Hoyland First PMS Medical Practice

Quality Report

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Date of inspection visit: 16 December 2014
Date of publication: 31/03/2015

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Hoyland First PMS Practice, also known as Walderslade Surgery on 16 December 2014. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services to the six population groups we inspect.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of those relating to recruitment checks.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw areas of outstanding practice:

- The practice had commissioned the Pharmacy First Scheme for minor ailments to ease patient access to

Summary of findings

appointments. This service is available to all patients; those who pay for prescriptions are charged for the medications, normally cheaper than prescriptions. Patients who do not pay for their prescriptions do not pay for these medications.

- The practice used computerised tools such as the 'Electronic Checking Leading to Improved Safety and Efficiency' (ECLIPSE) to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We saw the personalised plans and records, which showed areas of identified risk and how these risks were reviewed.

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 and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Systems were in place to ensure all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. We also saw evidence to confirm these guidelines were positively influencing and improving practice and outcomes for patients. Data showed the practice was performing highly when compared to neighbouring practices in the CCG. The practice was using innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP. There was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand. Evidence showed the practice responded quickly to issues raised and there was learning from complaints with staff and other stakeholders.

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Are services well-led?

Good

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

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

People with long term conditions

Good

The practice is rated as good for the care of patients with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. The practice used computerised tools such as the 'Electronic Checking Leading to Improved Safety and Efficiency '(ECLIPSE) to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We saw the personalised plans and records, which showed areas of identified risk and how these risks were reviewed. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young patients. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Summary of findings

Working age people (including those recently retired and students)

Good

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

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of patients whose circumstances may make them vulnerable. It held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. All patients with a learning disability had received an annual health check and offered a longer appointment to meet their needs.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of patients experiencing poor mental health (including people with dementia). All patients experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) when they may have been experiencing poor mental health. Staff had received training about how to care/ support people with mental health needs and dementia.

Summary of findings

What people who use the service say

We observed staff interaction with patients in the waiting area; we spoke with four patients and reviewed the report of the most recent patient survey. We also considered the 17 completed CQC comment cards. In summary patients were very positive about how the practice worked and met their needs**.** Four comment cards had identified they had difficulty getting an appointment with the GP of their choice and they felt some of the reception staff were not always helpful.

- The practice's patient survey and the CQC comment cards showed that patients were mostly content with the current appointment system. They felt they could access medical attention and advice when needed. Same day appointments or telephone consultations were available.
- Patients we spoke with said they would recommend the practice to other people. They felt listened to and involved in their treatment. It was evident patients felt all staff and doctors worked hard to ensure their healthcare needs were met.
- Patients knew they could speak to someone in private if necessary. They were aware of the chaperone facility offered when personal examinations were undertaken. All patients were happy with the cleanliness of the surgeries.
- The Patient Participation Group (PPG) was an active group. This was facilitated by the practice manager and one of the lead partners. It was evident the PPG was active and had contributed feedback about patients' views and in turn these had contributed to changes within the practice.

Outstanding practice

- The practice had commissioned the Pharmacy First Scheme for minor ailments to ease patient access to appointments. This service is available to all patients; those who pay for prescriptions are charged for the medications, normally cheaper than prescriptions. Patients who do not pay for their prescriptions do not pay for these medications.
- The practice used computerised tools such as the 'Electronic Checking Leading to Improved Safety and Efficiency '(ECLIPSE) to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We saw the personalised plans and records, which showed areas of identified risk and how these risks were reviewed.

Hoyland First PMS Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP and a practice manager.

Background to Hoyland First PMS Medical Practice

The Hoyland First PMS Practice catchment area includes the villages of Hoyland, Elsecar, Hoyland Common, Birdwell, Jump, Hemingfield, Tankersley, Pilley, Wentworth and Harley. They also cover part of Wombwell and Worsbrough Bridge. The practice population is currently over 13,000 and growing. There are six GP partners and three salaried GPs. One Advanced Nurse practitioner, four practice nurses and three heath care assistants. The practice is registered with the CQC to provide primary medical services. It provides Personal Medical Services (PMS) under a contract with NHS England, within the Barnsley Commissioning Group (CCG) area. This is a training practice for student doctors and qualified doctors who wish to undertake the postgraduate qualifications to become a GP. In addition the practice is participating in a pilot scheme offering student nurse placements to help encourage nurses on qualifying, to work in general practice.

The practice is open each weekday from 8am until 6.30 pm. In addition there are a number of pre-bookable appointments offered through the Extended Hours Access scheme. These are from 6.30-7.30 pm on Monday and Tuesday evenings and from 7am until 8am on Friday mornings. A small number of these appointments are reserved for same day/ urgent demand. The practice also offers a number of telephone appointments which can be booked in advance and on-line. GPs routine working weeks are advertised on the practice website. This helps inform patients which doctor is available and when. They have a duty doctor on call each day of the week who is responsible for patients needing urgent care/advice. When the surgery is closed, patient calls are automatically diverted to the Out of Hours service commissioned by NHS England.

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

Detailed findings

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations, such as NHS England local area team and Barnsley Clinical Commissioning Group (CCG), to share what they knew.

We carried out an announced visit on 16 December 2014. During our visit we spoke with a range of staff including GPs, registrars, practice nurses, health care assistant (HCA), two receptionists and the practice manager. We also spoke with four patients who used the practice including a member of the practice's Patient Participation Group (PPG).

We observed communication and interactions between staff and patients both face to face and on the telephone within the reception area. We reviewed 17 CQC comment cards where patients had shared their views and experiences of the practice. We also reviewed records relating to the management of the practice.

Information from the General Practice Outcome Standards (GPOS), Quality Outcomes Framework (QOF) and Barnsley CCG information showed the practice rated as a high achieving practice.

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

The practice had systems in place to record, monitor and learn from incidents which had occurred within the practice. Safety was monitored using information from a range of sources including the QOF, patient survey results, patient feedback forms, the Patient Participation Group (PPG), clinical audit, appraisals, professional development planning, education and training. We reviewed safety records and incident reports and minutes of meetings where these were discussed. This showed the practice had managed these consistently over time and so could demonstrate a safe track record over the long term.

Staff were able to give examples of the processes used to report, record and learn from incidents. They confirmed these were discussed in the regular monthly practice meetings.

Learning and improvement from safety incidents

The Practice had a system in place for reporting, recording and monitoring significant events. The practice manager provided a summary of the 26 significant events which occurred in 2014. We also reviewed the significant events records at the practice. Significant events and complaints were a standing item on the monthly practice meeting agenda. There was evidence the practice had learned from these and the findings were shared with relevant staff. For example, following an incident relating to a patient's repeat prescription not being available at the chemist; the prescribing lead had followed this up with the pharmacist who made changes to their system to help prevent a recurrence.

We saw records of incidents, investigation and actions taken. We saw where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken. We found action had been taken following incidents where necessary, to safeguard patient's health and welfare. We saw where incidents had involved other organisations these had been communicated to the relevant department and action had been taken to minimise the risk of errors recurring.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records, which showed all staff had received relevant, role specific, training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed a dedicated GP lead in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training at level 3 to enable them to fulfil this role. All staff we spoke with were aware who the lead was and who to speak to in the practice, if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. All nursing staff, including health care assistants, had been trained to be a chaperone.

Medicines management

There was a named GP lead prescriber, who worked closely with the primary care prescribing team. This helped to ensure prescribing within the practice was up to date and following current best practice guidance. In addition there was a named medication administrator who supported the prescribing within the practice. We saw records of practice meetings which noted the actions taken in response to a review of prescribing data. For example, patterns of

antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The nurses and the health care assistants administered vaccines using Patient Group Directions (PGD) and Patients Specific Directions (PSD) which had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence of the nurses and the health care assistants having received appropriate training.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. 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.

Cleanliness and infection control

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

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We were told how the audit and training process was currently being reviewed and updated.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. They were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury; staff we spoke with confirmed their understanding. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

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

Equipment

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

Staffing and recruitment

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

Staff told us about the arrangements for planning and monitoring the number and skill mix of staff needed to meet patients' needs. We saw there was a rota system for the different staffing groups, to ensure enough staff were on duty. There was an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there was always enough staff on duty to maintain the smooth running of the practice and keep patients safe. The practice manager showed us records to

Good

Are services safe?

demonstrate actual staffing levels, succession planning and the skill mix required to deliver quality care and treatment. We saw evidence of recruitment planning to help ensure there was sufficient staff to provide safe and effective care.

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 and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw any risks identified were discussed at GP partners' meetings and within team meetings.

We saw staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example:

- There were emergency processes in place for patients with long-term conditions. Staff gave us examples of referrals made for patients whose health deteriorated suddenly.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed 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 it was checked regularly. The notes of the practice's significant event meetings showed staff had discussed a medical emergency concerning a patient and the practice had learned from this, appropriately.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed them to focus on specific conditions. Clinical staff we spoke with told us how they asked for and alternatively provided colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for all conditions. Our review of the clinical meeting minutes confirmed this happened.

One GP partner showed us data from the local CCG of the practice's performance for antibiotic prescribing, which was comparable to similar practices. The practice had also completed a review of case notes for patients with high blood pressure which showed all were receiving appropriate treatment and regular reviews. The practice used computerised tools such as the 'Electronic Checking Leading to Improved Safety and Efficiency '(ECLIPSE) to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We saw the personalised plans and records, which showed areas of identified risk using a RAG(Red, Amber & Green) rating and how these risks were reviewed. This helped to prevent any untoward incidents. We were shown the process the practice used to review patients who were recently discharged from hospital. This was within one week, or sooner depending upon their needs.

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

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed the culture in the practice was that patients were cared for and treated based on need. The practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

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

We were shown clinical audits which had been undertaken in the last year. All of these were completed audits where the practice was able to demonstrate the changes implemented since the initial audit. We saw the learning points identified in 2013, in relation to patients with breast cancer were maintained. Other examples included audits to confirm the GPs who undertook minor surgical procedures were doing so in line with their registration and National Institute for Health and Care Excellence guidance.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of analgesics and nonsteroidal anti-inflammatory drugs. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated care and treatment and documented the success of any changes.

Good

Are services effective?

(for example, treatment is effective)

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

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 100% of patients with diabetes had an annual medication review, and the practice met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF (or other national) clinical targets.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked patients receiving repeat prescriptions had been reviewed by the GP. They also ensured all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm, after receiving an alert, the GPs had reviewed the use of the medicine in question. Where it was continued to be prescribed, they documented the reasons why. The evidence we saw confirmed the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the needs of patients and their families. Staff training and better understanding of the needs of these patients meant the practice had increased the number of patients on the register.

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

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors with a number having additional interests in mental health, child and maternal health and surgery. All GPs were up to date with their continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals where learning needs were identified and action plans were documented. Our interviews with staff confirmed the practice was proactive in providing training and funding for relevant courses, for example infection control. As the practice was a training practice, doctors who were training to be qualified as GPs offered extended appointments and they had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with.

Practice nurses were expected to perform defined duties and were able to demonstrate they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology. Those with extended roles e.g. seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease were also able to demonstrate they had appropriate training to fulfil these roles. We also saw their mentor qualifications as they supported student nurses who had the opportunity to have a 12 week placement in the practice.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we

Good

Are services effective?

(for example, treatment is effective)

spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year, of any results or discharge summaries not followed up appropriately.

The practice was commissioned for a new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw the policy for actioning hospital communications was working well in this respect. The practice undertook a yearly audit of follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed.

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

Information sharing

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made 75% of referrals last year through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported this system was easy to use.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. One GP showed us how straightforward this task was using the electronic patient record system, and highlighted the importance of this communication with A&E. The practice has also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

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

Consent to care and treatment

We found staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and they were able to describe how they implemented it in their practice. However, the practice was updating their consent policy to reflect current best practice guidance.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child under 16, has the maturity to make their own decisions and to understand the implications of those decisions). There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

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

Health promotion and prevention

The practice had met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

Good

Are services effective?

(for example, treatment is effective)

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. The system in place using the GP-GP transfer of information was effective in raising awareness of medical problems very soon after registering with the practice. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed patients in this age group were beginning to take up the offer of the health check. A GP showed us how patients were followed up immediately if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and all were offered an annual physical health check. Practice records showed they had received a check up in the last 12 months. The practice had also identified the smoking status of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was very high which was better than others in the CCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend. There was also a named nurse responsible for following up patients who did not attend screening.

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

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey in 2013, a survey of patients undertaken by the practice's patient participation group (PPG) and patient satisfaction questionnaires sent out to patients. The evidence from all these sources showed patients were satisfied with how they were treated and this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' from patients who rated the practice as good or very good. The practice was also above average for its satisfaction scores on consultations with doctors and nurses. Patients stated the GP was good at listening to them and they all said the GP gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received seventeen completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Four comments were less positive with a common theme of accessing appointments and reception staff being less than helpful. We also spoke with four patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

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

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

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning. This included making decisions about their care and treatment and generally rated the practice highly in these areas. For example, data from the national patient survey showed 70% of practice respondents said the GP involved them in care decisions and 70% felt the GP was good at explaining treatment and results. The results from the practice's own satisfaction survey showed that 79% of patients said they were sufficiently involved in making decisions about their care.

Patients we spoke with on the day of our inspection told us health issues were discussed with them. They felt involved in decisions about the care and treatment they received. They also told us they felt listened to and supported by staff. They had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

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

Population group evidence

Good

Are services caring?

- Older people – there was evidence of care plans and patient involvement in agreeing them. We saw information was available about end of life planning.
- People with long-term conditions – there was evidence of care plans and patient involvement in agreeing the actions.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it highly in this area. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, they highlighted how staff responded compassionately when patients/carers needed help and how they provided support when required.

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

Staff told us when families suffer a bereavement their GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The NHS England Area Team and Clinical Commissioning Group (CCG) told us the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population.

The practice had applied for and was successfully awarded an innovation fund. They were using it to increase the co-ordination of care for their patients with chronic diseases. They had identified patients' needs were not always met in a timely way. The fund allowed for better coordination so that medical, social care or other support was available when needed.

The practice had health trainers in attendance weekly, to support patients with weight loss and life style changes. We were told of a new position which was to be undertaken by an existing staff member. They were to be called patient liaison care. They would update the carers register and sign post patients appropriately to social care and patient groups.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). This included a new hearing loop and training for staff to understand sensory impairment. Braille signs were now in place close to the lift. The PPG were involved in being pro-active in the waiting room, supporting patients to use the automated check in. They had promoted on-line services too, to free the receptionists to answer telephone calls.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Patients who were carers were flagged on the IT system so clinical staff could explore their health and social support needs. This was documented so future consultations would consistently follow up issues identified.

The patients had access to online and telephone translation services. The practice had a population of 97% English speaking patients though it could cater for other different languages through translation services.

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

The practice was purpose built with most services for patients on the ground floor. There was lift access to the first floor. We saw the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

Appointments were available from 8am to 6.30pm on weekdays. The practice's extended opening hours was particularly useful to patients with work commitments. These were each Monday and Tuesday when pre-bookable appointments from 6.30 pm until 7.30pm. Additionally, there were early morning pre-bookable appointments available on certain Fridays each month from 7am-8am.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. In addition we saw a timetable on the web site stating GP availability each week. Patients could plan who to see and when more easily because of this information.

Longer appointments were also available for patients who needed them and those with long-term conditions. This included appointments with a named GP or nurse. Home

Good

Are services responsive to people's needs?

(for example, to feedback?)

visits were made to four local care homes by a named GP, who reviews care plans on a regular basis and corroborates with other professionals e.g. pharmacists to manage on-going care. . Home visits were available each week day to those patients who needed a home visit.

Patients were generally satisfied with the appointments system. They confirmed they could see a doctor on the same day if needed. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that those in urgent need of treatment had been able to make an appointment on the same day of contacting the practice.

Population Group Evidence:

- For older patients and those with long-term conditions, we found home visits were available to all patients over 70 and where needed. Most had longer appointments to meet their needs.
- Families, children and young people, we found appointments were available outside of school hours for children and young people. The premises were suitable for children and younger patients. The practice offered a full range of sexual health and contraceptive services.
- Working age patients' needs were understood and services reflected this with extended opening hours. Online booking system was available and it was easy to use. There were, text message reminder for appointments and test results, for those who had consented to receive them. There were telephone consultations available too, where appropriate.

Listening and learning from concerns and complaints

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

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

We looked at 14 complaints received in the last 12 months and found they were handled in a timely manner according to practice policy. The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on.

- Minutes of team meetings reviewed showed complaints were discussed to ensure all staff were able to learn and contribute to determining any improvement action required.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and five year business plan. The practice vision and values included to provide the best possible service for all their patients. They wanted to involve patients in their own care and work with them to promote their health and well-being.

We spoke with six members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. We looked at minutes of the practice monthly meetings and saw staff had discussed and agreed the vision and values were still current.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop of any computer within the practice. We looked at some of these policies and found most staff had completed a cover sheet to confirm when they had read the policy. Some of the policies were in the process of being updated; others we looked at had been reviewed and were up to date. The practice had outsourced this area to a human resources firm.

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

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

The practice had an ongoing programme of clinical audits which it used to monitor quality to identify where action should be taken.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed some of the potential issues. Risk assessments were beginning to be carried out where risks were identified action plans had been produced with short medium and long term actions to be completed.

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

Leadership, openness and transparency

We saw from minutes of team meetings these were held regularly, at least monthly. Staff told us there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We also noted once a month the practice closed for training and updates when all staff attended.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, which included disciplinary procedures, and the induction policy which were in place to support staff. These human resources policies were in the process of being updated. Staff we spoke with knew where to find the information, or who to ask if required.

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

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. We looked at the results of the annual patient survey and 63% of patients agreed telephone consultations would be useful. We saw as a result of this the practice had introduced telephone consultation appointments.

The practice had an active patient participation group (PPG) which has steadily increased in size. The PPG included representatives from various but not all population groups. They were looking to recruit younger patients and were considering going into schools. The PPG had carried out quarterly surveys and met every quarter. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website.

The practice had gathered feedback from staff through staff away days and staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and

Are services well-led?

Good

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

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

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

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four staff files and saw regular appraisals took place which included a personal development plan. Staff told us the practice was very supportive of training and they had staff training afternoons where guest speakers and trainers attended.

The practice was a GP training practice, with three GP trainers. The nursing team was participating in the Advanced Training Pilot for student nurses, to encourage nurses on qualifying to consider practice nursing as a career choice. The tutorials and mentoring helped the clinical teams to remain up to date in their fields. In addition they were participating in the Hoyland project where motivational interviewing techniques were being developed.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients. We saw how steps had been implemented to check dates of birth when similar names are identified. There was an additional flag on the IT system too.