Royston Group 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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection visit on 3 December 2014. The overall rating for the practice was good. Additionally, we found the practice was good in providing: safe, responsive and effective care for all of the population groups it serves.

Our key findings were as follows:

• Where incidents had been identified relating to safety, staff had been made aware of the outcome and action taken where appropriate, to keep people safe.

• All areas of the practice were visibly clean and where issues had been identified relating to infection control, action had been taken.

• 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 practice ensured patients received accessible, individual care, whilst respecting their needs and wishes.

• We found 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 investigated and learned from concerns and complaints engaging in extensive audits to examine their own professional practice to satisfy themselves they worked in the best interest of the patient.
- The practice promoted patients on going health with tailor made healthier living programmes, with specialist nurse support and an on site health trainer.
- The practice used the 'choose and book' system effectively by ensuring all patients had a referral made before they left the surgery.

Summary of findings

All patients, but particularly those who worked, had access to appointments during early mornings and all day Saturday openings throughout the year. These patients could also access the GP for telephone advice if attending the practice was difficult.

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. The practice provided opportunities for the staff team to learn from significant events and was committed to providing a safe service. Information about safety was recorded, monitored, appropriately reviewed and addressed. The practice assessed risks to patients and managed these well.

Are services effective?

Good

The practice is rated as good for providing effective services. The practice was proactive in the care and treatment provided for patients with long term conditions such as asthma and diabetes and they regularly audited areas of clinical practice. There was evidence the practice worked in partnership with other health and social care professionals, such as health visitors district nurses, psychiatric services and social workers.

Staff received training appropriate to their roles and the practice supported and encouraged their continued learning and development.

Are services caring?

Good

The practice is rated as good for providing caring services. Patient surveys showed that patients rated the practice higher than other practices regarding several aspects of care. All the patients who responded to CQC comment cards, and those we spoke with during our inspection, were very positive about the service. They all confirmed staff were caring and compassionate and felt the practice provided a good service.

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 and that 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 and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders.

Summary of findings

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 people. 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.

They were responsive to the needs of older patients, including offering home visits and urgent appointments for those vulnerable patients with additional needs. We also saw that the practice provided support to care homes in the area which included an elderly patient group. They supported the care homes with regular weekly visits and provided appointments when required at the practice.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check their health and medication needs were being met.

Patients with long term conditions were monitored and discussed at multi-disciplinary clinical meetings so staff could respond to their changing needs. Information was made available to palliative care teams and out of hours providers for those on end of life care to ensure appropriate care and support was offered.

The practice had regular nurse run clinics for conditions such as diabetes and asthma to ensure patients' conditions were appropriately monitored, and that they were involved in making decisions about their care. The practice had good systems in place to contact non-attenders to ensure their health was continually supported. The practice contacted patients with long term conditions annually on their birthday to ensure their health checks were not over looked.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up

Summary of findings

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.

There were pre and post natal clinics. Patients also had easy access (within the same building) to health visitors and midwifery services. Full post natal and six week baby checks were carried out by GPs and the practice nurse, and regular baby clinics could be accessed. We saw good examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Outstanding ☆

The practice is rated as outstanding for the care of working-age people (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 offered patients extended opening hours and opened 08:30am to 4pm on Saturday throughout the year for both emergency and pre-bookable appointments. The practice was also proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability and offered longer appointments to accommodate their needs.

Where patients needed support with substance misuse or alcohol addiction there were health clinics to support them held at the practice The practice also had good links with local support agencies, who specialised in supporting patients with substance misuse.

The practice also had arrangements in place for longer appointments to be made available where patients required translation services. There was a hearing loop system for patients who had hearing difficulties and information was available in larger print and could be made available in additional languages if required.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).The practice had access to professional support such as the local mental health team and psychiatric support as appropriate.

Repeat prescribing for patients receiving medication for mental health needs was monitored by the GP. The practice monitored patients with poor mental health according to clinical quality indicators and in line with good practice guidelines.

The practice had supported patients experiencing poor mental health by referring to local Mental Health Teams and working closely with Psychiatrists and Community Psychiatric Nurses. They also signposted patients for further help and counselling support was provided at the practice. If required patients were referred to local support groups based in the community.

Summary of findings

What people who use the service say

Whilst the GP patient survey of 2012-13 show that a comparatively low proportion (65%) of patients said they would recommend the practice to others, their own survey of 2013 reported that 89% of 320 patient respondents rated the care from the practice as good or excellent.

We received 35 completed patient CQC comment cards and spoke with five patients on the day of our visit. We spoke with people from different age groups and people who had different physical care needs and who had varying levels of contact with the practice. All these patients were complimentary about the care provided by the GPs, clinical and reception staff. They all felt the doctors and nurses were caring and compassionate about their health needs. The negative comments from discussion with patients and the CQC comment cards were about access to booked appointments. The practice had responded to these concerns and along with the Patient Representative Group (PRG) had looked at ways to improve the service. They had introduced an on line booking system and an automated telephone system which gave the callers a choice of services. The practice had also set up text messaging to remind patients of their appointments.

We spoke to a member of the PRG who felt they were well supported by the management team and their ideas and suggestions were listened to and acted upon. They told us that they had conducted a patient survey to identify problem areas. From this they had been involved with looking at ways to improve the telephone systems, looking at training for reception staff and the refurbishment of the building when the building was purchased by the present GPs.

Areas for improvement

Outstanding practice

- The practice investigated and learned from concerns and complaints engaging in extensive audits to examine their own professional practice to satisfy themselves they worked in the best interest of the patient. For example, they had conducted a full audit of GPs issuing of sick notes to ensure that they were consistent. Following review of the information it was confirmed consistency was in place but changes were implemented and additional checks were put in place to ensure more detailed information was collected by GPs to meet with best practice.
- The practice promoted patients on going health with tailor made healthier living programmes, with specialist nurse support and an onsite health trainer.
- The practice was proactive about using the choose and book effectively by ensuring all patients had a referral made before they left the surgery on the day of their appointment.
- All patients, but particularly those who worked, had access to appointments during early mornings and all day Saturday openings throughout the year. This was for both emergency and pre bookable appointments. These patients could also access the GP for telephone advice if attending the practice was difficult.

Royston Group Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead inspector and included a GP and a practice manager.

Background to Royston Group Practice

Royston Group Practice is situated in the Royston area of Barnsley. The building has been recently renovated to meet the needs of all patients who use the practice and provide a good quality environment with good parking facilities and disabled access.

The practice is registered with the CQC to provide primary care services. It provides General Medical Services (GMS) for 8204 patients under a GMS contract with NHS England in the Barnsley Clinical Commissioning Group (CCG) area.

The practice has four GP partners, an advanced practioner, practice nurse, three healthcare assistants and an experienced administration and reception team. The reception team consists of a practice manager and six reception and administrative staff.

The practice is open Monday to Friday from 8.00am to 6.30pm with extended opening hours on a Saturday 8.30pm to 4pm throughout the year. The practice treats patients of all ages and provides a range of medical services. Patients also have access to primary care services such as health visitors and midwives, district nurses and an independent pharmacy is located next door.

When the practice is closed patients can access the out of hour's provider service via NHS 111 service. The practice population is made up of a predominately working aged patients up to 65 years. Eighteen per cent have a caring responsibility and the practice has a higher than the national average amount of patients with a long term health condition.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people

Detailed findings

- 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)

We carried out an announced visit on 3rd December 2014. During our visit we spoke with a range of staff including the practice manager, two GP partners, one advanced practioner, one practice nurse, and four reception and administrative staff. We also spoke with five patients and one member of the practice's patient representative group.

We observed communication and interactions between staff and patients both face to face and on the telephone within the reception area. We reviewed 35 CQC comment cards where patients and members of the public had shared their views and experiences of the service. We also reviewed records relating to the management of the service.

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, staff identified where a patient's test results had not been followed up and this had delayed treatment. This was shared with the team to learn from incidents and minimise future risk.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. This showed the practice had managed these consistently over time and so could show evidence of a consistent safe track record.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these. Significant events was a standing item on the practice meeting agenda and a dedicated meeting was held weekly to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff, including receptionists, administrators and nursing staff. All staff knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. We saw evidence of action taken as a result, for example, a patient had been given the wrong information by staff about their appointment. This was reviewed by the practice and we confirmed that where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at practice meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

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 that all staff had received relevant role specific training on safeguarding. We asked clinical 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 how to contact the relevant agencies. We noted that the contact details of the safeguarding agencies were easily accessible.

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke to were aware who to speak to in the practice if they had a safeguarding concern. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies, for instance involvement meetings with agencies such as police and social services.

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 patients who may require a longer appointment and children subject to child protection plans. The computer software used by the practice meant staff entered codes which then flagged up where a patient (child or adult) was vulnerable or required additional support, for instance if they were a carer. The practice also had systems to monitor babies and children who failed to attend for health checks, childhood immunisations, or who had high levels of attendances at A&E.

We saw the chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. There was evidence of patients being offered chaperone services

during consultation and treatment and staff had appropriate guidance and training. All appropriate staff, including health care assistants, had been trained to be a chaperone.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of steroid and antipsychotic prescribing within the practice. Audits and other reviews of medication had been conducted by the pharmacist advisor to the practice.

There were standard operating procedures (SOP) in place for the use of certain medicines and equipment. The nurses used patient group directives (PGD). PGDs are specific written instructions which allow some registered health professionals to supply and/or administer a specified medicine to a predefined group of patients, without them having to see a doctor for treatment. For example, flu vaccines and holiday immunisations. PGDs ensure all clinical staff follow the same procedures and do so safely. The data from 2013 NHS England showed 96% of children aged 24 months had received their vaccinations.

There was a process to regularly review patients' repeat prescriptions to ensure they were still appropriate and necessary. Any changes in medication guidance were communicated to clinical staff. 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.

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 of the practice.

The practice had a member of staff who was responsible for infection control. We saw evidence that the infection control lead had carried out audits and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed and any action required put into place. We also noted all staff received infection control training specific to their role and received annual updates.

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. Staff were able to describe how they would use these to comply with the practice's infection control policy.

We saw appropriate sharps receptacles in place in the treatment rooms. Separate containers were provided for the disposal of cytotoxic and contaminated sharps such as used needles. Staff told us they ensured spillage kits were available to clean areas contaminated with body fluids. The practice had a needle stick injury policy in place, which outlined what staff should do and who to contact if they suffered this injury.

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 that confirmed the practice was in the process of implementing regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

The practice had appropriate equipment for managing emergencies. Emergency equipment included a

Are services safe?

defibrillator and oxygen. These were readily available for use in a medical emergency and were checked regularly to ensure they were in working condition. We spoke with staff and they were clear about where emergency equipment was held in the building and what action to take in the event of a medical emergency. All relevant staff had completed Cardio Pulmonary Resuscitation (CPR) training.

The practice also had electrocardiogram monitoring equipment and 24 hour blood pressure monitoring equipment on site at the practice.

We saw the practice had annual contracts in place for portable appliance tests (PAT) annual gas maintenance and also for the routine servicing and calibration of medical equipment.

Staffing and recruitment

We confirmed 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 that set out the standards it followed when recruiting clinical and non-clinical staff.

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 that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

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 risk. We saw that any risks were discussed at team and staff meetings.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, we saw that the practice monitored repeat prescribing for people receiving medication for mental ill-health. Patients were encouraged to attend for a full health check and their medications continually monitored. We also saw 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). Staff knew the location of this equipment and records confirmed it was checked regularly.

Emergency medicines were available, such as, medicines for the treatment of cardiac arrest and anaphylaxis, and staff knew their location. Processes were in place to check emergency medicines were within their expiry date.

The practice had a disaster/ business continuity plans in place to deal with emergencies that may interrupt the smooth running of the service such as power cuts and adverse weather conditions. The plans were accessible to all staff and kept in reception. The plan included an assessment of potential risks that could affect the day-to-day running of the practice.

Arrangements were in place to protect patients and staff from harm in the event of a fire. This included staff designated as leads in fire safety and carrying out appropriate fire equipment checks.

There was evidence that learning from incidents and responding to risk had taken place and appropriate changes implemented. The practice management team looked at safety incidents and any concerns raised. They

then looked at how this could have been managed better or avoided. They also reported to external bodies such as the Clinical Commissioning Groups (CCG), the local authority and NHS England in a timely manner.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice aimed to deliver high quality care and participated in the Quality and Outcomes Framework (QOF). This is a national incentive and reward scheme that helps practices to focus on better outcomes for patients for example conditions such as coronary heart disease and high blood pressure. The practice achieved 99 % in total of the QOF framework points in year 2013, which showed their commitment to providing good quality of care.

We found clinical staff had a good awareness of recognised national guidelines. For instance they used National Institute for Health and Care Excellence (NICE) quality standards and best practice in the management of conditions such as asthma and diabetes. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines.

The GPs and Advanced Nurse Practioner, told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. We saw minutes of practice meetings where new guidelines were shared with staff, 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 the best health outcome for them.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

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 and deputy practice manager to support the practice to carry out clinical audits.

The practice showed us three clinical audits that had been undertaken in the last year. All these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, we saw extensive audits of anti-pyschotic medication to ensure patients prescribing was safe. The practice also worked closely with the consultant psychiatrist to ensure medication was prescribed to best meet the patients mental health needs.

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 national performance measurement tool. For example, we saw an audit regarding the prescribing of anti-psychotic medicines. Following the audit, the GPs had carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. The GPs told us following some of the prescribing reviews significant resources had been able to be redirected into enhancing other areas of the service.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, patients with diabetes had an annual medication review and the practice met all the minimum standards for QOF in diabetes, asthma and chronic obstructive pulmonary disease (COPD).

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.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions

Are services effective?

(for example, treatment is effective)

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 that, after receiving an alert, the GPs had reviewed the use of the medicine in question and where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed the GPs had oversight and a good understanding of the best treatment for each patient's needs.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

We found the practice completed full health checks on new patients and follow on support for any identified health needs. Special clinics for health needs such as, coronary heart disease, diabetes, asthma and COPD were held and systems were in place to identify patients who met the criteria to attend.

Mothers and babies were supported with antenatal clinics, with health visitor support and child health and immunisation clinics.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We saw checks were made on qualifications and professional registration as part of the recruitment process and additional checks were made throughout the clinician's appointment.

There was a comprehensive induction programme in place for new staff which covered generic issues such as fire safety and infection control. We saw evidence staff had completed mandatory training, for example basic life support, safeguarding and infection control.

The practice manager told us the staff completed some training electronically and other training at their monthly training sessions. Staff had trained in areas specific to their role for example, women's sexual health and heart disease, diabetes and COPD.

We saw evidence of regular in house training for all staff to attend. For instance, they had recently had training in cardiopulmonary resuscitation (CPR) and fire safety.

All GPs were up to date with their yearly continuing professional development requirements and all had either been revalidated or had a date for revalidation.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed the practice was proactive in providing training and funding for relevant courses. For example, to address the needs of the practice for female patients, additional training had been put into place in women's health.

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 and cervical cytology. Those with extended roles, such as supporting patients with diabetes, weight management and smoking cessation, were also able to demonstrate they had appropriate training to fulfil these roles.

Working with colleagues and other services

We saw evidence the practice worked closely with other professionals. For example they worked with palliative care nurses, health visitors, social services, substance misuse workers and care home staff to support patients. Specialised training and care plans had been developed to assist staff in meeting the needs of these patients. The staff attended multidisciplinary team meetings (MDT) every two months to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. Decision and care planning from these MDT meetings were documented in a shared care record.

The practice worked with other service providers to meet people's needs and manage complex cases. 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 spoke with understood their roles and felt the system in place worked well.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was

Are services effective?

(for example, treatment is effective)

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. We spoke with practice staff about the formal arrangements for working with other health services, such as consultants and hospitals. They told us how they referred patients for secondary (hospital) care and booked an appointment using the 'choose and book' system before the patient left the surgery.

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 on the system, 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 in the system for future reference. We saw evidence audits had been carried out to assess the completeness of these records and that 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 were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff, for example with 'do not attempt resuscitation' orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

We saw clinical staff were familiar with the need for capacity assessments and Gillick competency assessments of children and young people. These assessments check whether children and young people had the maturity to make decisions about their treatment. We found clinical staff understood how to facilitate 'best interest' decisions for people who lacked capacity and seek appropriate approval for treatments such as vaccinations from children's legal guardian.

Health promotion and prevention

It was practice policy to offer a health check with the 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. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering smoking cessation advice to smokers.

The practice raised patients' awareness of health promotion. This was via their web site and leaflets in the practice. This information covered a variety of health topics including smoking cessation, stroke support and diabetes. Patients confirmed with us they had access to the information and staff regularly discussed health promotion with them during their consultations and on home visits.

The practice identified 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 100% were offered an annual physical health check 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 prompted with those patients a healthier lifestyle. For example, they had regular clinics with the nurse to support individuals and also offered a personal 'health trainer'. We spoke with the health trainer who told us they worked with the patients on a tailored programme of health promotion and fitness, teaching life skills for change.

The practice held flu virus and vaccination sessions and provided child immunisation programmes.

We saw the practice website included information about how to access appropriate influenza advice and support. 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.

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. The evidence showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example the practice was rated with 91 % for its satisfaction scores on consultations with nurses with 80 % of practice respondents saying the overall experience of the surgery was good or very good.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 35 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and told us staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Of those comments only three were less positive around the access to appointments. We also spoke with five 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.

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

The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted it enabled confidentiality to be maintained.

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

Patients' on going emotional needs were supported. We saw leaflets were available in the waiting room which offered support to patients for areas such as; bereavement counselling, mental health support and also support with conditions such as cancer.

Care planning and involvement in decisions about care and treatment

The results from the practice's own satisfaction survey showed 80 % 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 and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and 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 and there were leaflets available in reception translated into other languages.

Patient/carer support to cope emotionally with care and treatment

The practice provided a service for all age groups and needs. We found GPs and other staff had the overall competence to assess each patient and were familiar with the individual needs and the impact of their socio-economic environment. Longer appointments were made available for people who needed them and those with long term conditions. This also included appointments with a named GP or nurse.

There was a register of the housebound and home visits were made to local care homes and to those individual patients who needed one.

The practice's computer system alerted GPs if a patient was also a carer. There was written information available for carers to ensure they understood the support available. Staff told us families who had suffered bereavement were supported by signposting to other agencies, to support

Are services caring?

counselling and were contacted by their own GP. Notices in the patient waiting room and patient website also signposted patients to a number of support groups and organisations.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The 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. For example the practice worked with the local CCG in 'The Physical Activity Care Pathway', promoting health for patients with long term conditions.

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). These were improving the telephone system, the refurbishment of the building and developing staff training.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The premises and services had recently been adapted to meet the needs of people with disabilities. We found the practice was accessible to patients with mobility difficulties, we saw there was level access throughout and automatic doors at the front with good parking facilities disabled parking bays and the premises were all on one level. 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. There was also a hearing loop available.

The practice had access to online and telephone translation services and GPs who spoke different languages.

Access to the service

Appointments were available from 08:00 am to 18:30 pm on weekdays. With Saturday opening from 08:00 am to 16:00 pm. Bookable appointments and emergency appointments were made available each day. Patients could make appointments and request prescriptions at the surgery, by telephone and on line. The practice also provided a 'text' reminder service to reduce the risk of patients missing their appointment.

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 new telephone system. 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 also available for people who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to local care homes, by a named GP and to those patients who needed one. GPs also triaged calls to the surgery and offered telephone consultation where they felt this was appropriate.

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

The practice's extended opening hours on Saturday was particularly useful to patients with work commitments causing less disruption to their working week.

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 information was available to help patients understand the complaints system. Information on how to make a complaint was available in a practice booklet in

Are services responsive to people's needs?

(for example, to feedback?)

reception. There was a suggestion box available in the waiting area for patients use. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

We looked at 2 complaints received in the last 12 months and found these were handled in a timely way, with, openness and transparency. The practice provided extensive details about investigations they had conducted following a concern raised at the practice. Following these concerns they had conducted a full audit of GPs issuing of sick notes to ensure they were consistent. Following review of the information it was confirmed consistency was in place but changes were implemented and additional checks were put in place to ensure more detailed information was collected by GPs to meet with best practice.

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. We saw these investigations were thorough and impartial and learning from these was discussed at practice meetings.

Are services well-led?

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

Our findings

Vision and strategy

We saw there was input from key stakeholders, patients and staff which ensured the practice regularly reviewed their aims to ensure they were being met.

Staff we spoke with shared joint values about the practice and knew what their responsibilities were in relation to these. We looked at minutes of the practice meetings and saw staff had discussed the joint vision of the practice.

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 on any computer within the practice. We looked at the recruitment, safeguarding and infection control policies. All policies and procedures we looked at had been reviewed annually and were up to date.

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 GP was the lead for safeguarding. Staff we spoke with all 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 that QOF data was regularly discussed at monthly 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 and systems to identify where action should be taken. For example, prescribing audits to review anti-psychotic medication and prescribing of medication for the over 75s to look at polypharmacy to reduce the risk of patients being wrongly or over prescribed medication.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues, such as management and safety of medicines. We saw the risk log was regularly discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented, for example in relation to the management of vaccines.

The practice held weekly governance meetings. We looked at minutes from the last meetings and found performance, quality and risks had been discussed.

Leadership, openness and transparency

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.

Staff and team meetings were held weekly. Minutes from these meetings were available to all staff. Action was delegated at the meetings and we saw these were followed up at a later stage. It was clear from these records staff raised areas for discussion and were encouraged to do so.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patients' surveys. We looked at the results of the annual patient survey and 72% of patients agreed telephone consultations would be useful. We saw as a result of this the practice had introduced telephone consultation appointments. We reviewed a report on comments from patients between January and June 2013, which had a common theme of the waiting room not being very inviting or comfortable. Following these comments improvements had been made, which included an extensive refurbishment throughout the building.

The practice had an active patient representative group (PRG). The group met every two months. This included representatives from most of the various population groups. The results and actions agreed from these meetings were available on the practice website. We spoke to a representative of the group who was very positive about their role and contribution to the quality of the service. They were able to give us several examples of where the group had been involved improvements at the practice. For example, the PRG was active in the refurbishment of the practice and instrumental in looking at ways the practice could offer patients better access to appointments.

The practice had gathered feedback from staff, through staff training days and generally through staff meetings,

Are services well-led?

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

appraisals and discussions. Staff had appraisals and attended regular staff meetings. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff confirmed they felt 'listened to' by management and opinions were respected and involved and engaged in the practice to improve outcomes for both staff and patients.

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 three 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 days where guest speakers and trainers attended.

Staff also attended regular practice meetings and action and learning were shared throughout the team. We saw evidence the practice improved the service following learning from incidents and reflecting on their work.