Dr De Weever & 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?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This is the report of findings from our inspection of Dr DeWeever & Partners practice at Partington Health Centre, Central Road, Partington Manchester.

We carried out a comprehensive inspection on 26 January 2015. We spoke with patients, members of the patient participation group and staff, including the management team.

The practice was rated as good overall. A safe, caring, effective, responsive and well-led service was provided that met the needs of the population it served.

Our key findings were as follows:

- All staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal incidents were maximised to support improvement.
- Feedback from patients was on the whole positive; however patients told us there were problems with booking appointments with named GPs.
- We found an open culture and evidence that staff were motivated and inspired to provide kind and compassionate care. The leadership culture was open and transparent. We found high levels of staff satisfaction.
- The practice had a clear vision which had quality and safety as top priorities. This vision was shared by all the practice staff with evidence of team working across all roles.
- Patients told us they were treated with compassion, dignity and respect and they were involved in care and treatment decisions.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).

We saw several areas of outstanding practice including:

- All annual staff appraisals regardless of role included feedback from all other staff members, this process is known as 360 Degree appraisal.

Summary of findings

- The practice was using the new Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms which are transferable across all health care areas.

In addition the provider should:

- Ensure there is an auditable system for reviewing and monitoring the recording of serial numbers on blank hand written prescriptions pads held in storage and once allocated to GPs.
- Ensure all clinical staff have access to an agreed protocol when they use and for the management of patients after use of nebulisers within the practice.
- Encourage all members of the multi-disciplinary team especially palliative care staff to attend practice meetings, where this is not possible ensure accurate minutes are circulated to staff who could not attend.
- Include reference to checks with the criminal records service through the Disclosure and Barring Service (DBS) within the practice recruitment policy.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risk management was comprehensive and well managed. There were sufficient staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Clinical Commissioning Group (CCG) data showed patient outcomes were at or above average for the locality. National Institute of Health and Care Excellence (NICE) guidance was referenced routinely. The practice had links to neighbouring practices to share best practice. Patients' 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 received training appropriate to their roles and further training needs were identified and planned. The practice carried out 360 degree appraisals and formulated personal development plans for staff. Multidisciplinary working was evidenced.

Are services caring?

Good

The practice is rated as good for providing caring services. Results from patient surveys showed patients rated the practice higher than other practices for several aspects of care. Patients said they were treated with compassion, dignity and respect. They were involved in planning for their care and treatment. We observed a patient centred culture and found strong evidence staff were motivated and inspired to offer kind and compassionate care. Staff were familiar with patients and recognised when patients needed extra support or assistance and strived to ensure this need was met.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice reviewed the needs of their local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to ensure they could respond to the needs of their patients. Most patients reported good access to the practice for urgent appointments but identified some issues with non-urgent appointments with a named GP. The practice promoted patients accessing a named GP for continuity of care where possible and tried to accommodate this but did acknowledge there was

Summary of findings

sometimes a wait for these appointments. Urgent same day appointments were available everyday with either a nurse of GP; these appointments were subject to telephone triage as required. Reception staff also informed partients of the availability of the 'Pharmacy first' scheme available within the practiced based pharmacy.

The practice had appropriate facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff.

Are services well-led?

Good

The practice is rated as good for providing well-led services. The practice had a clear vision which had quality and safety as its top priority. High standards were promoted and owned by all practice staff with evidence of team working across all roles. Governance and performance management arrangements were proactively reviewed. We found there was a high level of constructive staff engagement at all levels and a high level of staff satisfaction. The practice sought feedback from patients and acted upon it where possible.

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. Patients at risk of an unplanned hospital admission had a care plan in place. Nationally reported data showed that 18.4% of the patient population were aged 65 or above this was below the national average. 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 patients in its population and had a range of enhanced services, for example, avoidance of unplanned admissions to hospital (patients at risk of an unplanned hospital admission had a care plan in place), support for people with dementia. The practice was using the new Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms that transferred with the patient to any subsequent care provider areas including the local NHS Trust. The practice provided flu vaccination and shingles vaccination programmes for those aged 70 and above. The practice was responsive to the needs of older people including offering home visits as required.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There was a high prevalence (63.8%) of patients with long standing conditions, such as cardiovascular disease, Chronic Obstructive Pulmonary Disease (COPD) and diabetes amongst the patient population. There were named GP leads for each area. Nursing staff had received appropriate training which enabled them to focus upon specific chronic conditions and appropriately assist in the management of them through a comprehensive schedule of clinics. These patients were recalled annually which ensured they had structured annual reviews to check their health and medication needs were being met. For those with the most complex needs GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care. The practice offered enhanced services to meet the needs of patients with long-term conditions such as avoidance of unplanned admissions to hospital through care planning.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Systems were in place for identifying and following up children who were at risk. For example, children and young people who had a high number of A&E attendances. Immunisation clinics for babies and young children were available on a weekly

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basis. A range of enhanced services were available such as whooping cough in pregnant women, hepatitis B for new born babies, Measles Mumps and Rubella (MMR) vaccination for young people. Contraception services were available within the practice building but were provided on a community level, however long standing contraception needs of patients were met by the practice. Appointments both routine and urgent were available outside school hours and the premises were suitable for children and babies. Children and young people were treated in an age appropriate way and recognised as individuals. The population group of under 18 year olds accounted for 26% of the practice patient population which is above both the Clinical Commissioning Group (CCG) and national average for this age group.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of this group had been identified and the practice had adjusted the services it offered to ensure these were accessible. A full range of health promotion and screening which reflected the needs for this age group was available.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of this group had been identified and the practice had adjusted the services it offered to ensure these were accessible. A full range of health promotion and screening which reflected the needs for this age group was available.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Patients within this group received a timely recall for their annual physical health check. The practice worked with multidisciplinary teams in the case management of people experiencing poor mental health.

The practice provided an enhanced service with a view to facilitating timely diagnosis and support for people with dementia which they were actively working to improve upon. To address the need for timely diagnosis and onward referral where necessary, the nursing team had been trained to assist with the basic assessment of this group of patients. This ensured timely assessment by the GP using a recognised cognitive process could be carried out for patients identified as at risk of dementia.

Summary of findings

Staff told us the practice had sign-posted patients experiencing poor mental health to various support groups, and they were proactive in helping patients address issues to improve all aspects of their health. The practice supported the group 'Bluesci' to support patients with a mental health need within the practice by offering consultation rooms to encourage patients in the locality to attend the service.

Summary of findings

What people who use the service say

All patients commented on the practice environment. They told us it was always safe and hygienic and was so much better than the old premises.

We received 36 completed Care Quality Commission (CQC) comment cards which included feedback from male and female patients across a broad age range. Patients spoke positively about the practice, and the care and treatment they received. Their descriptions of staff included helpful, friendly, thorough and kind. Patients told us staff understood and they were treated with dignity, compassion and respect. They told us staff listened to them and took time to discuss and explain treatment options. Patients felt involved in planning their care and treatment. Four patient feedback cards identified problems with appointments for named GPs, of these two indicated they would see any GP if the appointment was urgent in nature.

Patients told us urgent appointments were always available and they were sure they would be 'slotted in' even if all appointments were taken should they need it. They told us telephone triage was used and they felt this was appropriate and sometimes saved them coming to the surgery unnecessarily. One patient told us they had been advised by the receptionist about the 'pharmacy first' scheme where they could get medication for common ailments from the pharmacy free of charge if they met the set criteria and this had resulted in them not needing to see the GP on that occasion.

We spoke with the chair of the patient participation group (PPG) who was very positive about the practice. They told us they felt fully involved in the practice and felt their views were listened to and acted upon when appropriate.

Areas for improvement

Action the service SHOULD take to improve

- Ensure there is an auditable system for reviewing and monitoring the recording of serial numbers on blank hand written prescriptions pads held in storage and once allocated to GPs.
- Ensure all clinical staff have access to an agreed protocol for the use of and management of patients after using nebulisers within the practice.
- Encourage all members of the multi-disciplinary team especially palliative care staff to attend practice meetings, where this is not possible ensure accurate minutes are circulated to staff who could not attend.
- Include reference to checks with the criminal records service through the Disclosure and Barring Service (DBS) within the practice recruitment policy.

Outstanding practice

- All annual staff appraisals regardless of role included feedback from all other staff members, this process is known as 360 Degree appraisal.
- The practice was using the new Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms which are transferable across all health care areas.

Dr De Weever & Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector. The team included a GP and a specialist advisor

Background to Dr De Weever & Partners

Dr DeWeever & Partners practice is situated on a busy road in Partington. There are currently 5100 patients registered with the practice

The patient population groups are in line with national averages. This practice has a minimal annual turnover of patients. Information published by Public Health England rates the level of deprivation within the practice population group as one on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest.

The practice team comprises of four GPs including two females, a practice nurses and a health care assistant working a variety of hours. The practice manager is supported by a team of reception and administrative staff. The practice has a patient participation group with approximately 10 active members.

Opening hours are 8.30am to 6.00pm from Monday to Friday. Surgeries are available mornings, afternoons and evenings. When the practice is closed an out of hours service, Mastercall, meets the care and treatment needs of patients.

The practice is a training practice for doctors who wish to become GPs. There was one trainee GPs and one trainee hospital doctor attached to the practice at the time of inspection.

The CQC intelligent monitoring placed the practice in band 6. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Why we carried out this inspection

We carried out 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.

How we carried out this inspection

Summarise the inspection process, including the activities carried out by those involved, how the location was reviewed and on what basis, and the methods used to gather information from people who use services and staff as well as others e.g. LMCs, LHW, HOSC, etc. Include the following details:

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

Detailed findings

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

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

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

Before visiting, we reviewed a range of information we hold about the practice, together with information the practice had submitted in response to our request. We also asked other organisations to share what they knew. We spoke with the chair of the practice Patient Participation Group. The information reviewed did not highlight any risks across the five domain areas.

We carried out an announced visit on 26 January 2015. During our visit we spoke with GPs, members of the nursing team, the practice manager, reception and administrative staff. We observed how people were communicated with. We reviewed CQC comment cards where patients and members of the public were invited to share their views and experiences of the service. The CQC comment cards were made available at the surgery prior to inspection.

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 financial 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.

We reviewed a range of information we hold about the practice and asked other organisations such as NHS England and the Clinical Commissioning Group (CCG) to share what they knew. No concerns were raised about the safe track record of the practice. Information from the Quality and Outcomes Framework (QOF), which is a national performance measurement tool monitored by the CCG, showed that in 2013-2014 the practice was appropriately identifying and reporting significant events.

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 clinical meeting agenda. 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.

We tracked two incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result including retraining and circulating any new guidance to ensure all staff were up to date with this. Where patients had been involved they were given a feedback on actions taken in a timely manner.

National patient safety alerts were disseminated by the electronic records systems to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at staff meetings especially if they had been dealt with by the medicines management team at the Clinical Commissioning Group (CCG) to ensure staff were aware of any that was relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

There were systems to manage and review safeguarding 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. The practice nurse was the identified safeguarding lead for children and adults but all GPs had undertaken level 3 training.

When we spoke with both clinical and administration staff, it was clear that they had a good understanding of their responsibilities and staff could articulate the procedures required should any concerns be raised. GPs told us that attendance at case conferences and serious case reviews was difficult due to the short notice of meetings but that reports were submitted as requested.

The practice had a current chaperone policy in place. We saw evidence that clinical and non-clinical staff had received appropriate training on how to act as a chaperone when requested. Information about requesting a chaperone was displayed in the waiting area.

The practice had systems in place to highlight vulnerable patients and for patients with complex medical conditions. A register was also maintained for patients who were house bound. Action was taken when children and young people were identified with a high number of attendances at the out of hours (OOH) service or the local A&E department. Children who failed to attend for immunisations were identified and action taken to rearrange as soon as possible. There was a comprehensive register for patients who were registered with the practice and had learning disabilities (LD) this was updated annually with the Community based LD team to ensure accuracy. Joint assessment of need was undertaken with the community team if deemed necessary. 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. Information was available to make staff aware of any relevant issues when patients attended appointments.

Staff were familiar with the term whistleblowing. We were told consistently by staff we spoke with that they would have no hesitation about raising any concerns about any member of staff. They were also positive about the support that would be provided if they ever had to raise concerns about a colleague. Staff and the member of the patient participation group we spoke with were aware of external organisations such as the Care Quality Commission, Nursing and Midwifery Council and the General Medical Council in the event of needing to report any professional or clinical concerns.

Medicines management

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.

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.

Appropriate medicines for emergency use were readily available. This included adrenaline (used to treat anaphylactic shock) and benzyl penicillin (used as first line treatment in cases of meningitis). At the time of the inspection the contents of the doctors 'grab bag' used for home visits did not have a standard content, individual GPs took different medicines out with them. The practice was currently reviewing medication that was taken out on home visits to ensure they had appropriate medicine to treat situations that may occur. This would standardise the contents of the bag and allow for audit of the contents.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of directions and evidence that nurses had received appropriate training to administer vaccines.

We saw evidence that regular medicine reviews were undertaken both on a planned basis and an ad-hoc basis for infrequent attenders, this ensured patient's medication was appropriate to their current need.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms used in the electronic system were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. Prescription pads for handwritten prescriptions were not tracked appropriately. The practice should ensure there is an auditable system for reviewing and monitoring the recording of serial numbers on blank hand written prescriptions pads held in storage and once allocated to GPs.

All requests for repeat prescriptions were handled in line with the practice policy and protocol and monthly checks were made on uncollected prescriptions. These prescriptions were returned to the GP, who then recorded this on the patient's records as uncollected, disposed of securely and discussed with the patient at the next opportunity.

The practice had clear guidelines on repeat prescriptions for patients with long standing conditions and checks were made to ensure the patients were managed within these guidelines. Patients on complex or restrictive medication were given limited amounts of their medication to ensure safety of the person and the medicine. An example of this was patients on weekly medication who came to collect their medicine and confirm compliance with taking it before they were given the next weeks medicines.

Cleanliness and infection control

We saw the premises were clean and tidy. Cleaning was carried out by an external provider from the building management company responsible for whole of the building. 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 prevention and control (IPC) who had undertaken training to enable them to provide advice on the practice infection control policy. The IPC policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. This provided guidance on specific situations, for example, use of

personal protective equipment, dealing with spillage of blood and responding to a needle stick injury. We saw there were adequate supplies of equipment available to staff to enable them to follow the protocols. Staff were able to describe how they would use these to comply with the practice's infection control policy. Annual IPC audits were carried out by the local NHS Trust IPC lead and action plans were in place to address any issues identified. . Minutes of practice meetings showed that the findings of the audits were discussed with all staff groups.

All staff received induction training about infection control specific to their role

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 systems in place for segregation of clinical and non-clinical waste. There were sharps bins in each treatment room which were not readily accessible to patients. An external contractor attended the practice on a regular basis to collect clinical waste and remove it off site for safe disposal.

Clinical staff were responsible for maintaining infection control measures within their own consultation and treatment rooms during the course of the day. Regular room audits were carried out and any actions were addressed in a timely manner. The practice undertook minor surgery within one of the treatment rooms and there were procedures in place for the safe handling of instrumentation. All instruments used were single use and disposed of in accordance with manufactures guidelines.

Equipment

All equipment seen was in good condition and maintained to a good standard. Electrical equipment had been portable appliance tested (PAT) and had labels indicating the next date for testing. Contracts were in place for service and maintenance and calibration of equipment.

Staff told us that they felt they had access to appropriate equipment to carry out care and treatments.

All equipment used for minor surgery was single use and was checked for expiry date before use and safely and securely disposed of after use in line with manufacturer's guidelines.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. The policy did not include reference to checks with the criminal records service through the Disclosure and Barring Service (DBS) the practice manager assured us this would be included immediately.

We looked at six staff record files and found they contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references and qualifications. The staff team was well established and most had worked at the practice for many years. All clinical staff had checks with the criminal records service through the Disclosure and Barring Service (DBS).

Systems were in place to check on the registration of nurses with the Nursing and Midwifery Council (NMC) and the General Medical Council (GMC) for the GPs within the practice. Checks were also made for professional indemnity of the GPs.

Staff told us there were always enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Annual Leave for GPs was booked where possible in advance to allow for appropriate cover by other GPs within the practice.

Monitoring safety and 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 annual and monthly 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.

Emergency equipment was readily available. Emergency medicines were checked as required. Staff had received annual training in basic life support.

Risk assessments and annual reviews had been undertaken.

All patients requesting urgent on the day appointments were seen at some point during the day of their request,

these appointments were five minutes in length and designed to address specific urgent issues that could not wait for a routine appointment. Telephone triage assisted with management of risk as patients could be directly signposted to more relevant or appropriate services if their needs dictated this.

Arrangements to deal with emergencies and major incidents

The practice had a current and comprehensive business continuity plan in place. This gave staff detailed guidance on how to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. When we spoke with staff they were fully aware of the plan.

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. The practice had identified a fire marshal and a fire log was maintained. Fire extinguishers and alarms were checked and maintained by an external company.

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.

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 whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients we spoke with said they received care appropriate to their needs. They told us they were involved in decisions about their care as much as possible. New patient health checks were carried out by the practice nurses or health care assistant and regular health checks and screenings were ongoing in line with national guidance.

The GPs told us they led in specialist clinical areas and the practice nurse was fully involved in the care of patients with chronic disease such as diabetes and chronic heart disease. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. People with long term conditions were helped and encouraged to self-manage, and checks for blood counts, eye disease, blood pressure and general wellbeing had been combined into single appointments to create a holistic approach.

The practice had systems in place to ensure best practice was followed. This was to ensure that people's care, treatment and support achieved the best possible outcomes and was based on the best available evidence. Treatment was based on nationally recognised guidance. These included the National Institute for Health and Care Excellence (NICE).

Care plans had been put in place in line with national guidelines for patients who met the criteria to avoid unplanned admissions to hospital. This was part of local enhanced services and GPs had initiated the plans with patients in their own home and included their family and/or carers where appropriate.

The practice was using the new Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms that transferred with the patient to any subsequent care provider areas including the local NHS Trust. These had been completed with the patients and where requested their family to ensure the patient's preferences for their end of life care were fully recorded.

Multi-disciplinary meetings were held regularly to discuss individual cases making sure that all treatment options were covered

We were told from regular review of treatments and prescribing, following any frequent episodes of recurring issues such as asthma attacks, the practice was able to review medications and stabilise patients based on current guidance and recommendations.

Discussion with the GPs and nurse verified that patients were being effectively assessed, diagnosed, treated and supported, whilst considering current guidance.

Management, monitoring and improving outcomes for people

Care plans were in place for patients with complex or multiple health conditions. This enabled the practice to effectively monitor patients at regular intervals. Electronic systems had alerts when patients were due for reviews and ensured they received them in a timely manner, for example, reviews of medicines and management of chronic conditions. The practice had systems to follow up and recall patients if they failed to attend appointments, for example, non-attendance at a child vaccination clinic.

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included the management of Atrial Fibrillation which is described as the rapid, irregular and unsynchronised contraction of muscle fibres. Audits had also been completed looking at females within the practice who were taking oral contraception medicines and checking if they had regular blood pressure and weight management records. The results had demonstrated they needed to carry further work to reduce the numbers of females who were struggling to maintain an appropriate weight whilst on the medication. Further audit demonstrated their recording and results had improved but the GP involved told us they were striving to reduce the number of females they had on this medication who were overweight and as such the audit was still ongoing and would be reviewed in another six months.

The practice reviewed patients under a locally enhanced service to minimise admissions to hospital. The practice frequently used 'Pharmacy first' for their patients which signposted sign posted patients to the pharmacy to assist them with minor ailments rather than having an appointment with the GPs or nurse. Information regarding this service which gave details for patients who would not usually pay for their prescriptions was displayed and this information had assisted the practice staff to encourage patients to use the service.

Are services effective?

(for example, treatment is effective)

Regular clinical meetings took place with multi-disciplinary team (MDT) attendance to share information and provide reflection and learning to benefit the patients. However some members of the MDT did not attend on a regular basis or receive documented minutes of the meeting.

One of the GP partners undertook minor surgical procedures within the practice in line with their registration and NICE guidance.

Effective staffing

The practice manager maintained a training matrix and this demonstrated that staff received annual mandatory training. This included basic life support, safeguarding, fire and infection control. We saw training certificates to verify that clinical staff had updated training. Most staff were multi-skilled and able to carry out the role of their colleagues. There was enough staff to meet the demands of the practice.

We saw training and competency assessments had been completed to enable the health care assistant to undertake health checks and participate in review of patients with long term conditions.

All the staff except one member were long serving. There was an induction process for any new staff which covered the practice ethos, introduction to policies and procedures, medical etiquette and duty of care.

GPs were up to date with their yearly continuing professional development requirements and had either been revalidated or had a date for revalidation. Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council.

We saw annual 360 degree appraisals for all staff. Each staff member contributed to feedback on a variety of areas of performance. Staff confirmed that they were supported in identifying any training needs or personal areas for development.

Patients told us that they felt staff were confident in their roles and that they seemed knowledgeable when discussing individual conditions or treatments.

Working with colleagues and other services

The practice worked effectively with other health and social care services. The GPs were responsible for the amendments to any medications in patient records following hospital admissions. All patients were contacted after discharge from hospital and offered either home visits or appointments in the practice if this was appropriate.

Information from the out of hours service or when patients attended A&E were received the following day and acted upon appropriately

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. Telephone messages about specific patients were always passed where possible to the named GP for that patient as were home visit requests. This encouraged continuity of care for the patient. Where this was not possible, the telephone message was triaged by the doctor-on-call to decide whether the patient could wait for a routine visit or required a more urgent visit by someone else.

The practice had regular clinical meetings and the relevant health professional was invited to discuss and manage future care of patients. Palliative care staff had limited attendance at these meetings and communication with this team was on a one to one basis this was currently being addressed by the practice.

Patients we spoke with said that if they needed to be referred to other health providers this was discussed fully with them and they were provided with enough information to make an informed choice.

CQC comments cards told us patients felt they had been referred for hospital appointments within an appropriate timescale.

Information sharing

Patient information was updated electronically, with all letters and other relevant patient documentation scanned onto the practice system.

The out of hours services and other community health staff were alerted to any possible emergencies that could occur out of surgery hours, when a patient's condition had deteriorated via summary care records where patients had agreed to this.

Are services effective?

(for example, treatment is effective)

The partner GPs attended CCG meetings and disseminated information in clinical and practice meetings. This kept all staff up to date with current information around enhanced services and requirements in the community.

The practice was using the new Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms that transferred with the patient to any subsequent care provider areas including the local NHS Trust. These forms were included in the summary care record for the patients.

Patients and individual cases were discussed between the practice clinicians and also with other health and social care professionals who were invited to attend meetings as appropriate.

There was a practice website with information for patients including signposting, services available and latest news. There were information leaflets available within the practice waiting room.

Consent to care and treatment

The practice had an up to date consent policy. Consent to care and treatment was obtained in line with the ethos of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004.

Clinical staff told us that they were aware of issues in regards to consent and the Mental Capacity Act 2005; however they had not attended formal training.

Staff had a good understanding of what was required to determine a patient's best interests and how these were taken into account, if a patient did not have capacity to make a decision. Clinical staff demonstrated an understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the capacity to consent to medical examination and treatment).

Patients we spoke with and via the completed CQC comment cards said that they were provided with enough information to make a choice and give an informed consent to treatment.

The 2014 national GP patient survey indicated 76% of people at the practice said the last GP they saw or spoke to was good at explaining tests and treatments, 84% said the last GP they saw or spoke to was good at treating them with care and concern and 96% had confidence and trust in the last GP they saw or spoke to.

Health promotion and prevention

New patients when registering with the practice were offered a health check with the health care assistant or practice nurse. The GPs were informed of all health concerns detected and these were followed up in a timely way.

Within the reception area and waiting room there was a large variety of health promotion leaflets. There was information on carer support, self-help groups and signposting to a range of community services.

The practice had a range of enhanced services which included illness prevention such as, pneumonia and shingles in older patients. A register was maintained of patients who were identified as being at high risk of hospital admission due to long term conditions or who were at end of life.

A children's immunisation and vaccination programme was in place. For older patients there was a shingles vaccination catch-up scheme for patient's 71-79years of age.

Patients who were receiving care at the end of life had been identified and joint arrangements were in place as part of a multi-disciplinary approach with the palliative care team.

We were told for all patients who were bereaved the GP would make contact to provide support where required. Bereavement leaflets and booklets were available to patients and patients were able to be referred for bereavement counselling. One patient we spoke with told us she had accessed this support and had found it to be beneficial and was offered in a timely manner to support her needs.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patient feedback was very complimentary about the practice and the care and treatment they received. Patients told us staff were kind, friendly and helpful. They told us they were well looked after and staff were genuinely concerned and attentive to their needs. One person commented that staff at the practice especially reception staff always went the extra mile. One patient told us a member of the reception team had collected their relative's prescription for them due to the weather being poor and delivered it to her door.

Patient feedback from the most recent results available from the national patient survey showed that 85% of patients who responded would recommend the practice to another. 85% of respondents said that GPs were good at giving them enough time whilst 97% said the same of nurses. 83% of respondents said GPs at the practice were good at listening and treating them with care and concern. With 98% of respondents saying the same about the nurse. 93% of all respondents said their last appointment was at a time convenient for them.

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

The practice had a confidentiality policy. We noted that reception staff were careful to follow the policy when speaking with patients in order that confidential information was kept private. The reception area itself was spacious and seating was located as far from the reception desk as possible to prevent conversation being overheard. There was an area away from the main reception desk where patients could speak with reception staff in private if they wished.

Care planning and involvement in decisions about care and treatment

Patients were encouraged to take responsibility for their conditions and to be involved in decisions about medication and other forms of treatment.

Patients we spoke with told us they were always asked for their consent before any procedure or treatment was undertaken. We were also told there was ample opportunity to discuss any health concerns and patients told us that they were "never rushed" during consultations

All the staff we spoke to were effective in communication. We found translation services were available for patients who did not have English as a first language though we were told these were rarely used. We saw that patients' information was treated with confidentiality and that information was shared appropriately when necessary using the correct data sharing methods.

We looked at the consent policy and talked to clinical and administration staff about consent. We saw the policy provided clear guidance about when, how and why patient consent should be requested. There was reference to children under the age of 16, patients with limited capacity and chaperoning requirements.

The practice was participating in an enhanced service aimed at avoidance of unplanned hospital admissions. They proactively reviewed patient data to identify vulnerable patients at increased risk and then agreed a care plan with the patient to reduce attendance at A&E. Examples included patients with chronic conditions and dementia.

Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms were fully discussed and completed with the patients and where requested their family were involved. This ensured the patient's wishes for their end of life care were met as requested.

The 2014 GP patient survey reported that 78% of respondents said the last GP they saw or spoke to at the practice was good at involving them in decisions about their care. 93% of respondents said the last nurse they saw or spoke to at the practice was good at involving them in decisions about their care.

Patient/carer support to cope emotionally with care and treatment

We were told by patients that because staff had been at the practice a long time, they felt staff knew them well and understood people's personal needs.

Are services caring?

Patients told us they felt safe in the practice and they felt supported when dealing with long term conditions or decisions about care and treatment.

A range of information about how to access support groups and self-help organisations was available and accessible to patients in treatment rooms and reception area. A counselling support service 'Bluesci' for patients suffering with a mental health related conditions was available at the practice to provide emotional support to patients following referral by the GP.

Staff told us that families who had suffered bereavement were called by their usual GP and offered support.

The 2014 GP patient survey reported that 83% of respondents said the last GP they saw or spoke to at the practice was good at listening to them. 98% say the last nurse they saw or spoke to at the practice was good at listening to them.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was pro-active in contacting patients who failed to attend vaccination and screening programmes and worked to support patients who were unable to attend the practice. For example, patients who were housebound were identified and visited at home by the practice nurses to receive their influenza vaccinations.

Practice staff told us they pro-actively followed up information received about vulnerable patients.

We were given examples where practice staff had been contacted by the pharmacy to say a patient had not been in when they tried to deliver medication and staff would call at the person's home in their own time to check on the person wellbeing. Staff gave us examples where they had been able to update records and practice staff with vital information such as a patient being discharged home before the hospital notification came through due to the fact they were all from the local area.

One patient told us a GP had made an impromptu home visit in their own time, to them to ensure they were they were ok after receiving some bad news. These impromptu interventions had clearly made a considerable positive impact to the patients' health and wellbeing.

The lead GP attended meetings with the CCG and received feedback and information from those meetings. The practice manager engaged with the CCG on a regular basis.

The practice responded to feedback on the NHS choices website. We saw that people were able to feedback both by comment card and verbally and their comments were responded to.

Tackling inequity and promoting equality

The premises were shared with another practice and community services. Initially it was unclear to us where patients should sit because the waiting room was also shared. None of the patients spoken with found this to be an issue and the staff said that new patients were clearly instructed about the layout. There had been instances where patients had waited in the wrong place and missed the screen which announced their appointment, but in those cases the reception staff pr GPs had come to reception to make sure the patient had arrived and had not left before being seen.

The seats in the waiting area were basic and all of one height and size. There was variation for diversity in physical health all of the chairs had arms on them to aid sitting or rising. The practice premises did not belong to the GPs themselves and the landlord was responsible for variations to the building. However, the GPs were able to make changes to the fittings and fixtures if they chose to.

The computer system enabled staff to place an alert on the records of patients who had particular difficulties so the GP could make adjustments. For example, carers support, learning or hearing difficulties. Longer appointment times were available for patients who required them.

Audio loop was available for patients who were hard of hearing and staff were knowledgeable about the different needs of the patients who attended. There was disabled toilet access and baby changing facilities were available.

Staff reported that there was little diversity within their patient population. However they were knowledgeable about language issues and told they were aware of the availability of interpreter services if needed. They also described awareness of culture and ethnicity and understood how to be respectful of patients' views and wishes.

Access to the service

Access at the front of the surgery was good with automatic doors to the entrance which was widen enough for wheelchair users and patients with prams.

There was a good appointment system where people could receive same day emergency appointments, telephone consultations with their named GP whenever possible, call backs, and home visits by the doctors. The nurses also went on home visits when appropriate to support the GPs.

Data from the national patient survey 2013 showed that the patients rated their experience of making an appointment at 81% positive. With 92% of respondent's commenting on the ease of getting through on the phone for making appointments.

We saw that the practice did respond to feedback where they were able.

Are services responsive to people's needs?

(for example, to feedback?)

A Patient Participation Group had recently advertised for members and as a virtual group they were hoping for members from younger age groups.

The practice was open from 8.30am until 6pm daily, with routine appointments available within 48 hours with any GP and named GP appointments usually within the next three working days for that GP.

Listening and learning from concerns and complaints

There was a system in place for handling complaints and concerns. The complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated person responsible for handling complaints in the practice. If a complaint was about this person then it would be dealt with by the lead GP.

We reviewed some complaints received and saw that they were dealt with in line with the practice policy. We saw that most complaints were brought to a conclusion which was satisfactory to the patient.

We saw minutes from clinical staff meetings which showed that all complaints were discussed and reflected upon. It was evident that if changes could be made to improve outcomes for the patients then this was done. All complaints were shared with non-clinical staff as appropriate.

We saw that compliments were also received regularly. We looked at thank you cards and received direct information from patients praising the staff and the care and treatment received.

The practice was taking part in the Friends and Family testing programme and had received positive feedback to date from the process.

Are services well-led?

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

Our findings

Vision and strategy

Staff had been working at the practice for a large number of years and had been part of the development and relocation of the service. All staff were clear on their roles and responsibilities and each strived to offer a friendly, caring good quality service that was accessible to all patients. Their told us their purpose was to provide patients with personal health care of high quality and seek continuous improvement on the health status of the practice overall. They told us they were responsive to patients' needs and expectations and reflected wherever possible the latest advances in primary health care.

There was an established leadership structure with clear allocation of responsibilities amongst the partner GPs and the practice staff.

We saw evidence of meetings that showed the GPs and practice manager met with the Clinical Commissioning Group (CCG) on a regular basis to discuss current performance issues and how to adapt the service to meet the demands of local people.

Governance arrangements

There were clear lines of responsibility and accountability for the clinical and non-clinical staff. The practice held regular clinical meetings and had diarised dates for formal practice staff meetings. The practice had struggled due to workload recently to meet as a whole practice but all relevant information was cascaded to staff in informal meetings on a weekly basis. We looked at minutes from recent clinical meetings and found that performance, quality and risks had been discussed. The minutes showed how and what actions needed to be taken and who was responsible. All actions were followed up at consecutive meetings. Multi-disciplinary team meetings to discuss patients at the practice we carried out every three months or sooner if patients' needs dictated this. The practice should ensure the palliative care team attend these meetings or have a mechanism to share the minutes of the meetings with this group of staff to ensure continuity of care for their patients.

It was evident from staff we spoke with that all staff were able to raise concerns in a constructive and fair manner. Staff were able to describe how and who they would raise any concerns with and explained how feedback and action was disseminated to staff.

The practice participated in the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing well against national standards. We saw that QOF data was regularly discussed at practice meetings and plans were produced to maintain or improve outcomes.

The practice had comprehensive arrangements for identifying, recording and managing risks. These included risks relating to the building, the environment, medicines management, staffing, equipment and a range of emergencies that may impact on the daily operation of the practice.

Leadership, openness and transparency

The practice had a clear, supportive leadership structure which had named members of staff in key roles. For example there were named GP leads for matters such as safeguarding and information governance. Reporting lines were well defined and understood. Staff we spoke with understood their roles and were clear about the boundaries of their abilities. They were aware of each other's responsibilities and who to approach to feedback or request information.

All staff regardless of role took part in annual 360 degree appraisal where all staff members were asked to comment on their colleague's performance throughout the year and identified their strengths and areas for development. Staff told us they were very comfortable with this process and felt the feedback given was constructive and helpful. Some staff told us they had struggled at first with giving feedback on the GPs but as the process had embedded itself they felt it had made them a more cohesive team with respect and understanding for each other's roles.

Staff told us they felt well supported and valued. We found that staff knew and understood the practice vision and values, and what their responsibilities were in relation to it. Staff consistently spoke of an open and honest culture within the practice. Staff we spoke with confirmed opportunities were available to raise issues and that they felt comfortable in doing so.

Are services well-led?

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

The practice had an appropriate range of human resource policies and procedures. These were readily accessible to staff and staff we spoke with knew where to find them. They included matters such as equal opportunities, equality and diversity, and whistleblowing.

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

The practice gathered feedback from all staff through meetings and 360 degree appraisals. When we looked at staff files it was clear that individual performance was monitored and that personal and professional development was encouraged.

The practice actively had sought feedback from patients through patient surveys and complaints received. We looked at the results of the 2014 GP patient survey and the last patient survey conducted by the Patient Participation Group (PPG). Both surveys reflected high levels of satisfaction with the care, treatment and services. However these did highlight some issues relating to availability of appointments with named GPs within the practice. The practice was aware of this and was proactively looking at new ways to try to address this.

We spoke with the Chair of the PPG who confirmed the practice and the PPG were continually seeking patients to join the PPG. Posters displayed in the waiting area attempted to encourage patients to join the group. The group had once had large numbers but this had decreased in recent years. The practice was actively trying to encourage young members to the group but this was also proving very difficult.

We saw evidence from meeting minutes that the practice did act on feedback and information raised via the PPG.

On the day of inspection we noted the practice had been proactive in encouraging patients to provide feedback on the service and contribute to the inspection process. The availability of comments cards was well publicised in the waiting area. One patient actively sought the inspection team out to give their comments.

The practice had a whistleblowing policy in place which was readily accessible to staff. Whistleblowing is defined as the disclosure by an employee of confidential information which relates to some danger, fraud or other illegal or unethical conduct connected with the workplace, be it of the employer or a fellow employee.

Management lead through learning and improvement

GPs were supported to obtain the evidence and information required for their professional revalidation. This is the process whereby doctors demonstrate to their regulatory body, The General Medical Council (GMC), that they were up to date and fit to practice.

Nurses were also registered with the Nursing and Midwifery Council, and as part of this annual registration were required to update and maintain clinical skills and knowledge. Clinical staff told us they were supported to maintain their continual professional development (CPD).

Staff told us they felt very well supported at work and that the management team had an open door policy so they could raise any concerns they had at any time.

The staff files we examined provided evidence that training was up to date and staff had completed appraisals in the last year. We also saw that new staff followed a formal induction programme where they received regular feedback and were in turn asked for their opinion of how their induction programme was being managed.

The GPs were involved in local clinical meetings. Similarly the practice nurses and practice manager regularly attended their professional forum groups established by the CCG to provide training and support and share good practice. The practice was a training practice for doctors wishing to become GPs and as such had close professional links with the local Deanery who oversee the training programmes.

The practice completed reviews of significant events and other incidents and shared with all staff to ensure the practice learned from and took action, which improved outcomes for patients.