Regent Square 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 inspection at Regent Square Group Practice on 27 January 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services for older people, people with long term conditions, families, children and young people and the working age population.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and managed, including those relating to recruitment checks.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Complaints would be addressed in a timely manner and the practice endeavoured to resolve complaints to a satisfactory conclusion.
- 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.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients.

Summary of findings

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence (NICE) guidance is referenced and used routinely. People's needs are assessed and care is planned and delivered in line with current legislation. This includes assessment of capacity and the promotion of good health. Staff have received training appropriate to their roles. The practice carries out regular appraisals and the personal development plans for staff.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

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

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a vision to deliver this. Staff were aware of the vision and their responsibilities in relation to this. There was a clear leadership

Summary of findings

structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and regular governance meetings had taken place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst 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 care. The practice was responsive to the needs of older people, and where appropriate provided home visits.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed longer appointments and home visits were available. Patients had a named GP and structured annual reviews to check their health and medication needs were being met. For those people with the most complex needs the named GP worked with health and care professionals to deliver a co-ordinated multidisciplinary package of care.

Families, children and young people

Good

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

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the 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 was proactive in offering online services as well as a full range of health promotion and screening which reflects the needs for this age group.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice held a record of patients living in vulnerable circumstances including homeless people, travellers and those with learning disabilities. The practice offered longer appointments for people with learning disabilities.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health including people with dementia. 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 in place advance care planning for patients with dementia.

Summary of findings

What people who use the service say

We received 35 CQC comment cards and spoke with six patients on the day of our visit. We spoke with people from different age groups and with people who had different physical needs and those who had varying levels of contact with the practice.

The patients were complimentary about the care provided at the practice and the overall friendliness and behaviour of all staff. They felt the doctors and nurses were competent and knowledgeable about their treatment needs and that they were given a professional and efficient service. They told us that their long term health conditions were monitored and they felt well supported.

Patients reported that they felt that all the staff treated them with dignity and respect and told us that the staff listened to them and were well informed.

Patients said the practice was very good and felt that their views were valued by staff. They were complimentary about the appointments system and its ease of access and the flexibility provided.

Patients told us that the practice was always clean and tidy.

Findings from the 2014 National GP Patient Survey indicated a high level of satisfaction with the care and treatment provided by the practice.

Regent Square Group Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team consisted of a CQC Lead Inspector and two specialist advisors (a GP and a practice manager).

Background to Regent Square Group Practice

Regent Square Group Practice is registered with CQC to provide primary care services, which includes access to GPs, family planning, surgical procedures, treatment of disease, disorder or injury and diagnostic and screening procedures. It provides GP services for patients living in the city area of Doncaster. The practice has four GPs, a management team, practice nurses, healthcare assistants and administrative staff. The practice occupies all of a large refurbished building which has offered over 100 years of family based medicine.

Regent Square Group Practice was open from 8am to 6pm Monday to Friday. Patients could book appointments in person and via the phone. When the practice was closed patients accessed the out of hours NHS 111 service.

The practice was part of NHS Doncaster Clinical Commissioning Group (CCG). It was responsible for providing primary care services to 9,680 patients. The practice population is made up of 50% male and 50% female patients.

The CQC intelligent monitoring placed the practice in band 6. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Why we carried out this inspection

Regent Square Group Practice was part of a random sample of practices selected in the Doncaster CCG area as part of our new comprehensive inspection programme covering Clinical Commissioning Groups throughout the country.

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 in accordance with the Care Act 2014.

Detailed findings

How we carried out this inspection

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

- 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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problems

Before our inspection we carried out an analysis of the data from our intelligent monitoring system. We also reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We reviewed the policies, procedures and other information the practice provided before the inspection. The information reviewed did not highlight any significant areas of risk across the five key question areas.

We reviewed all areas of the practice including the administrative areas. We sought views from patients through face-to-face interviews and via comment cards completed by patients of the practice in the two weeks prior to the inspection visit. We spoke with four GPs, the practice manager, assistant practice manager, clinical nurse, two health care practitioners, two administrative staff, a medical secretary and four receptionists.

We observed how staff treated patients visiting and phoning the practice. We reviewed how GPs made clinical decisions. We reviewed a variety of documents used by the practice to run the service.

Good

Are services safe?

Our findings

Safe track record

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

Staff who identified an incident could talk to the practice manager or a GP and there was a reporting form to record this information. Incidents were prioritised so that urgent action could be taken if required, otherwise they were discussed at a monthly meeting where minutes were kept and actions managed. We saw there was an issues log kept for matters such as delayed discharge summaries and these were relayed via the clinical commissioning group (CCG) monthly meeting.

There was a practice safeguarding protocol in place; a named GP was the safeguarding lead and could readily liaise with the social work team which were on site.

We reviewed safety records and 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 evidence a 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. Records were kept of significant events that had occurred during the last year and these were made available to us. A slot for significant events was on the practice meeting agenda and a dedicated meeting occurred every week to review actions from past significant events and complaints. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nurses were aware of the system for raising issues to be considered at the meetings.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding.

We asked members of the 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 regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours.

The practice had dedicated GP's and nurses appointed as leads in safeguarding vulnerable adults and children. These key staff had been trained to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak to in the practice if they had a safeguarding concern.

A GP and the practice manager have attended level three safeguarding training via a TARGET (Time for audit, research, governance, education and training) scheme); they followed the local safeguarding protocols. There was a monthly meeting that considered safeguarding incidents with local social services teams.

Chaperone training had been undertaken by all administration staff, including receptionists. The staff understood their responsibilities when acting as chaperones including where to stand to be able to observe the examination.

Safe procedures were in place to ensure that criminal record checks via the disclosure and barring service (DBS) were undertaken where necessary. Risk assessments of all roles and responsibilities had been completed to determine the need for a criminal record check. Criminal record checks of staff employed within the practice, were repeated at three year intervals.

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 medicines were kept at the required temperatures. This was being followed by the practice staff, and the action to take in the event of a potential failure was described.

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

Good

Are services safe?

Patients were routinely informed of common potential side effects at the time of starting a course of medication. The IT system allowed for 'on screen' messages which were discussed with the patient. Patients were also reassured of rarity of side effects.

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 or infection control.

The practice had a nurse lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training in infection control specific to their role and there after annual updates. We saw evidence the nurse lead had carried out audits for the last year and that any improvements identified for action were completed on time.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves and aprons 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.

Hand hygiene techniques guidance was displayed in staff and patient toilets. Hand washing sinks with hand gel and hand towel dispensers were available in treatment rooms.

Equipment

Staff we spoke with told us they had sufficient 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.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. The 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 via the disclosure and barring service (DBS).

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 they was enough staff 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.

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 and information was displayed for staff to see.

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

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 and an automated external defibrillator, which was used to attempt to restart a person's heart in an emergency. All staff asked knew the location of this equipment and how to use it and records we saw confirmed the equipment was checked regularly.

The practice had a business continuity plan specifying the action to be taken in relation to a range of potential emergencies that could impact on the daily operation of the practice. Risks identified included incapacity of the GP

Good

Are services safe?

partners and the loss of the computer and telephone systems. The document also contained emergency contact details for staff to refer to. For example, contact details of the company responsible for servicing the building.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patient's needs were assessed and care and treatment considered, in line with current legislation, standards and evidence-based guidance. We spoke with the GP who told us that they used relevant and current evidence-based guidance such as the National Institute for Health and Care Excellence (NICE) guidelines. These were applied during assessment, diagnosis, referral to other services and management of long term conditions or chronic conditions such as diabetes care.

The GPs told us they lead in specialist clinical areas such as diabetes, hypertension and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

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

Management, monitoring and improving outcomes for people

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

The practice showed us seven clinical audits that had been undertaken in the last year. All of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. The practice had a system in place for completing clinical audit cycles. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. An example audit we looked at in detail was for diabetes and related renal function. The aim of the audit was to ensure that all patients prescribed diabetes medicine were being managed in the safest way. The information was shared with GPs and patients were called back for a medication review. A second clinical audit was completed later which demonstrated that all patients were receiving the recommended dose.

Other examples included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and National Institute for Health and Care Excellence guidance.

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

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, all of 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 (lung disease). This practice was not an outlier for any QOF (or other national) clinical targets.

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 that all routine

Good

Are services effective?

(for example, treatment is effective)

health checks were completed for long-term conditions such as diabetes and that 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 that the GPs had oversight and a good understanding of best treatment for each patient's needs.

Effective staffing

Staff had the skills, knowledge, qualifications and experience to deliver effective care and treatment. Staff received appropriate training to meet their learning needs and to cover the scope of their work. Newly employed staff were supported in the first few months of working in the practice. We were able to review staff training records and we saw that this covered areas such as safeguarding, health and safety, fire and first aid.

Staff received an annual appraisal. Staff told us they were able to discuss any issues or training needs with their manager. Staff told us that they felt they had opportunities to develop and were able to take study leave and protected time to attend courses. Multi-disciplinary training and the open supportive culture were evident at this practice.

Working with colleagues and other services

The practice had clear arrangements in place for referrals to other services. Patients told us that they were given a choice of which hospital they would like to be referred to. It was the GPs responsibility to follow up on the referrals.

Staff worked together to assess and plan on-going care and treatment in a timely way when patients were discharged from hospital. We spoke with the practice manager who told us that discharge letters were scanned on to the patient's record. This enabled the practice to have an effective means of ensuring continuity of care and treatment of those patients discharged from hospital. Their records from the hospital were scanned onto the patients' records so a clear history could be kept and an effective plan made.

The practice had systems in place for managing blood results and recording information from other health care providers including discharge letters. The GP viewed all of the blood results and took action where needed.

In addition to the practices general medical services the GPs provided medical services for the 'special arrangements scheme'. This was a service for difficult to manage or potential violent patients. The practice currently provided this service for Doncaster, Rotherham, Sheffield and Barnsley. Patients, who were unable to attend the surgery, would be contacted by a GP and seen if necessary in a secure room at the Doncaster Royal Infirmary. The practice also offered telephone consultations for these patients when required.

Information sharing

The practice had a commitment to support six care homes. GPs visited the care homes as and when required. There were structured templates for each of the patients and this information was also cascaded to the out of hours provider. They would normally have access to the practices IT system but they also received faxed copies of special notes for each of these patients where appropriate. This demonstrated a good level of communications with other providers.

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 that 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 that staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their 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 required it. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision.

Good

Are services effective?

(for example, treatment is effective)

All clinical staff demonstrated a clear understanding of Gillick competencies. These helped clinicians to identify children aged under 16 who had the legal capacity to consent to medical examination and treatment.

Health promotion and prevention

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was average for the CCG. There was a clear policy for following up patients who did not attend for their appointment by the named practice nurse.

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

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. 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 diabetes checks to patients and offering smoking cessation advice to smokers.

Seasonal flu vaccinations were available to at risk patients such as patients aged 65 or over, patients with a serious medical condition or those living in a care home.

The nurse we spoke with us told us there were a number of services available for health promotion and prevention. These included child immunisation, hypertension, cervical screening and travel vaccination appointments.

Population Groups evidence

Older people

• The practice has an up to date register of patients identified as being at high risk of admission and end of life. 100% had up to date care plans in place. Details of patients at end of life were shared with other providers who may have been involved in their care i.e. Out Of Hours and community/McMillan nurses.

• 92% % of people discharged from hospitals that had follow-up consultation with either a GP or Nurse.

• 78% of people received structured annual medication reviews for polypharmacy.

• Provision of a named GP for patients over 75. All patients received a letter and a copy was kept in their record for audit trail purposes and read coded.

People with long term conditions

• Structured annual reviews for various Long Term Conditions (LTC) (e.g. Diabetes, Chronic obstructive pulmonary disease, Heart failure). All reviews at the practice were structured; nurses followed a template which was compliant with all the relevant areas required for Quality and Outcomes Framework (QOF) with a provision for 'free text' for any additional information.

- 89% Diabetics with annual foot check/ eye check
- 76% failure patients with a disease having annual medicines review

• 90% Adoption of Summary Care records

• Documentation of health promotion lifestyle advice in the notes which was integrated into the practice templates.

• System for risk stratifying patients/ identification of those at high risk of developing LTCs (using the electronic patient record) through data supplied by the Clinical commissioning groups via a risk stratification tool.

• Provision of a named GP as part of care plan for all patients.

Families, children and young people

• 90% immunisation rates for all standard Immunisations (e.g. diabetes prevention program trial , measles, mumps and rubella, Rotavirus)

• 2% rate of uptake of HPV vaccine for teenage girls

• Evidence of signposting young people towards sexual health clinics or offering extra services/ contraception. The practice offered a nurse led family planning service which was available weekdays from 8.30am to 6pm (patients were booked into a routine nurse clinic for ease of access for the patient) which included various methods of contraception. Two GPs were trained on implant fitting and removal.

Good

Are services effective?

(for example, treatment is effective)

Wherever possible the practice would deal with in house. However, should a patient be unable to attend for whatever reason, they would be signposted to the nearest clinic which was in close proximity to the practice.

• 78% of mothers with long-term conditions who received GP review of medication

Working age people

• Uptake rate for Health Checks, all new patients had a health check. 80+ for all patients who were eligible, 75 and over, patients over 45 for BPs annual review for clinical indicators for QOF.

• 83% Uptake rate for Cervical smears

• 89% people with Blood pressure checks

People whose circumstances may make them vulnerable

• Practice held a register of those in various vulnerable groups (e.g. homeless, travellers, learning disabilities. The learning disability register was Part of QOF, 24 patients were on the register. To date 20 patients had received an annual review which was recorded in the patients' electronic record.

• 87% of patients with learning disabilities received annual follow-ups

People experiencing poor mental health

• 90% of people with severe mental health problems who received annual physical health checks

• Follow-up rate of people with mental health problems who attended A&E is 100%. Contact was made with patient or key worker to ensure care plan and referral was in place.

• Evidence of Advance Care planning for patients with dementia was part of the annual review and avoiding unplanned admissions was recorded in the care plan.

• Evidence of staff undertaking additional training in mental health and all staff had undertaken training for Learning Disability in September 2014.

• Evidence of Multi-Disciplinary Team working / case management of patients with mental health problems. Patients on Mental Health register had a care plan in place as agreed with the consultant and the practice.

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 GP patient survey tool and feedback from patients undertaken by the practice via the patient participation group. The evidence from these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the GP patient survey showed the practice was rated 89% for patients rating the practice for the GP giving them enough time during appointments. The practice was above average for its satisfaction scores on 'had confidence and trust in the last GP they saw or spoke to' which was 98%.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 35 completed cards and all were positive about the service experienced. Patients said they felt the practice offered a good service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with seven patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice switchboard was shielded by partitions which helped keep patient information private.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff. There was evidence of learning taking place as staff meeting minutes showed issues had been discussed.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the GP patient survey showed 87% of practice respondents said the GP listened to patients and 92% felt the GP was good at explaining treatment and results. Both these results were above the average compared to the CCG area and nationally.

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 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.

We saw extensive evidence of comprehensive care planning for patients with long term conditions and those patients receiving palliative care. Anticipatory care planning reflected patients' wishes relating to hospital admission and end of life care agreed by the patient. Care plans were given to patients to ensure their full involvement and to facilitate sharing of information with other services, such as out of hours services.

Patient/carer support to cope emotionally with care and treatment

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

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

Good

Are services caring?

Staff told us families who had suffered bereavement were managed by their usual GP or nurse. The practice offered bereavement cards for families.

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 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.

The NHS Local Area Team (LAT) 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 minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. The practice had committed a lot of time and effort into responding to fluctuations of demand.

There had been very little turnover of staff during the last 10 years which enabled good continuity of care and accessibility to appointments with a GP of choice. Longer appointments were 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 nursing and residential care homes by a named GP.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services.

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

The practice provided equality and diversity training to its staff. Staff we spoke with confirmed that they had read the 'Dignity Policy' and that equality and diversity was discussed at staff appraisals and team events.

The premises and services had been adapted to meet the needs of people with disabilities. This included lowered windows for wheel chair users at the reception desk.

Access to the service

Appointments were available from 8am to 8pm on weekdays.

Comprehensive information was available to patients about appointments in reception and on the website. This included how to arrange urgent appointments and home visits and how to book routine appointments. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

The practice operated a flexible appointment system to ensure all patients who needed to be seen the same day were accommodated. Patients we spoke with were happy with the appointment system. This ensured patients were able to access healthcare when they needed to. Patients told us they could see another GP if there was a wait to see the GP of their choice.

The practice utilises a telephone based system to organise appointments. The practice also caters for walk in cases and people who do not have access to a phone. Reception staff are the first point of contact for patients. They are trained to take demographic data and brief medical details. Patients may be offered a routine appointment, a same day or an urgent appointment.

The latest GP national survey reported that 82% find it easy to get through to this surgery by phone. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. One patient we spoke with told us how they needed an urgent appointment; they walked into the practice and were seen by a GP that afternoon.

The practice offered a unique 'ring back' service to the patients. Each GP had a ring back list, this represented their availability that day. Patients wanting a consultation with the GP were put on that days ring back list, with a guarantee to be contacted with 24 hours. Once the ring back list for a particular doctor was full, they could either be offered another GP, or if all were full, the ring backs moved over to the next day. This system enabled the practice to never run out of availability and even in times of exceptional demand and with GPs on holiday, the practice were always able to meet demand. Patients may be dealt with by a telephone consultation or the GP may arrange to see them. Currently 50% of patients were seen face to face as a result of this system.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patients could book directly into nurse appointments or they may be contacted by reception to book appointments for chronic disease management. The nurses had recently started to provide a telephone follow up service for chronic disease management which was proving popular with patients.

The practice was located on both ground and first floors of the building, with all of services for patients based on the ground floor. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

The practice manager responded to complaints offering the patient the option to come in and discuss the issue. The manager contacted the GP concerned and the item was discussed at the weekly Friday team meeting.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We were told details of the vision and practice values were part of the practice's business plan. These values were at the heart of the staff we spoke with. The practice vision and values included 'providing both acute and chronic medical care, based on patient need' and 'to provide the service to all patients regardless of age, gender, race or creed'.

We spoke with 12 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. The staff overall understood and shared the vision for the practice and the GP partners had agreed the strategic approach of the business; we saw evidence of documented planning which supported their decision making.

The GP partners told us that they were in the process of recruiting another salaried GP to support succession planning and future sustainability 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 via the IT system. All the policies and procedures we looked at had been reviewed annually and were up to date.

The practice held monthly governance meetings. We looked at minutes from the last meeting and found that performance and quality had been discussed.

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

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us their risk log which addressed a wide range of potential issues. We reviewed the comprehensive range of risk assessments in place. These included assessment of risks associated with fire safety and medical emergencies. All risk assessments had been recently reviewed and updated.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We spoke with 12 members of staff and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

Staff told us they felt very well supported and knew who to go to in the practice with any concerns. The GPs fulfilled a leadership role within the practice, providing highly visible, accessible and effective support.

The practice had implemented a comprehensive schedule of meetings which provided staff with the opportunity to discuss concerns and disseminate information.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies which were in place to support staff. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through annual patient surveys, comment cards, suggestion box and complaints received. We looked at the results of the annual patient survey and were shown a report on comments from patients.

The practice had an active patient participation group (PPG). The practice manager was working with the PPG to have a broader representatives from various population groups; including people from ethnic backgrounds. The PPG meet every quarter. The practice manager showed us the analysis of the last patient survey which was considered in conjunction with the PPG.

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

The practice had a whistle blowing policy which was available to all staff within the practice.

Are services well-led?

Good

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

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 two 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.

The practice offered all GPs and nurses protected time to develop their skills and competencies. Staff who we spoke with confirmed this protected time was available. Staff also told us they were actively encouraged to take study time.

The practice has trained health care assistants in providing more effective patient care. Health care assistants take blood tests, carry out ECGs, do all the basic measurements for chronic disease management, provide aural hygiene and dressings, administer some vaccinations and assist GPs with minor surgical procedures. The practice has expanded the role of health care assistants with appropriate training to that of the traditional practice nurse.

Systems were in place for recording and monitoring all staff training needs. We reviewed staff training records and saw that staff were up to date with attending mandatory courses such as annual basic life support, infection control and safeguarding of children and vulnerable adults. Staff told us they also had opportunities for individual training and development. For example, the lead nurse for diabetes told us they had been supported in undertaking advanced training in diabetes.

The practice completed reviews of significant events and other incidents and shared the learning with the staff team to ensure the practice learnt from incidents to improve outcomes for patients. Significant events and incidents were discussed within weekly clinical meetings, GP partner meetings and monthly practice staff meetings.

The practice recorded all telephone consultations and used these calls for training and reviewing of complaints.