Firdale Medical Centre

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	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Good ●
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Outstanding ☆

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This is the report from our inspection of Firdale Medical Practice. We undertook a planned, comprehensive inspection of the practice on the 30 June 2015.

Overall the practice is rated as outstanding.

Our key findings across all the areas we inspected were as follows:

- There were systems in place to mitigate safety risks including analysing significant events and safeguarding. Systems were in place to ensure medication including vaccines were appropriately stored and in date. The practice was clean and followed best practice guidelines for infection control.
- Patients had their needs assessed in line with current guidance and specific clinics were set up in response to guidance.
- The practice accommodated other visiting healthcare professionals and advisory groups and had an ECG (heart monitoring) machine so that patients did not have to be referred elsewhere.
- Feedback from patients and observations throughout our inspection highlighted the staff were kind, caring and helpful.
- Staff were highly skilled and worked well as a team.

There were outstanding areas of practice including:-

- A practice ethos of focusing on the patient journey. The practice was one of only 45 practices in the country to win the Royal College of GPs Quality Practice Award twice (the highest award attainable) and had recently won three Carers awards.
- Systems in place to prevent child medical emergencies. For example, during the winter months the practice had review appointment times later in the day for acutely unwell children who had been seen in the morning so that the GP could monitor the child's progress, reassure the parent/guardian and reduce the likelihood of hospital admission.
- All members of staff had been trained to recognise early warning signs of domestic abuse and this had resulted in cases being identified.

Summary of findings

- Maximising use of IT systems for example, using a 'patient chase' software system had resulted in reducing time spent recalling patients for reviews. IT systems were used to organise documentation that underpinned the governance structures in place. All policies were practice specific and had input from staff and were constantly reviewed with a designated member of staff responsible for each policy which were reviewed at clinical meetings.
- Maximising the use of communication systems between staff to ensure patient welfare. For example, daily referral meetings held for all the GPs reviewing cases to provide peer support, in addition to weekly clinical meetings and regular whole team meetings.
- A strong learning and staff empowerment culture. For example, clinicians shared their personal summary of appraisals and personal development plans to generate the way forward for practice learning.
- Staff were empowered to be part of the continuous improvement processes of the practice and were involved in discussions about how to run the practice and how to develop the practice.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents. The practice used every opportunity to learn from internal and external incidents, to support improvement. Staff were actively engaged in this process and lessons learnt resulted in new protocols where necessary, with input from staff.

Risk management was comprehensive, well embedded and recognised as the responsibility of all staff.

There were safe processes in place to ensure the safeguarding of children and vulnerable adults. All staff had recently received additional training about domestic abuse (IRIS-identification and referral to improve safety). Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. The practice carried out large scale audits to improve outcomes for patients.

Patients' needs were assessed and care was planned and delivered in line with current legislation. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams and proactively managed patient care. For example, GPs held daily referral meetings and weekly clinical meetings.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice in line with or higher than other local and national data for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect and maintained confidentiality.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group

Summary of findings

(CCG) to secure improvements to services where these were identified. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff.

Are services well-led?

The practice is rated as outstanding for being well-led. The practice had a clear vision with quality and safety as its top priority. High standards were promoted and owned by all practice staff and teams worked together across all oles.Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice.The practice had reviewed its leadership structure and instead of having a practice manager, they had a patient services manager who focused on the needs of patients and staffing issues.

Outstanding ☆

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. All patients over 75 had a named GP. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs and longer appointments where necessary. GPs visited local nursing homes and were engaged with the local commissioning group and other practices in a nursing home project to improve continuity of care. The practice had access to community intervention beds which were utilised by the practice for those patients requiring care and rehabilitation when hospital admission was not appropriate and GPs attended weekly meetings with other healthcare professionals to monitor patients' care.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The practice maintained and monitored a register of patients with long term conditions and where possible the practice would review patients with multiple medical conditions at the same appointment.

Patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. 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

Outstanding

The practice is rated as outstanding for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. A health visitor attended the practice monthly to discuss children on risk registers. All staff had recently received additional training about domestic abuse (IRIS-identification and referral to improve safety.)

The practice had weekly immunisation clinics and immunisation rates were high for all standard childhood immunisations and there were systems in place to follow up appointments for children who did not attend.

Summary of findings

Children who were acutely unwell were seen as a priority. During the winter months the practice had review appointment times for acutely unwell children who had been seen in the morning so that the GP could monitor the child's progress and avoid any unnecessary hospital admittance, pressure on the acute services and reduce parental anxiety. The practice was well prepared to respond rapidly to a child medical emergency.

The practice addressed the needs of the younger population and had a dedicated noticeboard for younger adults in the waiting room. The practice had the highest Chlamydia screening rate in the local area.

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). Their needs had been identified and the practice adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group such as proactively offering NHS health checks.

The practice offered extended opening hours and was part of the 'Prime Minister's Challenge Fund' which meant the practice would be open from 7am on Wednesdays. The practice offered a text reminding service.

People whose circumstances may make them vulnerable

Outstanding

The practice is rated as outstanding for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. Patients had individual care plans which were regularly reviewed. Patients who attended hospital had a post review appointment and their cases were discussed at weekly clinical meetings. Patients were supplied with direct telephone access so they could access the practice in a timely way. The practice offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. For example, the practice worked with representatives from the local Carer's Trust and had recently won three awards for their involvement. The practice worked with a local drugs misuse service and one of their clinics was operated from the practice. Two of the GPs had certificate of training in substance misuse.

Summary of findings

People experiencing poor mental health (including people with dementia)

Outstanding 

The practice is rated as outstanding for the care of people experiencing poor mental health (including people with dementia). 94.55% of people experiencing poor mental health had an agreed care plan in place received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. For example, the practice had a weekly dementia clinic with a consultant attending.

The practice advised patients experiencing poor mental health about how to access various support groups and voluntary organisations and there was an onsite counselling service available.

Summary of findings

What people who use the service say

As part of our inspection process, we asked for CQC comment cards to be completed by patients prior to our inspection. We received two comment cards and spoke with a member of the Patient Participation Group (PPG). Reception staff, nurses and GPs all received praise for their professional care. Patients informed us that they were treated with compassion and that GPs went the extra mile to provide care when patients required extra support. We also reviewed information from the Friends and Family Test which was positive with the majority of patients extremely likely to recommend the service. However there were negative comments about appointments.

Our findings of the practice were in line with latest results received from the national GP Patient Survey (July 2015). For example, 122 patients responded to the survey and 86% described their overall experience of the practice as good and 89% found the receptionists helpful (which is consistent with the local CCG and national averages).

Results from the national GP Patient Survey also showed that 91% of patients said the last GP they saw or spoke to was good at treating them with care and concern, which is higher than the local and national average (85%) and 97% had confidence and trust in the last GP they saw or spoke to.

Seventy seven percent of patients found it easy to get through to the practice by phone which is higher than the local CCG average of 56% and in line with the national average of 73%. However, only 47% of respondents with a preferred GP said they usually get to see or speak to that GP compared to local CCG average of 55%**.**

Seventy seven percent of patients surveyed would recommend the practice to someone new to the area which is consistent with the local CCG average of 74% and the national average of 78%.

Outstanding practice

- A practice ethos of focusing on the patient journey. The practice was one of only 45 practices in the country to win the Royal College of GPs Quality Practice Award twice (the highest award attainable) and had recently won three Carers awards.
- Systems in place to prevent child medical emergencies for example during the winter months the practice had review appointment times later in the day for acutely unwell children who had been seen in the morning so that the GP could monitor the child's progress, reassure the parent/guardian and reduce the likelihood of hospital admission.
- Maximising use of IT systems for example, using a 'patient chase' software system had resulted in reducing time spent recalling patients for reviews. IT systems were used to organise documentation that underpinned the governance structures in place. All policies were practice specific and had input from staff and were constantly reviewed with a designated member of staff responsible for each policy which were reviewed at clinical meetings.
- Maximising the use of communication systems between staff to ensure patients' welfare for example there were daily referral meetings for all the GPs for reviewing cases to provide peer support in addition to weekly clinical meetings and regular whole team meetings
- A strong learning and staff empowerment culture, for example clinicians shared their personal summary of appraisals and personal development plans to generate the way forward for practice learning.

Firdale Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

by a CQC Lead Inspector. The team included a GP specialist advisor and a CQC inspection manager.

Background to Firdale Medical Centre

Firdale Medical Practice is a purpose built surgery located in a residential area near Northwich. At the time of inspection there were 8279 patients on the practice list and the majority of patients are of white British background.

The practice has three GP partners (one male and two female), a male salaried GP and a registrar. The registrar will become a salaried GP at the practice in August 2015. There are two nurses, a healthcare assistant and reception and administration staff. The practice is open 8.30am to 6.00pm Monday to Friday and closes for lunch between 12.30-1.15pm. The practice has late night surgery opening times until 8.30pm on Mondays or Thursdays on alternate weeks. In addition the practice is part of the 'Prime Minister's Challenge Fund' and this was due to start the day after our inspection with 7am opening hours on a Wednesday. The practice had a primary care services (PMS) contract.

Patients requiring a GP outside of normal working hours are advised to contact the practice and they are then automatically put through to the out of hours service provided by Nights Evenings and Weekends (NEW), based at Leighton Hospital.

The practice is a training practice and has been approved by Manchester University as a training practice for final year medical students and foundation year 2 doctors and by Liverpool University for GP registrars.

Why we carried out this inspection

We carried out a comprehensive inspection of the services under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We carried out a planned inspection to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to provide a rating for the services under the Care Act 2014.

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions

Detailed findings

• 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 the practice we reviewed information we held and asked other organisations and key stakeholders to share what they knew about the practice. We also reviewed policies, procedures and other information provided by the practice before the inspection day.

We spoke with a range of staff including GPs, nurses, reception staff and administration staff, on the day. We looked at comment cards and reviewed survey information and spoke with a member of the PPG.

Good

Are services safe?

Our findings

Safe track record

There was a system in place for reporting and recording significant events. There was also a recording form available on the practice's computer system. All written complaints received by the practice were fed into this system and automatically treated as a significant event. The practice carried out an analysis of these significant events and this also formed part of GPs' individual revalidation process.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. There was a log of safety incidents kept and there was a low threshold to reporting.

Learning and improvement from safety incidents

The practice had an embedded system in place for reporting, recording and monitoring significant events, incidents and accidents. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration and they felt encouraged to do so. One of the GP partners had received additional training in (root cause) analysis to help investigate incidents thoroughly.

Clinical staff meetings were held weekly to discuss learning from complaints or incidents. We viewed documentation for recent significant events which included details of the events and learning outcomes for what actions were to be undertaken to prevent reoccurrence. Additionally, in the staff office there was a white board used to communicate significant events and the level of progress and action taken as a result.

Reliable safety systems and processes including safeguarding

The practice had safeguarding vulnerable adults and children policies in place which were accessible to all staff. Staff had guides available for the safeguarding procedure and who to contact for further guidance if staff had concerns about a child's welfare.

There was a lead member of staff for safeguarding vulnerable adults and children. All clinical staff told us they had received safeguarding children training at a level suitable to their role, for example the GPs had level three training. All staff had recently received additional training about domestic abuse (IRIS-identification and referral to improve safety).

The practice had weekly clinical meetings where safeguarding issues were discussed as a matter of routine. GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. The practice had a computer system for patients' notes and there were alerts on a patient's record if they were identified as at risk. The health visitor attended the practice monthly to discuss children on the safeguarding register. Children who failed to attend appointments were actively followed up by the practice and the clinicians gave us examples of how the practice team worked closely with the health visitor if any concerns were identified.

The nurses acted as chaperones if required and a notice was in the waiting room to advise patients the service was available should they need it. All staff who acted as chaperones had received a disclosure and barring check (DBS). DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

Medicines management

The practice worked with pharmacy support from the local CCG. Regular medication audits were carried out to ensure the practice was prescribing in line with best practice guidelines.

The practice had three fridges for the storage of vaccines. One of the nurses took responsibility for the stock controls and fridge temperatures. We looked at a sample of vaccinations and found them to be in date. There was a cold chain policy in place and fridge temperatures were checked daily. Regular stock checks were carried out to ensure that medications were in date and there were enough available for use.

Emergency medicines such as adrenalin for anaphylaxis were available. These were stored securely and available in the reception area. In addition, there was emergency adrenalin available in each consultation room. One of the nurses had overall responsibility for ensuring emergency medicines were in date and carried out monthly checks. All the emergency medicines were in date.

Good

Are services safe?

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 had set up 'Firdale Prescription Service' in conjunction with a company so that patients when ordering their prescriptions on line could have their medications delivered to their home. This service had only been in operation for four weeks and the practice was aware they would have to evaluate the system to assess whether it was safe and working to patients' satisfaction in the future.

Cleanliness and infection control

Comments we received from patients indicated that they found the practice to be clean. Cleaning of the premises was regularly monitored.

Treatment rooms had the necessary hand washing facilities and personal protective equipment (such as gloves) was available. Hand washing gels were also available throughout the building.

Clinical waste disposal contracts and facilities were in place and spillage kits were available. Staff knew what to do in the event of a sharps injury and appropriate guidance was available.

One of the nurses was the designated clinical lead for infection control. On taking up the role they had invited the community infection control team to the practice to be advised on the latest guidance and what areas needed to be improved by way of an audit. The nurse had produced a list of items and we could see action had been taken. For example, all sharps bins in the treatment room were now wall mounted for safety reasons. The nurse also attended external meetings with the infection control team and cascaded any updates back to the practice. There was an infection control policy in place and staff had received up to date training. Infection control issues were discussed at clinical meetings as a fixed agenda item.

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

The practice had a designated room for patients who attended with potentially infectious conditions such as measles or patients who were at greater risk of contracting infection for example patients receiving chemotherapy.

Equipment

All electrical equipment was checked to ensure the equipment was safe to use. Clinical equipment in use was checked to ensure it was working properly. For example, blood pressure monitoring equipment was annually calibrated. Staff we spoke with told us there was enough equipment to help them carry out their role and that equipment was in good working order.

One of the nurses carried out regular checks on emergency equipment such as the defibrillator.

The practice had also invested in additional ECG equipment to prevent patients having to attend hospital.

Staffing and recruitment

Staffing levels were monitored and the practice had a policy of only allowing two members of staff to be off work simultaneously. Staff were highly skilled and there was a broad mix of skill utilised. Staff covered for each other in the event of unplanned absences and there were plans in place to improve on staff being able to cover one another's roles. The patient services manager had put systems in place to ensure there were receptionists at the desk to concentrate solely on the patient at the desk. Additional staff worked away from the front area of reception to deal with incoming telephone calls. The practice had an emergency clinic every morning and during the winter season the GP cover was doubled to respond to the risk of extra demand. There were systems in place to support and monitor any underperforming staff.

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. All clinical staff working at the practice had received a(DBS) check to ensure they were suitable to carry out their role. Non clinical staff had a risk assessment to ascertain the need for a check.

Monitoring safety and responding to risk

Good

Are services safe?

There were procedures in place for monitoring and managing risks to patient and staff safety. All new employees working in the building were given induction information for the building which covered health and safety and fire safety.

There was a health and safety policy available for all staff and a health and safety poster displayed in the staff room.

There was a fire risk assessment in place. Staff confirmed they carried out fire drills and were well versed in what to do in the event of fire. There was regular testing of smoke detectors and fire fighting equipment was checked annually.

The maintenance of the premises was monitored and fault report forms were available for staff and patients to use.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all the consultation and treatment rooms and separate panic buttons which alerted staff to any emergency. All staff received annual basic life support training and there were emergency medicines available centrally in the reception area. The practice had thought about the practicalities of emergencies and had kits already made up with the relevant medication for example a children's emergency kit, a nebuliser stored on top of the emergency unit for easy access and anaphylactic kits available to ensure a rapid response.

There was a defibrillator available on the premises and oxygen with adult and children's masks and portable suction for use to clear airways of obstruction. There was also a first aid kit and accident book available. After any emergency, the staff involved held reflective meetings to see whether their response to an emergency could be improved.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and a hard copy was available in case of computer failure.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line with best practice guidelines and had systems in place to ensure all clinical staff were kept up to date. The practice used a system of coding and alerts within the clinical record system to ensure that patients with specific needs were highlighted to staff on opening the clinical record. For example, patients on the 'at risk' register and palliative care register.

In discussions with the GPs we were given several examples of how the practice acted proactively to manage patient care. The practice was part of the Gold Standard Framework for palliative care and attended regular meetings with Macmillan and district nurses. Health care needs for patients who were vulnerable or needed end of life care were discussed at weekly clinical meetings.

The practice had clinical protocols in place in line with NICE guidelines. For example, they followed the guideline on atrial fibrillation and had set up a regular clinic.

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. For example the practice had a weekly dementia clinic with a consultant attending.

The practice had a vulnerable adults register and patients had care plans in place. Patients who had recently attended hospital had their care plans reviewed and the cases were discussed at weekly clinical meetings.

Interviews with GPs showed that the culture in the practice was that patients were cared for and treated solely based on need.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework system (QOF). This is a system for the performance management of GPs intended to improve the quality of general practice and reward good practice. The practice was not an outlier for any QOF clinical targets. The latest QOF points as a percentage of the total available showed the practice to have scored 94.4% which was similar to the national average of 94.2%.

The practice monitored its QOF scores and used outcomes from this to identify areas for improvement. For example, results for diabetes were lower than they expected and had therefore put a variety of measures in place to improve patient outcomes. For example, one of the GPs was to attend additional comprehensive training about diabetes care at diploma level.

The practice has a system in place for completing clinical audit cycles. Audit documentation was comprehensive and demonstrated that audits had been revisited and had resulted in improved outcomes for the patients. Outcomes of audits were discussed at weekly clinicians' meetings.

Examples of audits included various medication audits. Audits showed that patients were recalled and some were identified as no longer requiring their medication. For example, there was a large scale comprehensive audit for over 300 patients taking the contraceptive pill to ensure prescribing was in line with current standards. This resulted in 13 patients no longer taking the medication due to medical contraindications and a more robust system of medication and health check review being adopted by all clinicians. The practice ensured all women patients had six monthly reviews with the nurse before any further prescriptions were issued.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. Searches on record systems for patients who had long term conditions were carried out continuously so that their condition and medications could be reviewed at regular intervals with the nurses.

Effective staffing

The practice had an induction programme for newly appointed members of staff that covered such topics as fire safety, health and safety, confidentiality and information governance. There was a staff handbook available.

Staff received regular training that included safeguarding, fire procedures, basic life support, equality and diversity, infection control and information governance awareness. Additional training needs were identified at appraisals. The nurses had the opportunity to attend local forums and meetings.

All GPs were up to date with their yearly continuing professional development requirements and they had

Good

Are services effective?

(for example, treatment is effective)

been revalidated. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England). There were annual appraisal systems in place for all other members of staff that were held with the patient services manager and at least one GP.

Working with colleagues and other services

Incoming letters from hospitals were scanned onto patient notes and passed onto GPs for action and dealt with on a daily basis. The practice used the patient Choose and Book and system for referrals to hospitals.

The practice liaised with other healthcare professionals such as the health visitor at primary health care team meetings. The practice also liaised with a multi-disciplinary health care team to discuss patients on their palliative care register.

Information sharing

The practice planned and liaised with the out of hours provider regarding any special needs for a patient; for example faxes were sent regarding end of life care arrangements for patients who may require assistance during the weekend.

The practice maximised communications between staff by using emails, whiteboards, informal meetings and structured meetings. The practice operated a system of alerts on patients' records to ensure staff were aware of any issues.

Consent to care and treatment

The practice had a Mental Capacity Act Policy in place which described the main points of the Act. The practice had recently had a significant event around the Deprivation of Liberty Safeguards (DOLS) and as a result, the discussions and learning from this was disseminated to the team. Staff were involved in writing a policy around DOLS which would then be reviewed at a clinical meeting. Refresher training on the subject had been highlighted as an action and this was to be organised later in the year.

We spoke with the GPs about their understanding of the Mental Capacity Act 2005 and they demonstrated an awareness of the Act and when best interest decisions needed to be made.

GPs were also aware of Gillick guidelines for children. Gillick competence is used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

There were consent forms available for minor surgical procedures.

Health promotion and prevention

The practice had a variety of patient information available to help patients manage and improve their health. There were health promotion and prevention advice leaflets available in the waiting room, including information on various lifestyle management support.

The practice proactively offered NHS health checks to identify patients that may have underlying health issues and monitored this service. At the time of our inspection, 649 patients had received a check. This service helped identify patients with any underlying medical condition and provided an opportunity to discuss health promotion and reduce risk factors such as cardiovascular disease.

During the winter months the practice had reviewed appointment times for acutely unwell children who had been seen in the morning so that the GP could monitor the child's progress.

The practice offered a full range of immunisations for children in line with current national guidance. For 2013-2014, performance was consistent with local CCG averages for all child immunisations. For example, the first MMR vaccination uptake was 98.1% compared to the local average of 96.3%.

The practice had the highest Chlamydia screening rate in the local CCG area.

The practice hosted other visiting healthcare professionals and advisory groups so that patients did not have to be referred elsewhere. For example a dietician, counsellors, health visitors and midwifes and district nurses.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Throughout the inspection, we e observed that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone. CQC comment cards we received indicated that they found staff to be helpful, caring, and polite and that they were treated with dignity.

Results from the National GP Patient survey ((July 2015) also showed 86% described their overall experience of the practice as good and 89% found the receptionists helpful (which is consistent with the local CCG and national averages).

Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. The waiting room area was designed so that patients could sit in a partially enclosed room with a partial glass window away from the reception desk. This helped to prevent private conversations being overheard whilst still enabling reception staff to be able to see patients to check on their welfare.

There was a confidentiality policy in place and staff were aware of how to keep patients' private information safe.

Care planning and involvement in decisions about care and treatment

Results from the National GP Patient Survey showed that 95% said the last GP they saw or spoke to was good at explaining tests and treatments and 86% said the last GP they saw or spoke to was good at involving them in decisions about their care which was higher than the local and national averages. Eighty two percent of respondents said the last nurse they saw or spoke to was good at involving them in decisions about their care which was consistent with local and national averages.

The practice leaflet contained information for patients entitled 'Consent it's up to you' which explained the types of consent and capacity and how to give consent.

Patient/carer support to cope emotionally with care and treatment

Reception staff knew that when patients wanted to discuss sensitive issues or appeared distressed that they would offer them a private room to discuss their needs. Patients who had been bereaved were sometimes contacted to see if they required any additional support.

The practice worked with representatives from the local Carer's Trust who attended the practice monthly in an effort to improve the practice's identification and support for patients who were carers. The practice had a carer's noticeboard in the waiting room which was regularly updated and staff had attended a training session to ensure they were more vigilant in the support offered.

Information regarding support for carers was available in the waiting room and alerts were on carers' records to ensure staff could act on any of their needs. The practice had recently received three awards for their involvement in supporting carers.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. There had been a 5% increase in the number of patients over the past 18 months and the practice were currently accepting up to 30 new patients per week. This was predominantly due to a major housing plan in the area. To cope with the demand the practice was part of the Prime Minister's Challenge Fund to provide additional appointments with extended hours starting off with 7am appointments initially becoming available once a week.

Vulnerable patients who attended hospital had a post review appointment and their cases were discussed at weekly clinical meetings. Patients were supplied with direct telephone access so they could access the practice in a timely way. The practice offered longer appointments for people with a learning disability.

The practice had an established patient PPG which was previously an online forum (virtual group). The practice had recently altered the format of the group so that face to face meetings occurred. The PPG collated patient feedback and liaised with the practice to make improvements. One recent development was that patients were not happy with the answering message on the telephone and the practice had made the message shorter and more concise which included useful direct telephone numbers. They had also produced wallet sized cards to give to patients when collecting prescriptions with the telephone number of the reception main line, the home visit line and the prescription line.

The PPG advertised for members and displayed meeting minutes both on the practice website and on a noticeboard in the waiting room.

Tackling inequity and promoting equality

The majority of the practice population were English speaking patients but access to online and telephone translation services were available, if required. There was also information on advocacy services available for patients provided in the waiting room.

The building had appropriate access and facilities for disabled people. There was a hearing loop, type talk and access to sign language services if necessary.

The practice had an equal opportunities policy which was available to all staff on the practice's computer system and all staff received training around equality and diversity.

Access to the service

The practice was open 8.30am to 6.00pm Monday to Friday and closed for lunch between 12.30 to 1.15pm. The practice had late night surgery opening times until 8.30pm on Mondays or Thursdays on alternate weeks. The practice was part of the Prime Minister's Challenge Fund and was to open from 7am on Wednesdays.

Phone lines opened at 8am and the practice operated an emergency 'sit and wait' system every morning whereby patients telephoned the practice for an appointment. When patients attended they were triaged by the nurse first (with the exception of under two year olds who are automatically seen by a GP). Depending on the nature of the medical problem, patients were either seen by a GP immediately or for non-urgent cases asked to return at a later time. GPs checked when patients did not receive a GP appointment that this was appropriate.

National GP Patient Survey results showed 77% of patients found it easy to get through to the practice by phone which is higher than the local CCG average of 56% and in line with the national average of 73%. Only 47% of respondents with a preferred GP usually get to see or speak to that GP compared to local CCG average of 55**% and n**ational average of 60**%.** However, the practice used a **rota of different GPs to cover the emergency appointments in the morning. This was explained in the practice leaflet and patients with non-urgent conditions were advised to contact the practice after 9.30 am to book an appointment with the GP of their choice.**

Comprehensive information was available to patients about appointments on the practice website and patient information leaflet. This included how to arrange urgent appointments and home visits and how to book appointments through the website. The practice also offered a text reminding service.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

The practice was purpose built with easy access (automatic doors, no steps) for disabled patients and all patient areas were on ground level. There are disabled facilities and an automatic check in machine.

Listening and learning from concerns and complaints

The practice has a system in place for handling complaints and concerns. Its complaints protocol was in line with recognised guidance and contractual obligations for GPs in England. Information about how to make a complaint was available in the waiting room and in a practice leaflet. The complaints protocol clearly outlined a time framework for when the complaint would be acknowledged and responded to. In addition, the complaints protocol signposted who the patient should contact if they were unhappy with the outcome of their complaint.

The practice kept a complaints log for written and verbal complaints. The lead receptionist dealt with verbal complaints and had a private office where conversations could be discussed away from reception. There had been a total of nine complaints in the previous twelve months. Written complaints were automatically seen as a significant event and recorded and examined as such to draw out any lessons to be learnt if necessary.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and strategy

The overall aim of the practice was to provide a high standard of primary health care to all its patients. Staff were hardworking and engaged in promoting high quality care at every stage of the patient's journey.

The GP partners and management had quarterly meetings to discuss business plans. The practice worked with the CCG and their aim was to work with other practices in the area to adopt a co-ordinated way of working from the beginning of next year to improve patient access to a variety of services.

Governance arrangements

The practice had structures and procedures in place which incorporated seven key areas (pillars): clinical effectiveness, risk management, patient experience and involvement, resource effectiveness, strategic effectiveness and learning effectiveness.

The practice was one of only 45 practices in the country to win the Royal College of GPs Quality Practice Award twice (2006 and 2013) which is the highest award attainable from the college. The awards covered a large area of clinical effectiveness and an assessment of patient experience. The awards demonstrated that the practice had striven to continuously improve over time and they continued to do so.

The governance and performance management arrangements had been proactively reviewed and the practice actively tried innovative methods to improve patient experience. This included a new model of management structure. Instead of a traditional practice manager, there was a Patient Services Manager who specifically dealt with patients' complaints and feedback and staffing issues. There were separate managers for IT and finance and the reception staff were supported by a lead receptionist. Staff had lead roles such as safeguarding and infection control leads.

The practice had practice specific policies and procedures to support governance arrangements which were available to all staff on the practice's computer system. All staff had access to a spread sheet with individual sections (worksheets) for specific roles such as reception. The worksheet then had hyperlinks to all the relevant policies for that role and information about the date reviewed, who took ownership of the policy and the date for the policy to be revisited. Each policy was also then available in hard copy in case of computer failure.

Leadership, openness and transparency

The Patient Services Manager operated an open door policy and regularly checked on all staff during the day.

All staff were motivated and engaged with the ethos of the practice. Many staff were part time but voluntarily attended staff meetings even on their days off. Staff were empowered to be part of the continuous improvement processes of the practice and were involved in discussions about how to run the practice and how to develop the practice.

The practice maximised the use of communication systems between staff to ensure patient's welfare for example there were daily referral meetings for all the GPs to review cases and provide peer support in addition to weekly clinical meetings and regular whole team meetings. The practice had designated areas with white boards for specific teams of staff. For example, the nurses had a stock room in between the treatment rooms where there was a whiteboard used for all communications to ensure stock control checks, fridge checks, infection control checks and any other reminders were available centrally for the nursing team. The practice management were aware of the need to have satisfactory systems in place in case of staff absence. The practice had identified the need for continuous evaluation of any new systems in place.

Staff we spoke with were aware of what to do if they had to raise any concerns and told us there was an open culture.

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

Results of surveys and complaints were discussed at clinical meetings. The practice reception staff encouraged all patients attending to complete the new Friends and Family Test as a method of gaining patient feedback. The Patient Services Manager collected this information monthly to identify any trends.

The practice had an established PPG which regularly reviewed patient feedback from complaints, the suggestion box and emails on the website.

Management lead through learning and improvement

Are services well-led?

Outstanding ☆

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

Staff had annual appraisals where their future training needs were discussed. Staff had opportunities to develop further within the practice.

The practice was a training practice and one of the GPs also gave talks to sixth formers at the local school who were considering a career in medicine. The registrar was joining the practice as a salaried GP later in the year and had been encouraged and allowed time to access a further qualification to diploma level for diabetes care.

The GPs were all involved in revalidation, appraisal schemes and continuing professional development. The GPs had learnt from incidents and complaints and recognised the need to address future challenges. Clinicians shared their personal summary of appraisals and personal development plans to generate the way forward for practice learning.