Drs Coleman, Forbes, Sellars, Sharpe, Tupper and Leighton

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced inspection visit on 13 January 2015. The overall rating for the practice is good. Specifically, we found the practice was good in providing: safe, responsive and effective care for all of the population groups it serves.

Our key findings were as follows:

- Where incidents had been identified relating to safety, staff had been made aware of the outcome and action was taken where appropriate, to keep people safe.
- All areas of the practice were visibly clean and where issues had been identified relating to infection control, action had been taken.
- Patients received care according to professional best practice clinical guidelines. The practice had regular information updates, which informed staff about new guidance to ensure they were up to date with best practice.
- The service ensured patients received accessible, individual care, whilst respecting their needs and wishes.
- We found there were positive working relationships between staff and other healthcare professionals involved in the delivery of service.
- Evidence we reviewed demonstrated patients were satisfied with how they were treated and this was with compassion, dignity and respect. It also demonstrated the GPs were good at listening to patients and gave them enough time.
- The practice had an open culture that was effective and encouraged staff to share their views through staff meetings and significant event meetings.

We saw several areas of outstanding practice including:

- All patients, but particularly those who work, could access appointments during the week and Saturday morning openings throughout the year. Patients could

Summary of findings

also access the GP for telephone advice if attending the practice was difficult. The practice was also developing SKYPE technology to further enable consultations.

- The appointment system was effective and routine appointment waiting times were no longer than one to two days on average.
- The practice used the 'choose and book' system effectively by ensuring all patients had a referral made before they left the surgery on the day of their appointment.
- We saw that the practice recalled any patients who had not attended the practice for five years to review their health needs.

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

- Events and Incidents were reviewed by the GPs and discussed at their meetings. However, the systems in place did not always provide a detailed analysis and information was at times limited.
- A wide range of information about the practice and services was provided. However, key documents, such as the practice booklet and complaints procedure, were only available in English, which did not meet the language needs of some of the patient population.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated to improve the quality of the service. Information about safety was recorded, monitored, appropriately reviewed and addressed.

The practice was clean throughout and we confirmed infection control was well managed.

We saw there were safe systems in place to manage and monitor medicines and medical equipment.

It was evident good staffing levels were in place and there was an appropriate mix of skills within the team. We found staff recruitment was managed well with all the required checks in place and there were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Patients' needs were consistently met and referrals to secondary care were made in a timely manner. We saw patients' consent to treatment was consistently obtained.

The practice had carried out supervision and appraisals for staff. We saw staff had received training appropriate to their roles.

There were regular GP clinical meetings and evidence of positive working relationships with multidisciplinary teams. National Institute of Health and Care Excellence (NICE) guidance was referenced and used routinely. It was evident in practice and clinical meetings NICE guidelines were discussed and plans made for their implementation.

The practice raised awareness of health promotion in consultations, the practice waiting areas and their web site. There were screening programmes in place to ensure patients were supported with their health needs in a timely and safe way.

Are services caring?

Good

The practice is rated as good for providing caring services. Patient surveys showed patients rated the practice higher than other practices, regarding several aspects of care. All the patients who

Summary of findings

responded to CQC comment cards, and those we spoke with during our inspection, were very positive about the service. They all confirmed staff were caring and compassionate and felt the practice provided a good service.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The GP and staff understood the diverse needs of the different population groups they supported and made arrangements for these to be met. 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.

Are services well-led?

Good

The practice is rated as good for being well-led. There was a long standing visible management team, with a clear leadership structure. Staff felt supported by the management team. There were good governance arrangements and systems in place to monitor quality and identify risk.

We found the practice had an active Patient Participation Group (PPG) and had systems in place to obtain feedback from patients about the service they received. The practice proactively sought feedback from staff and patients, which it acted on. The results of this informed planning and helped to develop the service further for patients.

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

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

The practice ensured follow up consultations were in place for older patients when discharged from hospital. Patients over the age of 75 had a named GP. Annual health checks were in place for the over 75s and their medication was reviewed. Patients told us they were included in their care decisions and health promotion programmes were available.

People with long term conditions

Good

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

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

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 failed to attend appointments or clinics. Immunisation rates were relatively high for all standard childhood immunisations. We saw good examples of joint working with midwives and health visitors.

Summary of findings

Working age people (including those recently retired and students)

Outstanding ☆

The practice is rated as outstanding for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.

The practice 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. The practice was also developing SKYPE technology to further enable consultations. This will enable GP's to provide support to patients via the internet through voice calls and video.

We found that the practice recalled any patients who had not attended the practice for five years to review their health needs.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients with a learning disability and carried out annual health checks for this group. The practice also offered longer appointments for vulnerable patients.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. We saw evidence of practice staff advising and signposting vulnerable patients 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

We saw the practice monitored patients with poor mental health; they had audits which ensured patients had a regular physical health check and follow ups if there was non-attendance.

The practice offered structured reviews to all patients with severe and enduring mental health conditions with at least annual reviews of their physical and mental health, medicines and revision of their agreed care plan.

Summary of findings

What people who use the service say

In the most recent information from Public Health England 2013/14 showed 92% of people would recommend this practice to others and 90% were happy with the opening hours.

We received 9 completed patient CQC comment cards and spoke with five patients on the day of our visit. All these patients were positive about the care provided by the GPs the nurses and reception staff with many comments conveying the excellent service they received by the practice overall. They all felt the doctors and nurses were competent and knowledgeable about their health needs.

The practice had an active Patient Participation Group (PPG). We spoke to a member of the PPG during our visit. They told us they and had conducted their own patient's survey in 2013 and there was also a suggestion box in the practice waiting room. The practice had responded to the patient's survey and to individual suggestions by employing more reception and clinical staff to provide better access to the practice.

Areas for improvement

Action the service SHOULD take to improve

- Events and Incidents were reviewed by the GPs and discussed at their meetings. However, the systems in place did not always provide a detailed analysis and information was at times limited.
- A wide range of information about the practice and services was provided. However, key documents, such as the practice booklet and complaints procedure, were only available in English which did not meet the language needs of some of the patient population.

Outstanding practice

- All patients, but particularly those who work, could access appointments during the week and Saturday morning openings throughout the year. Patients could also access the GP for telephone advice if attending the practice was difficult.
- The appointment system was effective and routine appointment waiting times were no longer than one to two days on average.
- The practice used the 'choose and book' system effectively by ensuring all patients had a referral made before they left the surgery on the day of their appointment.
- We found that the practice recalled any patients who had not attended the practice for five years to review their health needs.
- The practice was also developing SKYPE technology to further enable consultations.

Drs Coleman, Forbes, Sellars, Sharpe, Tupper and Leighton

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead inspector and included a SPA Specialist advisor GP and a second CQC inspector.

Background to Drs Coleman, Forbes, Sellars, Sharpe, Tupper and Leighton

Kingthorne is located in the centre of Doncaster. The building is an older building with good parking facilities and disabled access. The practice also has a satellite branch based in Edenthorpe. This was not visited as part of this inspection.

The practice is registered with the CQC to provide primary care services. It provides Primary Medical Services (PMS) for 9798 patients under a PMS contract with NHS England in the Doncaster Clinical Commissioning Group (CCG) area.

The practice has six GP partners (four male and two female), two advanced nurse practioners, four practice nurses, three healthcare assistants and an experienced administration and reception team. The reception team consists of one practice manager and 11 reception and administrative staff.

The practice is open Monday to Friday from 8am to 6pm with extended opening hours on a Saturday morning 8.00am to 10.30am. The Edenthorpe site is open Monday to Fridays 8:15am to 12 noon and 2pm to 5pm.

The practice treats patients of all ages and provides a range of medical services. When the practice is closed patients can access the out of hour's provider service.

The practice population is made up of a predominately younger and working age population between the ages of 0- 49 years. Fifty three per cent of the patients have a long-standing health condition.

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

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health

Detailed findings

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. This practice was part of a random selection of practices in Doncaster CCG area.

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
- Working age people (including those recently retired and students)
- People living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew.

We carried out an announced visit on 13 January 2015. During our visit we spoke with a range of staff including the practice manager, two GP partners, one advanced nurse practioner, one practice nurse, two health care assistants and four reception staff. We also spoke with five patients on the day.

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

Good

Are services safe?

Our findings

Safe track record

The practice had systems in place to monitor all aspects of patient safety. Information from the Quality and Outcomes Framework (QOF), a national incentive and reward scheme that helps practices to focus better outcomes for patients, showed that in 2013-2014 the practice was appropriately identifying and reporting incidents. The practice had a rating of 99%. Information from the Clinical Commissioning Group (CCG) and NHS England indicated the practice had a good track record for maintaining patient safety.

Staff we spoke with understood their responsibilities to raise significant events. This included the process to report them internally and externally where appropriate.

Learning and improvement from safety incidents

There were effective protocols used to scrutinise practice. The practice had systems in place for reporting, recording and monitoring significant events, incidents and accidents. We looked at records of significant events that had occurred during the last 12 months. We saw incidents were discussed at weekly GP and monthly practice meetings. We talked with staff who confirmed any important information was passed onto them either via email or directly at team meetings.

We saw where patients had been affected by something that had gone wrong, in line with practice policy; they were given an apology and informed of the actions taken.

Staff told us they felt confident in raising issues with the GPs and felt action would be taken. It was clear there was a culture of openness operating throughout the practice, which encouraged errors and 'near misses' to be reported.

We saw however whilst GPs discussed the incident that occurred, analysis was not detailed and information was at times limited. For instance where a mistake had been made where a patient's letter had been wrongly sent out there did not appear to be an in-depth review of how this occurred and how it could be avoided in future.

Reliable safety systems and processes including safeguarding

The practice had systems in place to protect and safeguard children and vulnerable adults. The practice had a named lead GP for safeguarding. All GPs at the practice and staff had completed safeguarding training. All staff we spoke with confirmed they had completed recent training. We saw GPs and the advanced nurse practioners had the right training in place to support vulnerable patients. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. This helped to ensure the protection of children and vulnerable adults.

We confirmed staff used appropriate codes on their electronic case management system for children and vulnerable adults. This helped ensure risks to these groups were known and reviewed. This also flagged up where a patient (child or adult) was vulnerable or required additional support, for instance if they were a carer.

The practice had systems to monitor babies and children; for instance, where patients failed to attend for childhood immunisations, or who had high levels of attendances at A&E.

There were chaperone notices displayed on all consulting rooms doors and a chaperone policy in place. There was evidence of patients being offered chaperone services during consultation and treatment and staff had appropriate guidance and training.

Medicines management

There was a clear policy for ensuring medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Staff confirmed the procedure to check the refrigerator temperature every day and ensure the vaccines were in date and stored at the correct temperature. The staff showed us their daily records of the temperature recordings and the correct temperature for storage was maintained. The cold chain for vaccines was audited and closely monitored by staff.

The practice was not a dispensing practice. The amount of medicines stored was closely monitored and medicines were kept in a secure store with access by clinical staff only. We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw records of practice meetings that reviewed prescribing errors in the practice. There were systems in

place to ensure GPs regularly monitored patients medication and re issuing of medication was closely monitored, with patients invited to book a 'medication review', where required. There was a process to regularly review patients' repeat prescriptions to ensure they were still appropriate and necessary. Any changes in medication guidance were communicated to clinical staff, and staff were able to describe an example of a recent medical alert and what action had been taken.

The nurses and the health care assistant administered vaccines using Patient Group Directions(PGDs) produced in line with legal requirements and national guidance. We talked with staff who confirmed they had received appropriate training to administer vaccines. The data from 2013-14 NHS England showed 98% of children aged 24 months at the practice had received their vaccinations.

Cleanliness and infection control

We saw all areas throughout the practice were clean. We saw there were cleaning schedules in place and cleaning audit records were kept in each treatment room.

Patients we spoke with and responses from the CQC comment cards confirmed patients found the practice clean and had no concerns about cleanliness or infection control. Suitable arrangements were in place to help ensure the practice was cleaned to a satisfactory standard.

We saw liquid soap and paper hand towels were available in treatment rooms and public areas. Notices about hand hygiene techniques were displayed in staff and patient toilets.

We confirmed Personal Protective Equipment (PPE) was easily accessible to all staff. Single use equipment was available and safely managed and we confirmed part of the infection control audit. Sharps receptacles were in place in the treatment rooms and containers were provided for the disposal of cytotoxic and contaminated sharps such as used needles. The practice had a needle stick injury policy in place, which outlined what staff should do and who to contact if they suffered this injury.

We looked at the Infection Control Policy in place and noted it was up to date and regularly reviewed. The practice had a new lead for infection control who completed recent audits to ensure the treatment areas were safe. An infection control checklist was used to help identify any shortfalls or areas of poor practice. Where concerns were identified, an action plan was put in place. We confirmed infection control training had been completed by all the staff and refresher training was done on an annual basis.

The practice did not have a legionella assessments and audits in place. We discussed this with the practice manager who told us this would be put into place with immediate effect. The practice needed to ensure that risks associated with legionella disease were minimised by undertaking such assessments.

Equipment

The practice had appropriate equipment for managing emergencies. Emergency equipment included a defibrillator and oxygen. This equipment was based in the reception area and all staff we spoke with knew the location of the equipment. We confirmed equipment was checked regularly to ensure it was in working condition. A log of maintenance of clinical and emergency equipment was in place and staff recorded when any items identified as faulty were repaired or replaced.

We saw equipment was tested and maintained regularly and we saw equipment maintenance logs and other records confirmed this. We saw the practice had annual contracts in place for portable appliance tests (PAT), Gas and Electrical safety and also for the routine servicing and calibration, where needed, of medical equipment.

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

Staffing and recruitment

The practice had a recruitment policy in place. The policy stated all clinical staff should have a Disclosure and Barring Service (DBS) check and two references from their previous employment. We looked at a sample of personnel files for nurses, health care assistants and reception staff. Most of the staff had worked for the provider for several years. We looked at the most recently recruited staff and confirmed pre-employment checks were in place. Checks such as obtaining a full work history, evidence of identity, references and a DBS check, had been carried out prior to staff starting work.

Good

Are services safe?

The provider routinely checked the professional registration status of GPs and practice nurses against the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) register each year to make sure they were still deemed fit to practice.

We saw safe staffing levels had been determined by the provider and rotas showed these were maintained. Procedures were in place to manage planned absences, such as to cover training and annual leave, and unexpected absences such as staff sickness.

Monitoring safety and responding to risk

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

The practice had arrangements for monitoring safety and responding to changes in risk to keep patients safe. For example, the practice had a health and safety policy setting out the steps to take to protect staff and patients from the risk of harm or accidents.

The practice was positively managing risk for patients. Patients with a significant change in their condition or new diagnosis were discussed at GP and multi-disciplinary team (MDT) meetings, which allowed clinicians to monitor treatment and adjust support according to risk.

We saw information regarding palliative care patients was made available to out of hours providers so they would be aware of changing risks.

Arrangements to deal with emergencies and major incidents

We saw evidence all staff had received training in Basic Life Support. This was updated on a regular basis. There was an automatic external defibrillator (AED) in the practice. All staff knew where this was kept and how it should be used. Emergency medicines were available, such as for the treatment of cardiac arrest and anaphylaxis, and all staff knew their location. Processes were in place to check emergency medicines were within their expiry date.

We saw there were disaster/ business continuity plans in place to deal with emergencies that may interrupt the smooth running of the service such as power cuts and adverse weather conditions. The plans were accessible to staff and kept in reception. This provided information about contingency arrangements staff would follow in the event of a foreseeable emergency.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice aimed to deliver high quality care and participated in the Quality and Outcomes Framework (QOF). The QOF aimed to improve positive outcomes for a range of conditions such as coronary heart disease and high blood pressure. The practice achieved 100 per cent of the QOF framework points in year 2013-14, which showed their commitment to providing good quality of care.

All GPs and nurses demonstrated how they accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. For instance, they applied the NICE quality standards and best practice guidance in their management of conditions such as asthma and diabetes. We saw minutes of GP clinical meetings where new guidelines were disseminated and the implications for the practice's performance and patients were discussed. The GPs interviewed were aware of their professional responsibilities to maintain their knowledge.

We saw patients were appropriately referred to secondary and community care services. The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring each patient was given support to achieve the best health outcome for them. Feedback from patients confirmed they were referred to other services or hospital when required

All GPs we spoke with used national standards for referral, for instance two week referrals for patients with suspected cancer were done there and then, and other routines via 'choose and book' were also done the same day.

There were systems in place to identify and monitor the health of vulnerable groups of patients. Specific coding was used for patients on their electronic records. This coding records the everyday care of a patient, including family history, relevant tests and investigations, past symptoms and diagnoses. They improve patient care by ensuring clinicians base their judgements on the best possible information available at a given time. The GPs and nurses we spoke with were all familiar with read coding and its benefits when assessing patients' conditions.

Staff were able to demonstrate how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. The practice kept up to date disease registers, for patients with long term conditions. These included asthma and chronic heart disease and were used to arrange annual, or as required, health reviews.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included asthma audit, antipsychotic prescribing and management of COPD. The practice was making use of clinical audit tools to reflect on the outcomes being achieved and areas where this could be improved.

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

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. The evidence we saw confirmed the GPs had oversight and a good understanding of best treatment for each patients' needs.

The GPs from the practice met regularly with the CCG and other practices. These meetings shared information, good practice and national developments and guidelines for implementation and consideration.

Effective staffing

All the patients we spoke with were complimentary about the staff. We observed staff were competent and knowledgeable about the roles they undertook. The practice was organised so there were enough staff to meet the fluctuating needs of patients.

We saw checks were made on qualifications and professional registration as part of the recruitment process and additional checks throughout the clinician's appointment. There was a comprehensive induction programme in place for new staff which covered generic issues such as fire safety and infection control.

Good

Are services effective?

(for example, treatment is effective)

We saw evidence staff had completed mandatory training, for example basic life support, safeguarding and infection control. Staff had been trained in areas specific to their role for example, epilepsy care, wound management, heart disease, diabetes and COPD.

We saw evidence of regular TARGET (Time for audit, research, governance, education and training) training sessions regularly taking place. We noted the practice kept an accurate account of training completed or training requiring an update.

All GPs were up to date with their continuing professional development requirements. The nurses in the practice were registered with the Nursing and Midwifery Council (NMC). To maintain registration they had to complete regular training and update their skills. The advanced nurse practioner we spoke with confirmed their professional development was up to date.

The clinical and non-clinical staff confirmed they had appraisals. They told us it was an opportunity to discuss their performance and any training concerns or issues they had. All the staff we spoke with were unanimous they were well supported in their role and confident in raising any issues with the practice manager or the GPs.

There were Human Resources (HR) policies and procedures in place to support poor or variable performance amongst staff. We saw where performance concerns had been identified appropriate action had been taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs. Treatment information from hospitals and Out Of hours (OOH) services was received and reviewed as per the practice policy. 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 worked well.

We saw evidence the practice worked closely with other professionals. For example they worked with palliative care nurses, health visitors, social services, community learning disability teams and community mental health teams to support patients.

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

Information sharing

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the local 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.

The staff told us they liaised closely with the health and social care providers to ensure any health needs of their patients were promptly addressed, for example when someone was discharged from hospital. This was important to ensure integrated care and support was provided to the patients.

There was a practice website with information for patients including signposting services available and the latest news. Patients registered so they could access the full range of information on the website. Information leaflets and posters about local services were available in the waiting area. We noted however that important information was not translated to meet the different language needs of some patients who use the practice. This could mean that important information is missed by some patients. We also noted that the practice did not have a working induction loop. The practice manager informed us that the induction loop would be addressed with immediate effect to support the needs of all patients.

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. Staff told us they spent time discussing treatment options and plans with patients and were aware of consent procedures. They explained discussions were held with patients to assure their consent prior to treatment.

There was a practice policy on consent in place. Staff were able to provide examples of how they dealt with a situation if someone was unable to give consent, including

Good

Are services effective?

(for example, treatment is effective)

escalating this for further advice to a senior member of staff where necessary. We found clinical staff understood how to facilitate 'best interest' decisions for people who lacked capacity and would seek appropriate approval for treatments.

We saw clinical staff were familiar with the need for capacity assessments and Gillick competency assessments of children and young people. These assessments check whether children and young people had the maturity to make decisions about their treatment.

Health promotion and prevention

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

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed that reception staff were courteous and spoke respectfully to patients. They listened to patients and responded appropriately. The practice switchboard was located in an area away from the reception so calls could not be overheard.

The staff we spoke with told us they were always careful about what questions they asked patients at the reception desk and they were aware of the need to maintain confidentiality. In the NHS England survey 2013-14 the practice rated highly in patients responding that they felt the reception maintained confidentiality. We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private.

Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting and treatment rooms so that patient's privacy and dignity was maintained during examinations, investigations and treatments. We noted doors were closed during consultations and conversations taking place in these rooms could not be overheard. The staff were aware of the practice policy on chaperoning and familiar with arrangements to maintain the dignity and privacy of patients undergoing intimate examinations.

Patients' on going emotional needs were supported. Leaflets were available in the waiting room which offered support to patients for areas such as; bereavement counselling, mental health support and also support with conditions such as cancer. Staff also confirmed that GPs always contacted patients after bereavement in their family to offer condolences and further support.

Care planning and involvement in decisions about care and treatment

Patients were supported to express their views and were involved in making decisions about their care and treatment. Of the patients who participated in the national GP patient survey in 2013-14, 90% of respondents said the GP they visited was 'good' at treating them with care and concern and involving them in decisions about their care. They also expressed their GP had satisfactorily explained their condition and the treatment they needed. Patients we spoke with said they had been involved in decisions about their care and treatment, and staff explained things clearly to them.

We found staff communicated with patients so they understood their care, treatment or condition. We received positive comments from patients confirming they understood their treatment and options were discussed during their consultation.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection told us staff were caring and understanding when they needed help and provided support where required.

Notices in the patient waiting room and patient website also signposted patients to a number of support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer. There was written information available for carers to ensure they understood the support available.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice provided a service for all age groups. They covered patients with diverse cultural and ethnic needs and for those living in deprived areas. We found GPs and other staff had the overall competence to assess each patient and were familiar with individual's needs and the impact of their socio-economic environment.

Longer appointments were made available for people who needed them and those with long term conditions. This also included appointments with a named GP or nurse. There was a register of the housebound and patients who required palliative care.

We saw there was a process in place for 'Choose and Book' referrals to other services. We saw referrals the practice made to other services and saw these were done before the patient left the practice on the day of their visit.

We looked at how the practice met the needs of older people. We saw the practice had a named GP for over 75s and provided patients with an 'elderly health check' to support them with management of any long term conditions. This included a system that recalled patients annually for a comprehensive review.

Staff understood the lifestyle risk factors that affect some groups of patients within the practice population. We saw the practice provided a range of services and clinics where the aim was to help particular groups of patients to improve their health. For example, the practice provided patients with access to smoking cessation programmes, and advice on weight and diet.

Tackling inequity and promoting equality

There was ramp access to the building and accessible toilets. Disabled parking bays were available. There was a large waiting area on the ground floor and lift to the first floor to access additional surgeries and treatment rooms. We saw the ground floor waiting area was large enough to accommodate patients who used wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities including baby changing facilities were available for all patients attending the practice.

Staff told us translation services during consultations were available for patients who did not have English as a first language. We also noted that staff had been appointed with different language skills in reception to support people with making appointments and translating information where required.

A wide range of information about the practice and services was provided. However, key documents, such as the practice booklet and complaints procedure, were only available in English, which did not meet the language needs of some of the patient population.

The practice provided support to homeless and travelling people in the area and emergency appointments were made when required.

Access to the service

Of the patients who participated in the national GP patient survey in 2013-14, 97 % of patients reported a good overall experience of making an appointment at the practice.

The practice offered telephone and on line pre bookable appointments. Patients could also ring on the day for emergency appointments. Patients we spoke with told us that they always got an appointment the same day if it was an emergency. All children were seen the same day and usually within two hours of contacting the practice. Older patients were also seen the same day and home visits were available when required for housebound patients. Patients confirmed that the practice was accessible and they never waited longer than a couple of days to gain a routine appointment. Patients were also supported with texting services to help remind them of a forthcoming appointment.

We saw that good systems were in place to help patients order repeat prescriptions. Patients could use the web site, telephone or visit the surgery to order prescriptions.

Opening times and closures were stated on the practice website and in the practice leaflet with an explanation of what services were available.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England. There is a designated person, the practice manager, who handles all complaints in the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We saw information was available to help patients understand the complaints system. Information on how to make a complaint was available in a practice booklet in reception and displayed in the reception area. There was a suggestion box in the waiting area for patients use. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice. The practice manager kept a log of complaints about the practice. We looked at the complaints over the past 12 months. We saw these complaints were investigated and concluded in accordance with the practice's guidelines and procedures.

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

Staff we spoke with shared values about the practice and knew what their responsibilities were in relation to these. All staff spoke positively about the leadership and that they felt valued as employees at the practice. Staff told us that central to their values was the needs of the patient.

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

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at three of these policies and procedures. All policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear management structure in place. Allocations of responsibilities, such as lead roles were in place. All staff we spoke with said they knew their own roles and responsibilities within the practice.

We found effective monitoring took place, and this included audits to ensure the practice was achieving targets and delivering safe, effective, caring, responsive and well led care.

The practice had a system in place for completing clinical audit cycles. Examples of completed clinical audits included an audit of asthma and a management of COPD.

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

The practice sought feedback from patients and staff to help improve the service. All the staff we spoke with felt they had a voice and the practice was supportive and created a positive learning environment. They all told us they felt valued, supported and knew who to go to in the practice with any concerns.

Leadership, openness and transparency

All clinicians and reception staff told us there was an open culture within the practice and they were happy to raise issues at meetings. Systems were in place to encourage staff to raise concerns and a no blame culture was evident at the practice.

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

The practice had gathered feedback from staff, through staff training days and generally through staff appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff confirmed they felt part of the decision making in the practice and their contribution mattered to the team.

The practice surveyed the patient population with a qualitative questionnaire and took action from these results. For instance they had taken action to increase the staffing levels to improve access to appointments overall. We also saw that a suggestion box was in place and any comments received were acted upon.

The practice had an active patient participation group (PPG). We had positive feedback from the PPG regarding their role with the practice and ongoing engagement to improve the quality of the service for the patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. The practice was also a training practice for doctors wishing to become GPs.

We looked at three 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 and that they were given protected time to undertake further training.