Drs J M Pilpel & V C Tiguti

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 at Drs J M Pilpel & V C Tiguti on 6 February 2015. Overall the practice is rated as good.

We found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for older people, people with long-term conditions, families, children and young people, working age people, people whose circumstances may make them vulnerable and people experiencing poor mental health.

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

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

However there were areas of practice where the provider needs to make improvements.

Importantly the provider should:

- Introduce a system to check that GP prescription pads used for home visits are tracked through the practice.

Summary of findings

- Ensure that they follow their own standard operating procedures in the receiving of and dispensing of controlled drugs.
- Introduce regular staff meetings to support and involve staff.

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. There were enough staff to keep patients safe. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed however there was little evidence of learning over time. We saw that the practice did not always follow their own standard operating procedures in the receiving of and dispensing of controlled drugs.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams to ensure co-ordinated patient care.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice reviewed the needs of its local population and engaged with the NHS England Local Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a vision and strategy though it was not evident that this vision had been

communicated to all staff. There was a clear leadership structure and staff felt supported by the management. The practice had a number of policies and procedures to govern activity. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from patients, which it acted on. The patient participation group (PPG) was active and felt valued by the practice. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. Staff had received robust inductions and regular performance reviews but staff meetings had not been held since December 2012.

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. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

The practice was proactive in managing the care of vulnerable patients with long term conditions. The practice used a risk assessment tool to identity the top four per cent of vulnerable patients registered with the practice. The health care assistant acted as a care plan co-ordinator for these patients contacting them on a three monthly basis to update their personal and carer details. The GPs reviewed these patients on a three monthly basis and updated their care plans to meet their needs.

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 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 high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the

Summary of findings

working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. However, some working aged patients told us they found it difficult to get through by the telephone to make appointments but once they had, it was easy to make an appointment with a named GP and there was continuity of care.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Ninety-four per cent of people with dementia had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

The practice had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

All of the 12 patients we spoke with on the day of our inspection were complimentary about the care and treatment they received. We reviewed the 14 patient comments cards from our Care Quality Commission (CQC) comments box that had been placed in the practice prior to our inspection. We saw that comments were mostly positive. Patients told us the staff were professional and treated them with dignity and respect. They told us the receptionists were very friendly and helpful. They told us that the nurses and doctors listened and responded to their needs and they were involved in decisions about their care. Patients also told us that the practice was always clean and tidy. Two people told us that they were happy with the care they received but the system of booking an appointment did not support working age people.

The results from the National Patient Survey showed that 85% of patients said that their overall experience of the practice was good or very good and that 74% of patients would recommend the practice to someone new to the area. This was slightly below the Clinical Commissioning Group (CCG) regional average.

Areas for improvement

Action the service SHOULD take to improve

Introduce a system to check that GP prescription pads used for home visits are tracked through the practice.

Ensure that they follow their own standard operating procedures in the receiving of and dispensing of controlled drugs.

Introduce regular staff meetings to support and involve staff.

Drs J M Pilpel & V C Tiguti

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) lead inspector. The lead inspector was accompanied by a GP specialist advisor, a practice manager specialist advisor and an expert by experience. Experts by experience are members of the inspection team who have received care and experienced treatments from a similar service.

Background to Drs J M Pilpel & V C Tiguti

A team of two GP partners, a salaried GP, two GP registrars, four nurses and a health care assistant provide care and treatment for approximately 6,200 patients. GP registrars are qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine.

Drs J M Pilpel & V C Tiguti provide primary medical services from two practices. The main practice is based in Tean and includes a dispensary and there is a branch practice in Blythe Bridge.

The practice is a training practice for GP registrars and medical students to gain experience and higher qualifications in general practice and family medicine. The practice does not routinely provide an out-of-hours service to their own patients but they have alternative arrangements for patients to be seen when the practice is closed.

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.

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

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

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)

Before carrying out our inspection, we reviewed a range of information that we held about the practice and asked other organisations to share what they knew. Prior to our inspection we spoke with a midwife who worked with the practice, a representative for a care home where the practice provided care and treatment and a spokesperson from the Patient Participation Group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

We carried out an announced inspection on 6 February 2015 at the main practice. We did not visit the branch surgery at Blythe Bridge during this inspection. During our inspection we spoke with two GP partners, a salaried GP, two nurses, a health care assistant, two receptionists, the practice and assistant manager, a dispenser and 12 patients. We observed how patients were cared for. We reviewed 14 comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns and knew how to report incidents and near misses.

We reviewed safety records and incident reports where these were discussed but there was no robust system in place for reviewing incidents over time to identify trends. Staff told us they were informed of any learning from incidents through an e-mail, however there was no system in place to monitor if these e-mails had been read.

Learning and improvement from safety incidents

The practice had a system in place for reporting and recording significant events, incidents and accidents. There were records of two significant events that had occurred during the last year and we were able to review these. We saw that staff who had been involved in the significant event were involved in meetings to discuss the significant event and to identify ways of preventing the incident from occurring again. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration and they felt encouraged to do so.

Staff used incident forms to record significant events and sent completed forms to the practice manager. We tracked two incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example when a baby was given an immunisation one week too early, staff were made aware of the importance of the practice nurse making the appointment for childhood immunisations.

National patient safety alerts were disseminated by the practice manager 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. For example, one of the practice nurses told us about an alert they had recently received regarding a problem with a particular type of syringe used to deliver medicines to patients who used syringe pumps to deliver medicines.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children, young people and vulnerable adults. We looked at the training records for four members of staff which showed they had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. There were safeguarding policies available for staff to refer to and staff we spoke with were able to demonstrate how they would locate them for support and guidance.

The practice had appointed a dedicated GP safeguarding lead for children. We saw certificates demonstrating that they had completed level four training to enable them to support staff effectively. We saw that the other two GPs at the practice had completed level three safeguarding children training. There was some confusion amongst the GPs as to who the lead for safeguarding vulnerable adults was but both of the GP partners where aware of the procedures to follow if there were safeguarding concerns regarding a vulnerable adult. All the staff we spoke with were aware of the importance of raising concerns with the GP partners and the practice manager.

There was a system to highlight vulnerable patients on the practices' electronic records. This included information to make staff aware of any relevant issues when patients attended appointments, for example children subject to child protection plans and details of patient carers.

There was a chaperone policy available for patients on the practice website. There were posters informing patients of their right for a chaperone to be present during an intimate examination displayed throughout the practice. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). One of the practice nurses told us that only fully trained nurses acted as chaperones for the GPs.

We saw that Disclosure and Barring checks (DBS) had been carried out for all clinical staff working at the practice. Risk assessments had been carried out for all non-clinical staff

to determine if they needed to have a DBS check to ensure that patients were cared for by appropriate staff. DBS checks are carried out to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

There was a system in place that identified vulnerable adults and children and young people with a high number of A&E attendances. The safeguarding lead told us they reviewed A&E and hospital discharge letters and if a pattern was identified then recurrent attendees were contacted either by telephone or asked to attend the practice to discuss any underlying problems. We looked at information from the Clinical Commissioning Group's (CCG) urgent care dash board and saw that the number of patient emergency admissions to hospital for the practice was below the CCG regional average.

Medicines management

We checked the medicines stored in the 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. A log of the fridges' temperature ranges had been recorded daily which demonstrated that vaccines stored in the fridges were safe to use because they had been stored in line with the manufacturers' guidelines. The medicine management policy also described the action to take if vaccines had not been stored within the appropriate temperature range. Practice staff that we spoke with understood why and how to follow the procedures identified in 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.

The practice nurses administered vaccines using patient group directions (PGDs) that had been produced in line with legal requirements and national guidance. PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. We saw that some of the PGDs for the administration of childhood immunisations had expired in October 2014. Before the end of our inspection, we saw that these PGDs had been replaced with the most current PGDs. We saw that one of the practice nurses had put a system in place ensuring all of the nursing team were aware of the replacement PGDs and that PGDs would in future be replaced in a timely manner.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in the practice. The protocol complied with the legal framework and covered all required areas. For example, how staff who generated prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were appropriate and necessary. All prescriptions were reviewed and signed by a GP before they were given to the patient. We saw that prescription pads were stored in locked cupboards. However, blank prescription forms were not always handled in accordance with national guidance. There was no system in place to check that GP prescription pads used for home visits were tracked through the practice.

The practice offered a dispensary service for patients who lived more than one mile to their nearest pharmacy. Records showed that staff involved in the dispensing process had received appropriate training. Dispensing staff at the practice told us that all prescriptions were signed by a GP before being dispensed. The dispensary held stocks of controlled drugs (CDs) and had in place standard operating procedures that set out how they were managed.

We looked at the practices' standard operating procedures (SOP) for the ordering and receiving of CDs and saw that it followed "The Dispensing Doctors' Associations Guidelines for Dispensing Doctors 1999". We saw that the practice's SOP stated that when controlled drugs were received by the practice they should be entered into the appropriate section of the CD register and the entry should be countersigned by another authorised member of staff. We looked in the CD register and saw that only one signature had been entered into the register when CDs were received. This showed that the practice did not follow its own policy for the safe management of CDs. We asked a member of the dispensing staff who dispensed the CDs. They told us that they dispensed the CDs on their own. This was not in line with the best practice guidelines which state that, the doctor must check all prescriptions for controlled drugs before they are dispensed.

The practice had a system in place to assess the quality of the dispensing process. We saw that the practice had

carried out a dispensary satisfaction survey and that responses were mainly positive. Where an issue had been identified we saw that an action plan had been put in place and that the actions had been carried out.

Cleanliness and infection control

We observed the premises to be visibly 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. We saw evidence that annual infection control audits had been carried out at the practice and where issues had been identified, action plans had been put in place to address them.

Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these in order to comply with the practice's infection control policy. The GPs carried out minor surgery for some patients at the practice. We saw that single use instruments were used for minor surgery and there was a system in place for checking the instruments were in date. We looked at the instruments and saw that all but four instruments were in date. The practice nurse disposed of the out of date instruments immediately and told us that they would review their procedures for checking the instruments. There was a policy for needle stick injuries and staff knew what to do if this occurred. There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We saw evidence that their disposal was arranged through a suitable company.

The practice had taken reasonable steps to protect staff and patients from the risks of health care associated infections. We saw that staff had received the relevant immunisations and support to manage the risks of health care associated infections. A legionella risk assessment had been completed in August 2013 to protect patients and staff from harm. Staff described to us the actions they took to prevent the growth of the legionella virus. Legionella is a germ that can grow in contaminated water and can be potentially fatal.

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, auditory thermometers and blood pressure measuring devices.

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 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. One of the GP partners showed us records demonstrating that their actual patient list size was 6208 compared with their weighted list size 6752 meaning they had adequate GP sessions to support the needs of patients.

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, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy and had completed Control of Substances Hazardous to Health (COSHH) risk assessments. We saw that a management survey had been

Good

Are services safe?

completed in February 2015 which assessed risks within the building and that a fire risk assessment had been carried out in September 2014. Where issues had been identified we saw that these risks had been addressed.

There was a system to highlight vulnerable patients on the practices' electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

There were emergency processes in place for identifying acutely ill children and young people and staff gave us examples of referrals made. All the staff we spoke with told us that children were always provided with an on the day appointment if required. The practice used a risk assessment tool to help them to identify and support patients with complex long term conditions. This included close working with the Integrated Local Care Team (ILCT), a team that included health and social care staff such as community matrons and social workers.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen, airway management equipment for children and adults and an automated external defibrillator. All the staff we spoke with knew the location of this equipment. The practice nurse told us that this equipment was checked on a regular basis but there were no records to demonstrate this. We looked at the three oxygen cylinders. We saw that two were in date but one had expired in July 2005. The nurse told us that they did not use the out of date oxygen cylinder. We looked at the defibrillator and saw that it was fit for purpose.

Emergency medicines were available in a secure area of the practice and all the staff knew of their location. These included those for the treatment of anaphylactic shock (a sudden allergic reaction that can result in rapid collapse and death if not treated), cardiac arrest and low blood sugar. Processes were in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included loss of domestic services, flood, staff shortages and IT failure.

Following a recent fire risk assessment, fire drills had been introduced for staff at the practice. We saw records that showed staff were up to date with fire training and that a fire drill had been undertaken.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. 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 told us they led 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. We saw certificates that demonstrated that the practice nurses had received additional training to support them in the management of these long term conditions.

The practice used a risk assessment tool to identify the top four per cent of vulnerable patients registered with the practice with complex needs. We saw evidence that there was partnership working with other agencies to support the needs of these patients. This included working with the Integrated Local Care Team (ILCT), a team that included health and social care staff such as community matrons and social workers, to provide coordinated care for patients with complex long term conditions. We were shown the process the practice used to review patients recently discharged from hospital and patients receiving palliative care. We saw minutes from meetings confirming that multi-disciplinary working between the practice, district and palliative care nurses took place to support these vulnerable patients.

The practice recognised that patients with multiple long term health problems may be at risk of experiencing poor mental health. We saw that when they carried out health reviews for patients with long term conditions that if appropriate, they used recognised mental health assessment tools to determine the level of need for those patients.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that 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 to support the practice to carry out clinical audits.

The practice showed us two clinical audits that had been undertaken in the last year. One of these was a completed audit cycle where the practice was able to demonstrate the changes that had resulted since the initial audit in the prescribing of a medicine used to manage the clotting of blood. We saw that recommendations had been made and action plans put in place to carry out these recommendations.

The practice used the information collected for the Quality Outcome Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. The QOF rewards practices for the provision of 'quality care' and helps to fund further improvements in the delivery of clinical care. The practice met all the minimum standards for QOF in diabetes, asthma, chronic obstructive pulmonary disease (COPD is a lung disease) and coronary heart disease. We saw that the practice offered patients remote care monitoring for high blood pressure and COPD through a system called Flo. Flo monitoring was led by one of the practice nurses and supported patients to manage minor flare ups of their condition in their own home. It also enabled the practice to recognise a deterioration in a patient's condition and take appropriate action to possibly prevent a hospital admission.

The practice participated in the local Clinical Commissioning Group's (CCG) quality and performance framework. This showed how improvements had been made across the region, for example in the area of reducing avoidable hospital admissions. We saw that over a three year period the practice had consistently reduced the number of avoidable hospital admissions for patients with long term conditions and that their admission rates were

Good

Are services effective?

(for example, treatment is effective)

below the regional CCG average. We asked the GPs how they had achieved this. They told us it was because they proactively reviewed the needs of patients with long term conditions providing a nine monthly assessment as opposed to a 12 monthly assessment. They also used anticipatory prescribing in line with NICE guidelines to manage chest infections for patients with COPD. Anticipatory prescribing is designed to enable prompt symptom relief at whatever time the patient develops symptoms.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients who received repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The practice participated in a process of benchmarking. For example, we saw that the practice was below other practices in the region for the prescribing of antibiotics. Benchmarking is a process of evaluating performance data from the practice and comparing it to similar practices in the area.

Effective staffing

Practice staff included medical, nursing, dispensary, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. All the GPs were up to date with their yearly 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 NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice provided training and funding for relevant courses.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, the administration of vaccines and the performing of cervical screening. Those with extended roles were also able to demonstrate that they had appropriate training to fulfil these roles. We saw training certificates and other documentation demonstrating that one of the nurses had completed training in areas such as asthma, diabetic foot screening, cervical screening and the administration of childhood immunisations.

Working with colleagues and other services

The practice worked with other service providers to meet patients' 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 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.

We saw minutes that demonstrated that the practice held regular multidisciplinary team meetings with other services. For example, with the Integrated Local Care Team (ILCT), a team that included health and social care staff such as community matrons and social workers, to provide coordinated care for patients with complex long term conditions. They held three monthly meetings with the district and palliative nurses to discuss the needs of patients receiving end of life care.

They also worked closely with the midwifery service to discuss the needs of pregnant women registered with the practice. We spoke with the midwife for the practice who told us that the GPs were easily accessible if they had any concerns they needed to discuss and that they were responsive to her suggestions. The midwife told us they felt part of the team and that communication between themselves and the practice was very good.

Information sharing

The practice used several 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 referrals through the Choose and Book system. The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital.

Good

Are services effective?

(for example, treatment is effective)

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record in their computer system, EMIS web, to co-ordinate, document and manage patient's care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act (MCA) 2005 and their duties in fulfilling it. Mental capacity is the ability to make an informed decision based on understanding a given situation, the options available and the consequences of the decision. People may lose the capacity to make some decisions through illness or disability. We looked at the training records the practice had provided to us for four members of staff. We saw that staff had not received formal training in the MCA 2005. We saw evidence, and staff told us, that training was booked for 19 February 2015.

All clinical staff demonstrated a clear understanding of Gillick competence. A Gillick competent child is a child under 16 who has the legal capacity to consent to care and treatment. They are capable of understanding implications of the proposed treatment, including the risks and alternative options. Nursing staff told us how they considered Gillick competence when a young person attended for contraceptive advice. Nursing staff described to us how they ensured that parents who bought their children for immunisations were provided with information to enable them to make an informed decision when providing consent.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. We saw that a written consent form had been developed for patients to sign who received minor surgery at the practice.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patients' preferences for treatment and decisions.

Health promotion and prevention

The practice had met with the CCG to discuss the implications and share information about the needs of the practice population. They used the data from the quality and performance framework, urgent care dashboard, risk stratification tool and QOF to help to identify these needs.

All new patients over the age of 16 who registered with the practice were invited for a routine health check with the health care assistant (HCA). The HCA told us that if they identified a health need they sign posted patients to services such as smoking cessation and weight management classes. The practice offered NHS Health Checks to all its patients aged 45-75 and travel vaccinations when needed. Patients over 75 years of age had a named GP to provide continuity of care. Childhood vaccinations and child development checks were offered in line with the Healthy Child Programme. We saw that last year's performance for all immunisations was in line with, or above, the CCG regional average. One of the GPs at the practice provided enhanced family planning services for women including the insertion of intrauterine devices such as coils and contraceptive implants.

The practice had several ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of patients with a diagnosis of dementia. One of the GPs had carried out an audit to determine if their dementia register identified all the relevant patients. The results showed that prior to the audit there had been 20 patients on the dementia register but following recommendations from the audit which lead to a re-assessment of several patients, this had increased to 31.

There were systems in place to support the early identification of cancers. The practice carried out cervical smears for women between the ages of 25 and 64 years. We saw that the practice's performance for cervical smear uptake was 84% which was above the CCG regional average of 81%. The practice also proactively encouraged bowel cancer screening for appropriate patients. They told us that all non-attenders were written to and encouraged to attend the screening if they failed to following the initial referral.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey published in January 2015, a survey of 154 patients undertaken by the practice's patient participation group (PPG) and a survey of 58 patients who used the practice's dispensary service. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The evidence from these sources showed patients were mostly satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national GP patient survey showed that 85% of respondents said that their overall experience was good or very good and 74% of respondents would recommend the practice to someone new in the area. These results were slightly below the regional Clinical Commissioning Group (CCG) average. The practice was below the CCG regional average for its satisfaction scores for consultations with GPs but above for nurses. For example, 68% of respondents said the last GP they saw or spoke to was good at treating them with care and concern with 94 % satisfaction for nurses. Ninety-five per cent of respondents found the receptionists at this practice helpful.

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 14 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were professional, friendly, helpful, caring and treated them with dignity and respect. One comment about telephone access to appointments was less positive. We also spoke with 12 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. One patient told us that as a working age patient they found it difficult to get through to the practice to book an appointment because the times they were required to call for an appointment coincided with the time they travelled to work.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The reception desk was shielded by a glass partition which helped keep patient information private. Reception staff we spoke with demonstrated an awareness of the need to keep patient details and data confidential. We observed that they handled personal enquires and calls with sensitivity. We were shown the results of a recent dispensary patient satisfaction survey. We saw that patients had raised concerns about confidentiality at the dispensary. We saw that the practice had responded to this and a poster had been put in place to inform patients that if they needed to discuss any confidential issues they could request a private room to do so.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff. We observed that patients were treated equally irrespective of their age, culture or appearance.

Care planning and involvement in decisions about care and treatment

The national patient survey information we reviewed showed mixed patients' responses to questions about their involvement in planning and making decisions about their care and treatment. For example, data showed 65% of practice respondents said the GP involved them in care decisions and 74% felt the GP was good at explaining treatment. These results were below the CCG regional average. In contrast, 86% of practice respondents said the nurse involved them in care decisions and 89% felt the nurse was good at explaining treatment. These results were above the CCG regional average.

Patients we spoke with on the day of our inspection told us that 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

Good

Are services caring?

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.

The practice was proactive in managing the care of vulnerable patients with long term conditions. The practice used a risk assessment tool to identity the top four per cent of vulnerable patients registered with the practice. The health care assistant acted as a care plan co-ordinator for these patients contacting them on a three monthly basis to update their personal and carer details. The GPs saw these patients on a three monthly basis and updated their care plans to meet their needs. In addition to this, all patients with long term conditions received a nine monthly routine health review in contrast to the more usual 12 monthly health review offered by GP practices. We spoke with four patients with long term conditions on the day of our inspection and they spoke positively of the GP's interest and attention to their needs.

We looked at data from the Quality Outcomes Framework (QOF). The QOF is a national performance measurement tool. We saw that the practice was above the national average for the percentage of patients experiencing poor mental health who had an agreed care plan documented in their records.

Staff told us that translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

The practice had worked closely with their PPG to establish a support club for patients with dementia. This was held alternative weeks in a building next to the practice.

Notices in the patient waiting room, on the TV screen and patient website told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. There was a carer's information file available in the reception area informing them of the various avenues of support available to them.

The practice worked with district and palliative care nurses to provide care and treatment for terminally ill patients. The GPs told us that when a patient died, if their relatives needed emotional support they referred them to the local bereavement support centre.

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 that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw that the practice had adopted risk management tools provided by the CCG. This included an urgent care dashboard to identify trends in A& E admissions and a risk stratification tool to identify the practices' most vulnerable patients. We saw that systems had been put in place to support these patients.

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). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. For example, following a patient survey in 2013, 88% of patients responded to say that they found it easy or very easy to get an appointment. Following discussion with the PPG the practice increased the number of pre-bookable appointments from 30% to 40%. The PPG and the practice repeated this survey in 2014 which demonstrated that patient satisfaction with ease of getting an appointment had increased to 92%.

Tackling inequity and promoting equality

The practice recognised the needs of different groups in the planning of its services. The practice was situated on the ground floor with services for patients provided on there. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Facilities for patients with mobility difficulties included disabled parking spaces; step free access to the practice; toilets suitable for patients with mobility difficulties and a hearing loop for patients with a hearing impairment.

The practice population were mainly English speaking but for patients whose first language was not English, staff had access to a telephone translation service to ensure patients were involved in decisions about their care.

Patients over 75 years of age had a named GP to ensure continuity of care. Patients with learning disabilities were provided with annual health reviews at the practice. The practice did not have any registered homeless patients but from time to time provided care and treatment to travellers. They told us they had a policy to accept homeless or travelling patients irrespective of ethnicity, culture, religion or sexual preference. The practice actively undertook mental capacity assessments and dementia screening to assess and improve access to support services for these patients.

Access to the service

Appointments were available from 8am to 6pm on weekdays except Thursday afternoons when the practice was closed. Forty per cent of appointments were pre-bookable four weeks in advance for GPs with 60% of pre-bookable appointments available to book on-line. All practice nurse appointments were pre-bookable up to two months in advance. On the day appointments were also available if a patient needed to be seen urgently. Several patients we spoke with on the day of our inspection confirmed that they were able to get on the day appointments.

Comprehensive information was available to patients about appointments on the practice website and in the patient information 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, their call was diverted directly through to the out of hours service. Information on the out of hours service was provided to patients in the waiting room, in the patient information leaflet and through the practice's website.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to a local care home to those patients who needed one. We spoke with a representative from the care home who told us that the GP visited the home upon request.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patients were generally satisfied with the appointments system. They confirmed that they saw a GP on the same day if they needed to and they saw another GP if there was a wait to see the GP of their choice. Comments received from patients showed that patients in urgent need of treatment were able to make appointments on the same day of contacting the practice. Data from the national GP survey supported this. Eighty-nine per cent of respondents stated they were able to get an appointment last time they tried and 86% described their experience of making an appointment as good. This was above the regional CCG average.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. This was displayed on the practice's website, in the patient information leaflet and within the practice.

We looked at ten complaints received in the last 12 months and found that nine were dealt in a timely manner and handled appropriately. There had been a delay in the reporting of one complaint and we saw that the practice manager had raised the importance of forwarding complaints immediately with all members of staff. The practice reviewed complaints at partners meetings and staff were informed by the practice manager of any issues identified. Lessons learnt from individual complaints had been acted on as they occurred. We reviewed the ten complaints received in the last 12 months and saw that there was an underlying communication issue in six of these complaints. There was no system in place at the practice to identify trends in complaints over time so this had not been identified by 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

The practice had a vision to deliver high quality care and promote good outcomes for patients. We found that details of their vision and the practices' aims and objectives were included in their statement of purpose. They included, to provide a high standard of acute and chronic medical care, improve as a patient-centred service through decision-making and communication and to treat all patients and staff with dignity, respect and honesty. The practices' vision and values were not clearly communicated to staff. However, the practice manager told us that they aspired to provide good services for patients and a happy atmosphere for staff to work in.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff through the practice's intranet. We looked at 11 of these policies and procedures and saw that they had been reviewed within the last twelve months. Staff told us they were informed of any policy changes through an e-mail from the practice manager. No formal governance meetings took place. The practice manager told us that governance issues were discussed as an agenda item at other management meetings.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control, one of the GP partners was the lead for safeguarding and the other the

Caldecott Guardian (a person responsible for ensuring the safe keeping and appropriate use of information). We spoke with 11 members of staff and they were all clear about their own roles and responsibilities. They 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 is a national performance measurement tool. The QOF data for this practice showed it was performing above national standards by obtaining 506 QOF points out a possible 545.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. The practice had completed a number of clinical audits based on National Institute for Health and Care Excellence (NICE) guidance. For example, audits to monitor patients diagnosed with dementia and an audit of the prescribing of a medicine used to manage the clotting of blood. We saw that recommendations had been made and action plans put in place to carry out these recommendations.

The practice had some arrangements for identifying, recording and managing risks. There was no formal risk log in place to address a range of potential issues for the practice. However, the practice manager showed us their service continuity plan which included risk assessments and action plans for such disruptions to the service as IT failure, loss of domestic services and staffing.

Leadership, openness and transparency

Staff told us that there was an open culture within the practice and they were happy to raise issues directly with the practice manager and GP partners. However, they told us that staff meetings had not taken place for a long time. We looked at the minutes from the last team meeting and saw that there had not been a team meeting since December 2012. Staff told us they would like to be able to attend staff meetings so that they could directly represent themselves and be involved in decisions about the practice. The practice manager showed us evidence that they were in the process of trying to arrange a team meeting that all the staff could attend.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example the induction and recruitment policy which were in place to support staff. Staff we spoke with knew where to find these policies if required. The practice had a whistle blowing policy which was available to all staff via the practice's computer system. Whistle blowing occurs when an internal member of staff reveals concerns to the organisation or the public, and their employment rights are protected. Having a policy meant that staff were aware of how to do this, and how they would be protected.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. We looked at the results of the practice's patient survey that had been carried out in conjunction with the Patient Participation Group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. We saw that

Are services well-led?

Good

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

where concerns had been raised about access to appointments and repeat prescriptions the practice had tried to increase patient awareness of the facility to book or request these on line. We saw that patients were informed of this through the patient newsletter.

The practice had an active PPG. It included four male and six female patients whose ages ranged from 47 to 86 and they were all white British (the practice had a one per cent minority of ethnic patients). We spoke with a representative of the PPG prior to our inspection. They told us that the PPG met four times a year and were trying to recruit more patients to the PPG, such as younger and working age patients, so that the group was more representative of the practice population. They told us that the practice worked closely with the PPG and that their opinions were listened to and respected.

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training. One member of staff told us that they had asked for specific training in ear irrigation at their appraisal and that this had happened.

The practice was a GP training practice for GP registrars (qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine) and medical students. The GP partners were responsible for the induction and overseeing of the training for GP registrars and medical students. We were unable to speak to a GP registrar on the day inspection however, we spoke with a practice nurse who had recently started to work for the practice. They told us their induction had been fantastic and that the GP partners and nurses had been very supportive. They told us their training needs had been assessed and training provided.