shared and communication between the team was encouraged. Throughout the inspection we observed staff followed information governance guidance such as using a clear desk rule to ensure confidential patient information was protected.

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice.

The practice used the Quality and Outcomes Framework (QOF) to measure their 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 quarterly governance meetings and action plans were produced to maintain or improve outcomes.

Leadership, openness and transparency

All the staff we spoke with described a democratic leadership style that placed care and support for both patients and staff at the heart of their ethos. Staff told us that the practice was well-led with good team working and an open and transparent culture of working. The practice told us they aimed to provide high quality compassionate care to patients, alongside a happy working environment for staff. Staff agreed that the practice was meeting these aims through their open, supportive and transparent leadership.

We were shown a clear leadership structure which had 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. The staff we spoke with 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.

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

The practice was responsive to feedback. For example, the practice had received negative feedback from patients about their telephone access and had responded by changing their telephone system. At the time of the inspection the practice were undertaking a patient survey to establish whether the new telephone system had improved patients ability to contact the practice easily.

All the staff we spoke with told us they felt listened to, valued and supported. Staff described to us a number of changes the practice had made in response to their suggestions or concerns. These included changes to the way the answer phone was used to ensure urgent patient needs were quickly addressed, and changes to the system of testing patient blood pressure including the addition of a blood pressure machine in the waiting area.

The practice had a whistle blowing policy which was available to all staff electronically on any computer within

Are services well-led?

Good

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

the practice. Staff commented that the new management team had particularly fostered an environment that enabled staff to contribute to the practice development and express their concerns if needed openly.

Management lead through learning & improvement

The staff team met regularly through a variety of single discipline and full team meetings. These included daily GP meetings, and monthly partners meetings. There were weekly meetings that included the different teams within the practice such as nursing, reception and GPs. There were specific bi-monthly nurse meetings and quarterly clinical governance meetings. Records of these meetings showed a variety of topics were discussed and appropriate actions drawn up and carried out.

The practice had introduced appraisals in December 2013 and nearly all the team had been appraised at the time of the inspection. Staff told us that their appraisals enabled them to reflect on their skills and learning needs, and that the appraisal system made them feel encouraged, listened to and validated. The practice responded to staff learning needs identified through appraisals. For example, reception staff identified a need for further training on managing challenging situations and the practice responded to the need by arranging this training.

The practice had developed their teams to ensure staff could receive effective support, advice and guidance. For example, the practice had lead GPs in areas such as child/adult safeguarding, dementia, end of life care, mental health and information governance. The practice supported staff to develop their skills. For example, one nurse had started a prescriber course and had a nominated GP as their mentor. Discussions with the staff team evidenced that they felt able to access GPs and nurses for clinical guidance, and that the practice ensured that staff felt competent and safe in their role.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers Records showed that recruitment checks had not been fully completed for locum GPs. This meant that that information specified in Schedule 3 to The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 was not available in respect of all persons employed for the carrying on of a regulated activity. Regulation 21(b)