The Nayar Practice

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection visit on 21 January2015 and the overall rating for the practice was good. The inspection team found after analysing all of the evidence that the practice was safe, effective, caring, responsive and well led.

Our key findings were as follows:

- The practice provided good, safe, responsive and effective care for all population groups in the area it serves.
- All areas of the practice were visibly clean.
- Where incidents had been identified relating to safety, staff had been made aware of the outcome and action taken where appropriate, to keep patients and staff safe.
- Patients received care according to professional best practice clinical guidelines. The practice had regular information updates, which informed staff about new guidance to ensure they were up to date with best practice.
- The service was responsive and ensured patients received accessible, individual care, whilst respecting their needs and wishes.
- The service was well led and there were positive working relationships between staff and other healthcare professionals involved in the delivery of service.

We saw several areas of outstanding practice including:

- The practice participated in the pilot use of 'Cantab Mobile'. The computer technology uses a mobile screening tool, simple to use, and allows GPs to make informed decisions about their patients, and more efficient referrals into hospital, community or social care.
- Patients who required an annual or more frequent health review were contacted personally via the telephone. An appointment time convenient to the patient was then agreed. This had helped mitigate against non-attenders.

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

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. NICE guidance is referenced and used routinely. People's needs are assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health.

Staff had received training appropriate to their roles and further training needs had been identified and planned. The practice can identify all appraisals and the personal development plans for all staff. Multidisciplinary working was evidenced. Staff worked with multidisciplinary teams and proactively identified those patients at risk of developing long term conditions which were specific to their patient population. They had developed services and worked with local schemes, such as 'Cantab Mobile' linked to secondary care(hospital).

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice higher than other practices in the area for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice and a named GP and continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat

Summary of findings

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

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision and strategy to deliver this. 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 regular governance meeting had taken place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice did not have an active patient participation group (PPG). However they were looking at ways to develop further links with the community and identify patients who would be willing to form a PPG. 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 the practice had good outcomes for conditions commonly found amongst older patients. The practice offered proactive, personalised care to meet the needs of the older patients in its population and had a range of enhanced services, for example in dementia and end of life care. The practice was responsive to the needs of older patients, including offering 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 population group of patients with long term conditions. Emergency processes were in place to refer patients, in this group, who had a sudden deterioration in health. When needed, longer appointments and home visits were available. All these patients had a named GP and structured annual reviews to check their health and medication needs, were being met. We found these patients had personal invites to their reviews. We were told this had increased the uptake and in some cases patients health outcomes were improving. For those patients with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young patients. Systems were in place for identifying and following-up children living in disadvantaged circumstances and/or those who were at risk. For example, the practice followed up those 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 and we saw evidence children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We were provided with good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals made for children and pregnant women who had sudden deterioration in their health.

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Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age patients including those recently retired. The needs of the working age population and those recently retired, 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 which reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of patients whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with learning disabilities. The practice had carried out annual health checks for patients with learning disabilities; these appointments were longer than usual. Their invitations for review were in an easy to read font. If consent had been given, their carer or keyworker were informed of the date and time of the appointment. All of these patients had received follow-up care where needed.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. The practice had sign-posted vulnerable patients to various support groups and third sector 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 and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). One hundred per cent of 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 patients experiencing poor mental health, including those with dementia. The practice had in place advance care planning for patients with dementia. They worked in partnership with the local hospital dementia care team, for the benefit of patients. The practice had participated in the pilot of 'Cantabmobile' a mobile screening tool which identified patients who were at risk of

Summary of findings

developing dementia. In real terms for the practice population this had shown an increase in patients on the dementia register. These patients were now receiving appropriate health care interventions and improved health outcomes.

The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations including MIND. The practice had a system in place to follow up on patients who had attended accident and emergency where there may have been mental health needs. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We received 31 CQC patient comments cards where we found 29 very positive comments about the practice and the staff. We saw many comments about the excellent care patients and their families had received from all members of the clinical team. They had said they were involved in all aspects of their care and the GPs and nurses explained everything to them. Some of the comments were from people who had been patients since the practice opened. There were two comment cards that expressed whilst they were very happy with their care and treatment, they were however unhappy with the lack of smiles at the front desk.

We spoke with four patients, from different population groups, who told us the staff were very helpful, respectful and supportive of their needs. They felt all staff communicated well with them well; they were involved and felt supported in decisions about their care. They felt the clinical staff responded to their treatment needs and they were provided with a caring service.

Outstanding practice

- The practice participated in the pilot use of 'Cantabmobile'. The computer technology uses a mobile screening tool, simple to use, and allows GPs to make informed decisions about their patients, and more efficient referrals into hospital, community or social care.
- Patients who required an annual or more frequent health review were contacted personally via the telephone. An appointment time convenient to the patient was then agreed. This had helped mitigate against non-attenders.

The Nayar 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 SPA and another CQC inspector.

Background to The Nayar Practice

The Nayar Practice is located in a purpose built building, the Martinwells Centre in Edlington. The practice shares the building with another GP practice. There is a dental practice within the building too. There are offices for allied health services, such as the District Nursing Team and Health Visitors.

The practice provides General Medical Services (GMS) under a contract with NHS England Doncaster, to the practice population of 4,535 patients. Our information shows fewer patients over the age of 85, which reflects the life expectancy within the area. The practice deprivation score is the second most deprived decile. The practice is registered with the CQC to provide the following regulated activities: Maternity and midwifery services; Diagnostic and screening procedures; Treatment of disease, disorder or injury; and Surgical procedures.

The practice has three GP partners, one female and two male. They are supported by a First Contact Nurse Pracitioner(female) and two female practice nurses. Additonally there is a healthcare assistant providing clinical care. There is an administration team with specific roles identified and there is a practice manager.

The practice is open from 8am- 6pm Monday, Tuesday, Wednesday and Friday. On a Thursday the practice is open from 8am untl 2pm. The First Contact Nurse has emergency appointments available each day. Extended hours opening includes pre-booked appointments with the Practice Nurse or Health Care Assistant, from 8am each day. The GP has appointments available until 8pm on Tuesdays.

The practice has opted out of providing Out of Hours services to their patients. The practice uses Doncaster Emergency Out of Hours Service for its Out of hours cover from 6pm each evening. On a Thursday the practice uses Care UK who provides cover from 1.30-6pm for their patients.

The CQC intelligent monitoring placed the practice in band six. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience. This includes 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 the NHS Doncaster CCG, to share what they knew.

We carried out an announced visit on 21 January 2015. During our visit we spoke with a range of staff including two GPs, one First Contact Nurse Practitioner, one practice nurse, a health care assistant (HCA), two receptionists and the practice manager. We also spoke with four patients who used the practice.

We observed communication and interactions between staff and patients both face to face and on the telephone within the reception area. We reviewed 31 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 Doncaster Clinical Commissioning Group (CCG) information showed the practice rated as an 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, 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 weekly practice meetings.

Learning and improvement from safety incidents

The Practice has a system in place for reporting, recording and monitoring significant events. The practice manager provided a summary of the four 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 practice meeting agenda. There was evidence the practice had learned from these and the findings were shared with relevant staff.

We saw records of incidents, investigation and actions taken. We saw where patients had been affected by something which had gone wrong they were given an apology and informed of the actions taken. We found from records action had been taken, following incidents, to safeguard patient's health and welfare where necessary. 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 repeated errors.

Reliable safety systems and processes including safeguarding

There were comprehensive policies and protocols for safeguarding vulnerable adults and children. Any concerns regarding the safeguarding of patients were passed on to the relevant authorities by staff as quickly as possible. Staff had received training relevant to their role and this included safeguarding vulnerable adults and children training. The lead GP (for safeguarding vulnerable adults and children) and the other two GPs and the First Contact Nurse practitioner were trained to Level 3. The lead GP informed us they had participated in local safeguarding meetings for their patients, when required. We saw that alerts were placed on patients' electronic records to inform staff of any safeguarding issues for individual patients who attended for consultation.

We saw an up to date chaperone policy and protocol. The nurses and some previously trained administration staff undertook this role. When chaperoning had taken place this was recorded in the patient's records.

Medicines management

The practice was supported by a CCG pharmacist, who helped with prescribing audits to ensure patients received appropriate medicines. We saw the 2013/2014 prescribing audit report which identified the positive changes which had been undertaken within the practice. We saw two cycle audits for hypertension and found health improvements with the second audit. The GPs told us they received medicine alerts from the Clinical Commissioning Group (CCG), National Institute for Health and Care Excellence (NICE) and Medicines Products Regulatory Agency (MHRA). We saw evidence of the meetings between the GPs and the clinical team and how these alerts were actioned and followed up. We were told where there had been changes to guidelines for some medicines, audits had been completed. Any changes in guidance about medicines were communicated to clinical staff in practice meetings.

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 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.

Good

Are services safe?

Medicine fridge temperatures were checked and recorded daily. The fridges were adequately maintained by the manufacturer and the staff were aware of the actions to take if the fridges were ever found to be out of the correct temperature range.

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's landlord (for their building) had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings).

Equipment

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

We saw the locum pack to help support locums when first employed. Although we were told they were used rarely and they preferred to use locums who knew them.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure 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 to maintain the smooth running of the practice and likewise always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate actual staffing levels, succession planning and the appropriate skill mix. We saw evidence of succession 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.

Good

Are services safe?

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. The First Contact Nurse Practitioner had appointments available each day and a GP was always available for support if needed.

Arrangements to deal with emergencies and major incidents

There were disaster/ business continuity plans in place to deal with emergencies. Such as power cuts and adverse weather conditions which may interrupt the smooth running of the service. The plans were accessible to all staff. The plan included an assessment of potential risks which may affect the day-to-day running of the practice. This provided information about contingency arrangements staff would follow in the event of an emergency.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients we spoke with told us they were involved in decisions about their care and treatment. The clinicians were familiar with and were following current best practice guidance. New guidance from the National Institute for Health and Care Excellence (NICE) was reviewed at the regular clinicians' meetings and where appropriate, a plan made to implement into clinical practice. The GP and other clinical staff told us they had access to and followed NHS Doncaster CCG guidelines and care pathways for patients We saw patients treatment plans were reviewed in discussion with the GP and appropriate changes made where necessary. This was shared at the practice clinical meetings and multidisciplinary meetings.

From our discussions we found GPs and nurses were aware of the latest best practice guidelines and incorporated this into their day-to-day practices. Protocols from the local NHS trust were available and used to assist staff in maintaining the treatment plans of their patients. The practice used standardised local/national best practice care templates as well as personalised self-management care plans for patients with long-term conditions. This supported the practice nurse to agree and set goals with patients; these were monitored at subsequent visits.

The practice participated in the pilot use of 'Cantab Mobile' with support from the specialist dementia nurse. The medical software device is designed to give a quick and accurate assessment of a patient's memory. The device gives GP practices the opportunity to offer their patients a screening test which can identify a potential cognitive impairment, helping to detect the earliest signs of clinically-relevant memory problems and enabling patients to receive the best care possible. The technology is simple to use, and allows GPs to make informed decisions about their patients, and more efficient referrals into hospital, community or social care. Early diagnosis is critical as it gives patients, and their carers, better support, and much more opportunity to take an active part in their on-going healthcare.

National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. The GPs we spoke with used national standards for the referral of patients with suspected cancers 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. GPs in the surgery undertake minor surgical procedures in line with their registration and NICE guidance. The staff are appropriately trained and keep up to date. They also regularly carry out clinical audits on their results and used that in their learning.

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.

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

Good

Are services effective?

(for example, treatment is effective)

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, to improve patient's health outcomes.

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).

The First Contact Nurse Practitioner and the 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. All nurses had their 'fit for practise' reviewed each year via the Nursing and Midwifery Council (NMC) registration web site.

All staff had an 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.

Working with colleagues and other services

Staff we spoke with felt they were listened to and involved in the running of the practice. There were clear lines of accountability and staff understood their roles.

The practice used a computer system to store patient records. Staff input data such as discharge letters and blood results into the electronic records. Tasks were then sent electronically for the GP to review the information.

Staff told us they had regular meetings and were able to describe the content of the discussions in the meetings and any actions taken in response. Regular multi-disciplinary meetings were held to discuss patients with complex needs, end of life care and patients at risk.

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, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

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.

We saw evidence of multi-disciplinary team meetings where patients with complex needs were discussed to help ensure their changing needs were documented and discussed.

Consent to care and treatment

We found clinical 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. This was to include further training on the Mental Capacity Act 2005, for all staff.

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 they had a section stating the patient's preferences for treatment and decisions. There was a practice policy for documenting

Good

Are services effective?

(for example, treatment is effective)

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

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

Health promotion and prevention

It was practice policy to offer 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 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.

We saw evidence of health promotion materials in the practice waiting areas. We spoke with the local community officer for social inclusion. They were funded by NHS England and helped signpost patients to the most appropriate support groups, where necessary. The practice intended to participate in the forthcoming social prescribing pilot, to help reduce health inequalities within the practice population.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients completed CQC comment cards to tell us what they thought about the practice. We received 31 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. 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.

We saw staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey, and 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 GPs and all of the nurses listened to them and they said they always gave them enough time, when in consultation.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. We saw privacy curtains were provided in all consulting room so that patients' privacy and dignity was maintained during examinations, investigations and treatments. There were clearly visible notices in the patient reception area and GP surgeries informing patients they could request a chaperone.

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. They were confident these concerns would be investigated.

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

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning. 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 81% of practice respondents said the GP involved them in care decisions and 71.6% felt the GP was good at explaining treatment and results.

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

- 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 patient 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 the survey information. For example, they highlighted how staff responded compassionately when patients/carers needed help and how they provided support when required.

Good

Are services caring?

Notices in the patient waiting room 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.

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

The NHS England Area Team and Clinical Commissioning Group (CCG) told us the practice engaged regularly with them and other practices to discuss local needs and to prioritise service improvements. We saw minutes of meetings where the district nurse provision to a number of practices had been discussed and where changes were intended.

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 building which housed 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.

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.

Access to the service

Appointments were available from 8am- 6pm Monday, Tuesday, Wednesday and Friday. On a Thursday from 8am until 2pm. The First Contact Nurse had emergency appointments available each day. Extended hours opening included pre-booked appointments with the Practice Nurse or Health Care Assistant, from 8am each day. One GP had appointments available until 8pm on Tuesdays.

Comprehensive information was available to patients about appointments in the practice leaflet. 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.

Longer appointments were available for patients who needed them and those with long-term conditions. Patients who required an annual or more frequent health review were contacted personally via the telephone. An appointment time convenient to the patient was then agreed. This had helped mitigate against non-attenders. This included appointments with a named GP or nurse. Home visits were made to four local care homes on a specific day each week. 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 they needed to. 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 patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. This included seeing the First Contact Nurse Practitioner; patients were very confident with this part of the service.

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 evidence that complaints had been responded to in a timely way and followed the practice policy.

We saw information was available to help patients understand the complaints system. This was displayed in

Good

Are services responsive to people's needs?

(for example, to feedback?)

the waiting area, however it was not prominently displayed. We saw the notice was in small font and would not be easy for some people to read. We were assured the notice would be enlarged immediately. 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.

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

There was an established management structure within the practice. The GPs and staff we spoke with were clear about their roles and responsibilities. The practice was committed to deliver a service where patient care came first and where they 'were a name not a number'. They wanted to deliver personal services to their patients, which met their needs.

Governance arrangements

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

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 four 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 team meetings and action plans were produced to maintain or improve outcomes.

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

Leadership, openness and transparency

We saw from minutes of team meetings that they were held regularly, at least weekly. 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 week 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. 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. The staff felt they could raise concerns at any time with either the GPs or practice manager, as they were considered to be approachable and responsive. The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice did not have an active patient participation group (PPG). However they were looking at ways to develop further links with the community and identify patients who would be willing to form a PPG.

Management lead through learning and improvement

We saw an induction programme was completed by new staff and all staff had completed mandatory training. This included: fire safety awareness, information governance, safeguarding vulnerable adults and children and equality and diversity. The practice had clear expectations of staff attending refresher training and this was completed in line with national expectations. We saw the practice held a record of all training undertaken and details of when refresher training would be required. Staff told us the training they received helped to improve outcomes for the patients. The staff we spoke with told us they felt supported to complete training and could request any additional training which would benefit their role.

The practice used information such as the Quality Outcome Framework (QOF) and patient feedback to continuously improve the quality of services. Staff were able to take time out to work together to resolve problems and share information which was used proactively to improve the quality of services. 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.