Dr C P Myers & Dr N R Ravi

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Myers and Dr Ravi on 24 June 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, and responsive and well led services. It was also good for providing services for all the population groups.

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

- Patients said they found it easy to make an appointment with a preferred GP, there was continuity of care and open access appointments were available daily.
- 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 were involved in decisions about their care and treatment.
- Information about services and how to complain was available and easy to understand. Complaints were addressed in a timely manner and the practice endeavoured to resolve complaints to a satisfactory conclusion.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients.
- Risks to patients were assessed and well managed.
- The practice had a number of policies and procedures in place and held regular governance meetings.

We saw some areas of outstanding practice:

Summary of findings

- Home visits were made by the GPs to recently bereaved families.
- Post natal home visits were made by the GPs to new Mums and their babies.
- GP led acupuncture services were available at the practice.
- 'Drop in' open access appointments were available daily.
- Late night opening was available until 9pm one day per week.

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

Importantly the provider should

- Take steps to monitor equipment to ensure it is in date and suitable for use.
- Maintain clear records on prescription stationery stock, in line with guidance from NHS Protect.
- Maintain effective infection, prevention and control monitoring.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. There were enough staff to keep patients safe. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Lessons were learned and communicated to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were effective processes in place for safe medicines management.

Are services effective?

Good

The practice is rated as good for providing effective services. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and there was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Rotherham Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a preferred GP, there was continuity of care and open access appointments were available each day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available both in the practice and on the website.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well led. It had a vision and strategy and staff were clear about their roles and responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures in place and held regular practice meetings. There were systems in place to monitor and improve quality and identify risk. Staff received induction, regular performance reviews and attended staff meetings. The practice proactively sought feedback from patients and staff which it acted upon. There was an active patient participation group (PPG).

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. All patients over 75 years of age had a named GP and were offered an annual health check. The practice was responsive to the needs of older people, offering home visits and longer appointments. The practice worked closely with other health care professionals, such as the district nursing team and community matron, to ensure housebound patients received the care they needed.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. The practice had a GP led approach to long term conditions, supported by the nursing staff. There were structured annual reviews in place to check the health and medication needs of patients were being met. Longer appointments and home visits were available when needed. 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.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were good for all standard childhood immunisations. The practice told us all young children were seen on the same day as requested. Appointments were available outside of school hours and we saw good examples of joint working with midwives and health visitors.

Working age people (including those recently retired and students)

Good

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

Summary of findings

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 had carried out annual health checks for all of these patients. They also offered longer and flexible appointments for people with a learning disability and ensured they had access to both the GP and nurse to minimise number of attendances or number of visit times.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had counselling services based at the practice and sign posted patients experiencing poor mental health to other support groups and voluntary organisations.

Summary of findings

What people who use the service say

We spoke with seven patients on the day of our visit and we received 49 CQC comment cards which patients had used to record their experience of the service they received from the practice. The patients were complimentary about the care provided by the staff and their overall friendliness and behaviour. They felt the doctors and nurses were competent and knowledgeable about their treatment needs and the practice provided a professional service.

Patients reported they felt that all the staff treated them with dignity and respect, listened to them and kept them well informed. Patients said the practice was very supportive and felt their views were valued by staff. They were complimentary about the appointments system, its ease of access and the flexibility it provided.

The 2015 GP Patient Surveys showed 99% would recommend this surgery to someone new to the area (Clinical Commissioning Group (CCG) average 77%). We also saw 98% describe their experience of making an appointment as good (CCG average 70%).

The practice had formed a patient participation group (PPG). We met with members of this group and they told us the GPs and practice manager worked effectively to include them in decision making and they felt their opinion mattered.

Areas for improvement

Action the service SHOULD take to improve

Action the provider SHOULD take to improve:

- Take steps to monitor equipment to ensure it is in date and suitable for use
- Maintain clear records on prescription stationery stock, in line with guidance from NHS Protect.
- Maintain effective infection, prevention and control monitoring.

Outstanding practice

- Home visits made by GP for recently bereaved families.
- Post natal home visits to new Mums and their babies.
- GP led acupuncture services available at the practice.
- 'Drop in' open access appointments were available daily.
- Late night opening was available until 9pm one day per week.

Dr C P Myers & Dr N R Ravi

Detailed findings

Our inspection team

Our inspection team was led by:

The team included a lead inspector a second CQC inspector, a GP specialist advisor and a practice manager specialist advisor.

Background to Dr C P Myers & Dr N R Ravi

The medical services are provided to the local community in the Greasborough area of Rotherham. The building was purpose built in 1978 with good parking facilities and disabled access.

The practice is registered with the CQC to provide the following regulated activities: Maternity and midwifery services; Diagnostic and screening procedures; Treatment of disease, disorder or injury; and Surgical procedures. The practice provides Personal Medical Services (PMS) for a population of 5620 patients under a contract with Rotherham Clinical Commissioning Group (CCG).

The practice has two GP male partners, a female salaried GP, a trainee GP, an ANP (advanced nurse practioner) and one practice nurse and part time healthcare assistant. There was also an experienced administration and reception team. The reception team consists of a practice manager, assistant practice manager and seven reception staff. This is also an established training practice for new GPs. Dr Myers is a senior GP trainer, lead appraiser, member of the Deanery and vice chair of the Local Medical Council (LMC)

Dr Ravi is a member of the local Clinical Commissioning Group CCG and the Strategic Clinical Executive (SCE).

The practice is open Monday to Friday from 8am to 6:30pm with extended opening hours on Monday evening until 9pm. Morning surgeries are 'drop in' open access appointments with the afternoon and evening surgeries for pre bookable appointments only. When the practice is closed patients can access the out of hours provider service.

The practice population is made up of a predominately younger and working age population between the ages of 45- 69 years. Forty five per cent of the patients have a long standing health condition.

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 registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

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

- Is it safe?

Detailed findings

- 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 24 June 2015. During our visit we spoke with a range of staff including the practice manager, GPs, ANP, practice nurse, health care assistant and reception staff. We talked to some patients and members of the patient participation group (PPG). We also reviewed patient survey information.

We observed communication and interactions between staff and patients both face to face and on the telephone within the reception area. We looked at records relating to the management of the practice.

Good

Are services safe?

Our findings

Safe track record

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

We reviewed safety records, incident reports and saw evidence in minutes of clinical meetings where these were discussed. This showed the practice had managed these consistently and could demonstrate a safe track record over the long term.

Learning and improvement from safety incidents

There were systems in place for how the practice managed safety alerts, significant events, incidents and accidents. Significant event analysis was a standing agenda item on the weekly clinical meetings. They were also discussed at the bi-monthly practice meetings. Staff we spoke with confirmed there was an open and transparent culture. They knew how to raise issues for discussion and were encouraged to do so.

The practice manager showed us the electronic reporting system the practice used to record, manage and monitor all clinical and non-clinical incidents. We looked at four records of reported incidents and saw they had been completed in a comprehensive and timely manner. They included learning points or improvement actions.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed all the staff had received relevant role specific training on safeguarding. Staff we spoke with were aware of their responsibilities, knew how to share information, record safeguarding concerns and how to contact the relevant agencies in both working hours and out of normal hours. Safeguarding policies, procedures and the contact details of relevant agencies were available and easily accessible for all staff.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained to level three in safeguarding and could demonstrate they had the necessary skills to enable them to fulfil this role. All staff we spoke with were aware of who the lead was and who to speak to in the practice if they had a safeguarding concern.

There was a system in place to highlight vulnerable patients on the practice's electronic records. The practice held a monthly multidisciplinary meeting with other professionals, such as the health visitor and social workers to discuss concerns and share information about children and vulnerable patients registered at the practice.

There was a chaperone policy which was visible on the waiting room notice board. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. All nursing staff, including health care assistants, had been trained to be a chaperone.

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 that the correct temperature. The staff showed us their daily records of the temperature recordings and the correct temperature for storage was maintained. The use and storage of vaccines were 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.

We saw records of practice meetings where any identified prescribing errors were reviewed. There were systems in place to ensure GPs regularly monitored patients' medication. Repeat issuing of medication was closely monitored, with patients invited to book a 'medication review' where required. Any changes in medication guidance were communicated to clinical staff.

Good

Are services safe?

The nurse 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 100% of children aged 24 months at the practice had received their vaccinations.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were however not handled in accordance with national guidance. The monitoring of blank prescription forms was not effective as the serial numbers were not recorded when they arrived into the practice or when the forms were issued to the GPs. This is contrary to guidance issued by NHS Protect. We spoke with the practice manager who confirmed a recording and monitoring system would be put in place with immediate effect.

Cleanliness and infection control

The GP patient questionnaires and CQC comment cards confirmed patients found the practice clean and had no concerns about cleanliness or infection control.

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 saw all areas throughout the practice were clean.

We saw there were cleaning schedules in place. However there was no evidence of a cleaning audit in each treatment room. We spoke with staff who told us these used to be in place. The practice manager confirmed these would be put in place to ensure all areas were maintained consistently and cleaned to a satisfactory standard.

We confirmed personal protective equipment (PPE) was easily accessible to all staff. Single use equipment was available and safely managed. 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 required.

We looked at the infection control policy in place and noted it was up to date and regularly reviewed. The practice had a lead for infection control who completed a recent audit. 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 staff and refresher training was completed on an annual basis.

The practice had a recent legionella assessment and action plan in place. We discussed this with the practice manager who told us the action plan was in place to help reduce the risk of infection to staff and patients.

Equipment

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

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records confirmed this. A schedule of testing was in place. There was evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer. 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.

Acupuncture was carried out at the practice. We saw there were appropriate arrangements in place for the disposal of single-use instruments. However, some of the equipment and dressings for use in the treatment rooms was out of date. We discussed this with the practice manager; they told us the out of date equipment would be disposed of immediately and arrangements put into place to monitor stocks.

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 clinical and non-clinical staff. 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.

We noted the registered provider checked the professional registration status of GPs, including locums and nurses against the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) regularly.

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

The practice was positively managing risks for patients. Newly diagnosed cancer patients or terminally ill patients were discussed at GP and multidisciplinary 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

The practice had arrangements in place to manage emergencies. We saw evidence clinical staff had received training in basic life support. All staff knew where emergency equipment was located. There was resuscitation equipment and emergency medicines, such as for the treatment of cardiac arrest and anaphylaxis. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. The notes of the practice's significant event meetings showed staff had discussed a medical emergency concerning a patient and had learned from this appropriately.

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 all staff and kept in reception and hard copies kept in the GPs and practice manager's homes. This provided information about contingency arrangements staff would follow in the event of a foreseeable emergency.

The practice had carried out a fire risk assessment, this included actions required to maintain fire safety. Records showed staff were up to date with fire training and they practised fire drills.

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 92.5% of the QOF framework points in year 2013-14, which showed their commitment to providing good quality of care.

We were told weekly meetings were held where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed.

The clinical staff 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 and the practice performance and patients were discussed. The GP interviewed was aware of their professional responsibilities to maintain their knowledge.

We saw patients accessed specialist diabetic, asthma, coronary heart disease clinics. Also, they were supported with pre-conceptual advice and family planning services. Anti and post natal clinics were run from the practice and child health and immunisation services. Specialist acupuncture was provided to patients for support them with pain management. We also saw there was extensive support for substance and alcohol misuse and counselling support.

We saw patients were appropriately referred to secondary and community care services. The clinical 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.

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. This helped to improve patient care by ensuring clinicians based their judgements on the best possible information available at a given time. The clinical staff we spoke with were all familiar with the 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.

We saw staff had completed equality and diversity training and interviews with staff confirmed patients were cared for and treated based on need. The practice took into account a patient's age, gender, race and culture as appropriate and avoided any discriminatory practises.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. Clinical audit, clinical supervision and staff meetings were used to assess performance. The practice had an effective system in place for how they completed clinical audit cycles. An example of clinical audits included a diabetic keytone testing review which highlighted prescribing and education issues for the patient. After each audit, actions had been identified and changes to treatment or care had been made.

Staff regularly checked all routine health assessments were completed for long term conditions such as diabetes and the latest prescribing guidance was being used. There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. The evidence we saw confirmed the GPs had overview and a good understanding of best treatment for each patients' needs.

The partners from the practice met regularly with the CCG and other practices. These meetings were used to look at national developments and guidelines for implementation and consideration and also sharing information and good practice.

Good

Are services effective?

(for example, treatment is effective)

Effective staffing

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.

There was an induction programme in place for new staff which covered generic issues such as fire safety and infection control. We saw evidence staff had completed mandatory training, for example, safeguarding, infection control and basic life support. Staff had been trained in areas specific to their role for example, cervical cytology, wound management, vaccinations, travel health and diabetes.

The GP was up to date with their annual continuing professional development requirements and had been revalidated. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

The nursing team were expected to perform defined duties and able to demonstrate they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles for example, seeing patients with long term conditions such as asthma, chronic obstructive pulmonary disease (COPD), diabetes and coronary heart disease were able to demonstrate they had appropriate training. The nurse had their 'fit for practise' reviewed each year via the nursing and midwifery council (NMC) registration web site. We saw staff were up to date with their continuing professional development requirements.

Both clinical and non-clinical staff confirmed they had appraisals. This 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, nurses or the GPs.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services both electronically and by post.

We saw evidence the practice worked closely with other professionals. For example, it worked with palliative care nurses, health visitors, social services, community learning disability teams and community mental health teams to support patients. Practice staff also met monthly with a consultant psychiatrist to effectively support the needs of a specialist care home.

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 several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

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.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence audits had been carried out to assess the completeness of these records and action had been taken to address any shortcomings identified.

Good

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

We found staff were aware of the Mental Capacity Act 2005 and Children Acts 1989 and 2004. 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. They were aware of how to access advocacy services.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. 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 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 checked whether children and young people had the maturity to make decisions about their treatment.

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way.

The practice offered NHS health checks to all its patients aged 40 to 70 years. They were involved with national breast, bowel and cervical cytology screening programmes. The practice's performance for cervical smear uptake for 2013/14 was 100%, which was above the CCG average for the area

They offered a full range of immunisations for children, flu vaccinations and travel vaccinations in line with current national guidance.

The practice had numerous ways they could identify patients who needed additional support. For example, it kept a register of all patients with a learning disability, long term condition or mental health problem. These patients were offered an annual physical health and well-being check.

The practice raised patients' awareness of health promotion. This was in consultations, displays 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. The practice also provided support and health promotion for young patients' sexual health and a range of support for substance and alcohol misuse.

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 2015. There were 208 patient surveys sent out and 105 returned. The returned surveys confirmed patients were satisfied with how they were treated and this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was rated 96% in its satisfaction scores on patients confirming their GP was good at listening to them and 93% said the GP were also good at involving them in their care.

We observed 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 GP patient survey 2015 the practice rated 98% of patients responding they felt the reception staff helpful.

Staff 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 patients' 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.

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 105 patients who participated in the national GP patient survey in 2015, 100% of respondents said they had confidence in their GP.

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

Patient/carer support to cope emotionally with care and treatment

Patients' emotional needs were supported. Patients were offered information and support for areas such as; bereavement, mental health, substance misuse and alcohol dependency, and also support with conditions such as cancer. There was a counselling support clinic based at the practice. Notices in the patient waiting room also told patients how to access a number of support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice provided a service for all age groups. These 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.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, longer GP and nurse appointments were available for patients who had complex needs or where they were supported by a carer. Patients with multiple long term conditions had a single health check to avoid the need for multiple appointments. Home visits were also available for patients who found it difficult to access the surgery.

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.

Patients with immediate, or life-limiting conditions, were discussed at the weekly clinical meeting to ensure all practitioners involved in their care delivery were up-to-date and knew of any changes to their care needs.

Tackling inequity and promoting equality

There was easy access to the building. There was a large waiting area and level access to additional surgeries and treatment rooms. We saw the 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 were available for all patients and baby changing facilities available. An audio loop was in place in the reception/ waiting room area.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed they had completed the equality and diversity training in the last 12 months and equality and diversity was regularly discussed at staff appraisals and team events.

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

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

The surgery was open from 8am to 6:30pm Monday to Friday and included a late night opening until 9pm on a Wednesday. Each day the practice offered a morning 'drop in' service, with no one turned away. In the afternoon a pre-bookable appointment system was in place. The practice offered telephone and online pre-bookable appointments. 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. The practice also supported a local care home with home visits.

To help remind patients about their forth coming appointment the practice sent a 'prompt' text phone message to remind patients (who had consented to receive them) about their appointment In an attempt to cut down

Good

Are services responsive to people's needs?

(for example, to feedback?)

patients who did not attend appointments the practice displayed in the waiting area the number of 'missed appointments'. The practice continually reviewed how to improve access for all their patients.

We saw good systems in place to help patients order repeat prescriptions. Patients could use on line systems, telephone or visit the surgery to order their prescriptions.

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.

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. The practice manager kept a log of complaints about the practice.

We looked at how two complaints received by the practice had been managed. The records showed complaints had been dealt with in line with the practice policy and in a timely way. Patients had received a response which detailed the outcomes of the investigations. We saw where appropriate actions and learning from complaints were shared with staff.

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 joint values about the practice and knew what their responsibilities were in relation to these. All staff spoke positively about the leadership and they felt valued as employees at the practice. Staff told us the needs of the patient was fundamental to their work. They said the patient was central to the practice in all their decision making, planning and development.

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, safeguarding, infection control and complaints. All policies and procedures we looked at had been reviewed annually and were up to date.

There were clear leadership structures in place. Allocation of responsibilities, such as lead roles were in place. For example, there was a lead nurse for infection, prevention and control and a lead GP for safeguarding children and a lead GP for safeguarding adults. The staff we spoke with all understood their roles and responsibilities and knew who to go to in the practice with any concerns.

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 used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw QOF data was regularly discussed at practice meetings.

The practice had a system in place for completing clinical audit cycles. Examples of completed clinical audits included diabetes and memory screening.

The practice had arrangements in place 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. They completed patient surveys, families and friend's surveys and a comment box was in the waiting area. The practice manager explained if patients were unhappy they invited them to come into the practice and talk to them or if they prefer a GP, to resolve any concerns.

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

The practice manager was responsible for human resource policies and procedures. We looked at the recruitment and whistle blowing policies which were in place to support staff. Staff showed us how they accessed these if required.

Systems were in place to encourage staff to raise concerns and a no blame culture was evident at the practice. We saw weekly clinical meetings and bi-monthly team meetings were held where staff had the opportunity to raise issues.

The leadership displayed a duty of candour reflecting a culture of openness and transparency. We saw examples of the responses made to patients where patients received explanations and apologies where they felt their health needs could have been better met. This showed the practice were open and transparent about their need to improve and apologise to their patients.

We saw the practice minimised the effect of changes to the organisation by putting into place effective succession planning, both short and long term plans were in place to meet the future needs of 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

Are services well-led?

Good

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

give feedback and discuss any concerns or issues with colleagues and management. Staff confirmed they felt part of the decision making process in the practice and their contributions mattered to the team.

The practice had an active patient participation group (PPG). It met four times per year and had been involved in enabling better access to information and improving the display of information in the practice waiting area. All members of the PPG we spoke with felt that the GPs and practice manager worked hard to include them in decision making and they felt their opinion mattered.

Management lead through learning and improvement

The practice was a GP training practice. Staff told us the practice supported them to maintain their clinical professional development through training and mentoring.

We looked at three staff files and saw regular appraisals took place which. Staff told us the practice was very supportive of training and they were given protected time to undertake further training.

The practice used information such as the quality outcome framework (QOF) and patient feedback to continuously improve the quality of services. Staff were able to take time out to work together to resolve problems and share information which was used proactively to improve the quality of services. The practice had completed reviews of significant events and other incidents and shared the information at team meetings to ensure the practice improved outcomes for patients.