

Drs Gallagher, Singh and Boruch

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 comprehensive inspection at Daybrook Medical Practice on 18 November 2015. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.

- Whilst some patients said they found it difficult to get through to the surgery by phone, urgent appointments were available the same day and there was evidence of continuity of care.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from the patient participation group (PPG) and it's patients, which it acted on.
- The provider was aware of and complied with the requirements of the Duty of Candour.

The areas where the provider should make improvement are:

The provider should continue to improve telephone access to the practice.

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?

The practice is rated as good for providing safe services.

- There was an effective system in place for reporting and recording significant events. Staff we spoke with were able to provide examples of events and subsequent action taken.
- Lessons were shared to make sure action was taken to improve safety in the practice. This included reviewing procedure and training of staff.
- When there are unintended or unexpected safety incidents, people receive reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again. We found an open and transparent approach where the practice sought to meet with patients affected to discuss issues presented.
- We reviewed existing policy and spoke with a number of staff regarding safeguarding processes for vulnerable patients and children. This showed the practice had clearly defined and embedded systems, processes and practices in place to keep people safe and safeguarded from abuse.
- Risks to patients were assessed and well managed. For example, we found robust process in place in relation to infection control.

Good



Are services effective?

The practice is rated as good for providing effective services.

- Quality Outcomes Framework (QOF) data showed patient outcomes were generally below average for the locality with some exceptions such as dementia. The practice however, had low exception rate reporting compared with local and national averages. This affected their overall results.
- Staff assessed needs and delivered care in line with current evidence based guidance. This included the National Institute for Health and Care Excellence (NICE) guidance which was used routinely by practice clinicians.
- We reviewed four clinical audits. These demonstrated quality improvement and positive patient outcomes. The practice also worked with the local CCG pharmacist to undertake audits.
- Staff had the skills, knowledge and experience to deliver effective care and treatment. The practice had also recently

Good



Summary of findings

appointed new staff which included a GP partner, a nurse practitioner and another member of nursing staff. Staff we spoke with were positive about the new recruitment and meeting patient needs.

- There was evidence of an induction programme, training, appraisals and personal development plans for all staff. An induction pack had also been produced for locum doctors.
- Staff worked with multidisciplinary teams to understand and meet the range and complexity of people's needs. Our discussions held with staff, review of multi-disciplinary team meeting minutes and care plans implemented supported that the practice met patient's needs.

Are services caring?

The practice is rated as good for providing caring services.

- Data showed that patients rated the practice higher than others for several aspects of care. This included that patients felt GPs listened to them, gave them enough time and they felt confidence and trust in the last GP they spoke with.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible. This included information displayed in the practice and available on their website. The website information could be read in a number of different languages. Translation services were available to those who required this assistance.
- Carers were identified by clinicians and reception staff from markers placed on their files.
- We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

- It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. This included extended hours appointments in the mornings and on some weekday evenings. Same day appointments were available for children and those who urgently required them. Longer appointments were also available for those patients who were identified as requiring them.

Good



Summary of findings

- Whilst data suggested patients found it difficult to get through to the surgery by phone to make an appointment, a high proportion of patients still described their experience of making an appointment as good. We found urgent appointments were available the same day and there was evidence of continuity of care.
- The practice had good facilities and was well equipped to treat patients and meet their needs. The practice had undertaken a Disability Discrimination Act / Equality Act 2010 audit of their premises.
- Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and lessons learned.

Are services well-led?

The practice is rated as good for being well-led.

- It had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. The practice's mission statement was displayed in the practice waiting area. Staff were clear about the vision and their responsibilities in relation to this.
- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents. Learning points were shared amongst staff and documented.
- The practice proactively sought feedback from patients and it's patient participation group (PPG), which it acted upon. The practice welcomed staff feedback informally and through staff appraisals undertaken.
- There was a strong focus on continuous learning and improvement at all levels. This was demonstrated through clinical audits and national and local guidance. Learning was disseminated amongst practice clinicians.

Good



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

The practice is rated as good for the care of older people.

- The practice offered proactive, personalised care to meet the needs of the older people in its population. The practice list included 889 registered patients who were aged over 75.
- The number of patients who received the seasonal flu vaccination was in line with national averages. 72.83% of patients had received the vaccination which was comparable to the national average of 73.24%.
- Care plans were implemented for those patients identified as close to the end of life. The practice held regular multidisciplinary meetings where all patients on the palliative care register were discussed. The practice also followed the Gold Standards Framework (GSF) for end of life care guidelines.
- It was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs. This included 20 patients registered at the practice living in residential homes and 220 patients living in a local gated community.
- The practice identified patients with caring responsibilities and those who required additional support including health reviews. A member of reception staff was the nominated lead for carers and signposted these patients to a local carers hub.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions.

- Nursing staff had lead roles in chronic disease management and received close support from the advanced nurse practitioner. Patients at risk of hospital admission were identified as a priority and action taken to reduce attendance. Nursing staff took an active role in the regular review of unplanned admissions patients.
- National data showed the practice was performing under the local and national averages for eleven diabetes related indicators. The practice received total points of 69.8% compared with the CCG average of 87.3% and national average of 89.2%. The practice exception rate reporting was however lower than the CCG average in ten of the related indicators and lower than national average in eleven of the related indicators.

Good



Summary of findings

This varied from 0.6% to 10.5% across the eleven indicators. The practice had told us that recent investment in staffing would help to ensure their performance increased to similarly high levels as achieved in recent years.

- Longer appointments and home visits were available when required. Patient records were highlighted so reception staff knew to allocate a longer appointment time if needed.
- All these patients had a named GP and a structured annual review to check that their health and medicines 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.

Families, children and young people

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.
- The practice undertook joint working with the health visitor and with the school nurse who was able to provide information of concern about school aged children registered at the practice. Regular meetings took place which were documented.
- Immunisation rates were relatively high for all standard childhood immunisations and were similar to Clinical Commissioning Group (CCG) averages.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Clinicians recorded that young patients were competent in their notes when this was deemed appropriate. Young patients aged 13 or over were required to register themselves independently for the purpose of online access to the practice.
- A range of family planning services were available which included the fitting of contraceptive devices.
- National data showed the practice was above the local and national averages in relation to cervical screening indicators. The practice received total points of 100% compared with the CCG average of 99.8% and national average of 97.6%.
- Priority appointments were given to pregnant women and sick children. Appointments were available outside of school hours. The premises were suitable for children and babies.

Good



Summary of findings

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 offered extended hours appointments which included early morning weekday appointments starting at 7.30am and evening appointments up to 6.30pm on Mondays, Tuesdays and Fridays and 7.00pm on Mondays. Telephone appointments with a clinician were also offered if a patient was unable to attend the surgery.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group. This included health checks and new patient checks which were undertaken by a practice nurse.

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 sought to accommodate the needs of patients who were considered as vulnerable. This included those with a learning disability and carers.
- The practice cared for homeless patients who were temporarily residing at a local unit which provided 24 beds for these patients. The practice told us they knew who these patients were, would give them extra time and engage with their support workers.
- It offered longer appointments for people with a learning disability. Markers were placed on these patients' records so receptionists were aware when booking appointments.
- Annual health reviews were offered to patients who had a learning disability. Patients were given a 30 minute appointment with a practice nurse followed by a 30 minute appointment with a GP.
- The practice regularly worked with multi-disciplinary teams and other external contacts in the case management of vulnerable people. We were provided with an example where the practice liaised with a care nurse at the Accident and Emergency department (A & E) in respect of a frequent attender at the A & E department. A strategy was developed to redirect the patient towards their GP.

Summary of findings

- The practice had informed vulnerable patients about how to access various support groups and voluntary organisations. Information was available in the practice and on their website. The practice nominated a carers lead who signposted carers to a local carers hub.
- 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. We interviewed staff and reviewed practice policies and information displayed in the practice which supported this.

People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

- 83.3% of people diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months. This was lower than the CCG average of 87.8% but similar to the national average of 84%. The practice exception reporting was 1.8% which was under the CCG exception reporting average of 9% and the national reporting average of 8.3%
- 68.5% of patients on the practice's mental health register had received an annual health check from April 2015 to November 2015.
- 67.3% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive and agreed care plan. This was below the CCG average of 86.4% and the national average of 88.3%. The practice exception reporting was 5.5% which was significantly below the CCG exception reporting average of 18.6% and the national average of 12.6%.
- 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.
- Staff had a good understanding of how to support people with mental health needs and dementia. For example, the practice ensured that future appointments made for particular patients experiencing poor mental health or dementia recurred on the same day and time on a weekly / monthly basis. They said this had helped those patients to remember to attend the practice.

Good



Summary of findings

- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. This included Alzheimers Society, Healthtalkonline and the Mental Health Foundation.
- It had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health. The practice regularly analysed admissions into hospital and took appropriate action following discussion with the practice clinicians.

Summary of findings

What people who use the service say

The national GP patient survey results published on 2nd July 2015 showed the practice was performing in line with local and national averages with the exception of one area where it was below the local and national averages. 257 survey forms were distributed and 98 were returned. This was a response rate of 38.1%

- 48% found it easy to get through to this surgery by phone compared with a CCG average of 72% and a national average of 73%.
- 88% found the receptionists at this surgery helpful compared with a CCG average of 87% and a national average of 87%.
- 88% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 88% and a national average of 85%.
- 96% said the last appointment they got was convenient compared with a CCG average of 92% and a national average of 92%.
- 78% described their experience of making an appointment as good compared with a CCG average of 74% and a national average of 73%.

- 63% usually waited 15 minutes or less after their appointment time to be seen compared with a CCG average of 64% and a national average of 65%.

As part of our inspection we asked for CQC comment cards to be completed by patients prior to our inspection. We received 17 comment cards, 15 of which were positive about the standard of care received. Words on the comment cards used to describe clinical staff and receptionists included excellent, professional, kind, caring, compassionate and helpful. Two comment cards were from patients who suffered with poor mental health. They both praised the doctors and one said that just by speaking to a particular doctor made them feel happy, as they understood their needs. Two negative comments made were regarding the difficulty in obtaining appointments.

We spoke with six patients during the inspection. All six patients said that they were extremely happy with the care they received and thought that staff were approachable, committed and caring.

Areas for improvement

Action the service SHOULD take to improve

The provider should continue to improve telephone access to the practice.

Drs Gallagher, Singh and Boruch

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor, a practice nurse specialist advisor and a practice manager specialist advisor.

Background to Drs Gallagher, Singh and Boruch

Daybrook Medical Practice is located in Daybrook which is a suburb of Nottingham.

In 2006, the practice merged with another local practice, Bonnington Medical Practice. The patient list size increased to approximately 9,000 from around 6,000. The practice currently has around 9,268 patients registered.

The practice holds a Personal medical services (PMS) contract which is a locally agreed contract between NHS England and a GP to deliver care to the public. The Practice provides GP services commissioned by NHS Nottingham North and East Clinical Commissioning Group. (CCG)

The practice has a slightly higher than national average number of patients with long standing health conditions, carers and those who are disability allowance claimants.

The practice is managed by four GP partners, (two male, two female). Three GP partners work full time and one works 50% of a full time role (0.5 Whole Time Equivalent, WTE). They are supported by three part time salaried GPs (two 0.3 and one 0.6 WTE) and other clinical staff including

an advanced nurse practitioner, three nurses, two healthcare assistants, practice manager, assistant practice manager and a team of reception, clerical and administrative staff.

The practice is open from Monday to Friday at 7.30am. It closes at 7.00pm on Mondays and at 6.30pm Tuesdays to Fridays. Urgent appointments are available on the day. Routine appointments can be pre-booked four weeks in advance in person, by telephone or online. Home visits are available daily as required.

The practice has opted out of providing GP services to patients out of hours such as nights and weekends. During these times GP services are provided by Nottingham Emergency Medical Services (NEMS) through NHS 111. When the practice is closed, there is a recorded message giving out of hours details.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. This included the Clinical Commissioning Group, (CCG) NHS England and HealthWatch. We carried out an announced visit on 18 November 2015.

During our visit we:

- Spoke with a range of staff which included: 4 GPs, 3 nursing staff, 1 healthcare assistant, administrative staff and we spoke with six patients including members of the patient participation group (PPG) who used the service.
- Observed how people were being cared for and talked with carers and family members.
- Reviewed the personal care or treatment records of patients.
- Reviewed 17 comment cards where patients and members of the public shared their views and experiences of the service.

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 whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

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.

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was also a recording form available on the practice's computer system.
- The practice carried out a thorough analysis of the significant events. Whilst one of the GPs retained overall ownership for significant events, responsibility was shared amongst GPs and learning points discussed during practice management meetings.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, we were passed evidence of a significant event which related to a patient's test results. The results had been inadvertently filed in the patient's record without ensuring the patient's GP had seen a copy of the results report. We noted shared learning from the error made which included training to ensure clerical staff followed due process. The patient was asked to attend the practice and a full apology and explanation provided. Significant events recorded were reviewed at future intervals to check that learning had become embedded.

We found robust procedure in place for the checking of Medicines and Healthcare Regulatory Agency (MHRA) alerts. These were checked by the practice manager, distributed to GPs and discussed in practice management meetings. We were provided with an example of an MHRA alert which involved a requirement to review a particular prescribed medicine. This was to ensure it was not being administered over an extensive time period in which it could have an adverse effect. The GPs shared the undertaking of the review of patients affected. We were told how the practice pharmacist actively engaged when such alerts were received to ensure that appropriate medication changes were implemented.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies which had been subject to review this year, clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. A member of the nursing team told us that flow charts were available to assist in decision making. Staff we spoke with were aware of policy and external reporting mechanism for safeguarding concerns. This information was displayed in clinical treatment areas.
- GPs were trained to Safeguarding level 3. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. We saw evidence of safeguarding meeting minutes which involved health visitor attendance and also evidence of separate school nurse meetings held with the practice. This ensured any risks presented in respect of school aged children were highlighted and appropriately monitored. We checked that vulnerable patient records had been marked accordingly.
- A notice in the waiting room advised patients that they could request a chaperone, if required. We were advised that only nurses and healthcare assistants acted as chaperones. We found chaperones had been subject to disclosure and barring service checks. (DBS check). DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. The staff who acted as chaperones had not however received formal training to undertake the role. When we discussed this with the practice manager, a chaperone training course was immediately booked and we were provided evidence of this.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be visibly clean and tidy. The practice had included its infection control statement on its website and displayed this together with its latest audit results in the practice waiting area. These were recorded as 97.06%.
- The practice nurse was the infection control clinical lead and the assistant practice manager, the non-clinical lead. They liaised with the local infection prevention teams to keep up to date with best practice.

Are services safe?

- We reviewed evidence of a detailed audit which was undertaken one year ago with assistance from the local infection prevention team. The audit resulted in the formulation of an action plan which had been fully implemented. We also noted evidence in relation to handwashing and spot check audits.
- There was an infection control protocol in place and staff had received up to date training. Training programmes were developed for clinical staff to complete annually and non clinical staff bi-annually. We saw that a newly appointed member of clinical staff was undertaking infection control training as part of their induction.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. The practice told us that with assistance from the CCG pharmacy team they undertook a review of anticoagulant drugs prescribed. (NOACs). Anticoagulant drugs are used to help prevent strokes.
- We checked that prescription pads were securely stored and there were systems in place to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. The practice had a system for production of Patient Specific Directions to enable Health Care Assistants to administer vaccinations.
- We reviewed staff personnel files and found that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, qualifications, references and registration with the appropriate professional body if appropriate. We found that reception staff had not however been subject to a Disclosure and Barring Service check (DBS check) A risk assessment was provided and was completed in September 2014. This stated that reception staff presented a low risk as they would not see a patient in a closed door setting. This did not however acknowledge their privileged access to confidential patient data and other sensitive NHS information. Staff were however subject to a confidentiality agreement.
- The practice's recruitment policy stated that DBS checks were not required for GP staff as yearly registration

checks with the GMC were considered acceptable. This was found to be in alignment with the information held on all of the locum doctor files although we did find copies of some ported DBS certificates. We reviewed 15 locum doctor files. Of these, 11 files contained DBS certificates which had been provided by the locums from other employments. We found that from the files reviewed, 11 contained proof of identity including a photograph. The practice told us they knew the locum doctors but acknowledged that proof of identity should be held on all of the files to demonstrate due diligence. The practice informed us after the inspection that evidence of identity had been obtained for the other four locum doctors.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use. We saw test records dated January 2015. Clinical equipment was also checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella. We saw records completed by an approved contractor who undertook six monthly service visits.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The practice told us that previously, their efforts to ensure sufficient staffing had presented a challenge because of staff turnover and other leave. The practice had therefore relied more on locum doctors in the past. The practice had more recently recruited a nurse practitioner and a new GP partner. Nursing staff we spoke with were confident about the new provision in place and said that it had helped in meeting patient demand.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

Are services safe?

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- Staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with both adult and children's masks. There was also a first aid kit and accident book available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan identified four alternative locations which could be used if the existing building was not fit for use. The plan included emergency contact numbers for staff.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from the National Institute for Health and Care Excellence (NICE) and used this information to deliver care and treatment that met peoples' needs. We saw that the practice referenced a number of guidelines and research toolkits for example, The Royal College of General Practitioners clinical and research toolkits.
- The practice monitored that these guidelines were followed through its own policy provisions, risk assessments and audits conducted. The practice had adopted a NICE guidance protocol which involved the practice manager disseminating a monthly summary of NICE guidance received from the CCG to the practice GPs.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results (2014/15) showed the practice had received 86.1% of the total number of points available, with 6.4% exception reporting. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). Exception reporting overall was lower than the CCG average of 9.1% and lower than the national average of 9.2%. Data from 2014/15 showed mixed results;

- Performance for diabetes related indicators was 69.8% which was lower than the CCG average of 87.3% and lower than national average of 89.2%. The practice exception rate reporting was however, lower than the

CCG average in ten of the related indicators and lower than national average in eleven of the related indicators. This varied from 0.6% to 10.5% across the eleven indicators.

- The percentage of patients with hypertension having regular blood pressure tests was 96.2% which was lower than the CCG average of 98.9% and lower than national average of 97.8%. Again, the practice exception rate reporting was lower than the CCG average of 4.1% and lower than the national average of 3.8%.
- Performance for mental health related indicators was 69.2% which was significantly lower than the CCG average of 93.8% and lower than national average of 92.8%. The practice exception rate reporting was however, lower than the CCG and national averages in all seven related indicators. This varied from 2.3% to 13.1% across the seven indicators.
- The dementia diagnosis rate was 96.2% which was above the CCG average of 93% and above the national average of 94.5%.

We were informed that the practice had experienced staffing resource shortages which had an adverse effect on their ability to fulfil some of their performance expectations, particularly concerning QOF. Following recent recruitment of additional clinical staff the practice expected their performance data to improve accordingly.

We reviewed e-healthscope data which was information collated by the Clinical Commissioning Group (CCG). We found the number of all Emergency Admissions between the period of April to July 2015 had decreased in comparison to the previous two years over the same months. The practice was ranked eleven out of twenty one practices within the Clinical Commissioning Group (CCG) in order of numbers of emergency hospital admissions.

The data showed the practice was ranked as fourth highest out of twenty one practices within the Clinical Commissioning Group (CCG) for Accident and Emergency attendance. The practice told us they had reviewed this data and stated that one patient who had had a very high number of attendances affected the overall performance statistics.

Are services effective?

(for example, treatment is effective)

The practice was ranked as fifth best out of twenty one practices for patient attendance at minor injuries units and walk in centre attendances over the same period.

Clinical audits demonstrated quality improvement.

- We were provided with evidence of four clinical audits, three of which had been completed within the last two years. For example, an audit of diabetes glycaemic control in patients not on diabetes medication (October 2014) contained clear and demonstrable outcomes. The results highlighted a number of patients to be recalled for further consultation.
- The practice was more recently engaged in an audit to evaluate antibiotic prescribing for sore throat symptoms. This was consistent with their antimicrobial policy (November 2015) which identified the threat of antibiotic resistance to public health.
- Learning points from the audits undertaken were shared amongst the practice clinicians.
- The practice participated in applicable local audits, national benchmarking, accreditation, peer review and research. We spoke with the practice and the Clinical Commissioning Group (CCG) who informed us about audits conducted with assistance from the local CCG pharmacist. These included controlled drugs, ADHD drugs, repeat prescribing for care home patients and review of patients on unlicensed drugs. The practice undertook peer review and invited other local practices to attend education sessions.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for newly appointed clinical and non-clinical members of staff that covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. Staff we spoke with regarding the induction programme spoke positively regarding the review process in place for inductees. One member of staff stated they felt it had improved however since they had commenced into their post. A newly appointed member of staff was currently working through their induction which included e-learning and review of policies in place. An induction programme for locum doctors had also been created.

- The practice could demonstrate how they ensured role-specific training and updating for relevant staff e.g. for those reviewing patients with long-term conditions, administering vaccinations and taking samples for the cervical screening programme. Since appointed to post, the advanced nurse practitioner had worked to provide clinical support and supervision to nursing staff and healthcare assistants.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Nursing staff attended monthly meetings coordinated by the nurse practitioner. We were provided with an example whereby spirometry training updates were discussed during a session held. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support during sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for the revalidation of doctors. Staff had received an appraisal apart from those more recently appointed.
- Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring people to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they were discharged from hospital. We saw evidence that

Are services effective?

(for example, treatment is effective)

multi-disciplinary team meetings took place monthly and were attended by key staff including practice clinicians and practice manager, community nurses and Macmillan nurses where palliative care patients were discussed.

We spoke with doctors and administrative staff who told us that the GPs reviewed all discharge letters personally and then decided on the next best course of action.

We were also shown the system in place for weekly review of unplanned admissions and readmissions when correspondence was received by a patient's GP from the Accident and Emergency department. This involved consultation with other clinicians in the practice management weekly meetings held. This also identified any safeguarding concerns with children or vulnerable patients.

We found that care plans were routinely reviewed and updated. We reviewed the palliative care protocol in place which aimed to identify patients with life-limiting diseases and provide them with appropriate care. The protocol referred to completion of the ePaCCs template (electronic palliative care co-ordination system) for patients who were near to the end of life. The electronic palliative care co-ordination systems (ePaCCS) enable the recording and sharing of people's care preferences and key details about their care at the end of life. We were shown an example of a completed plan.

The practice followed the Golds Standards Framework (GSF) for end of life care guidelines. The national gold standards framework helps clinicians provide the highest possible standard of care for all patients who may be in the last years of their life.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. The practice had a Mental Capacity Act policy.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance. Young

patients aged 13 or over were asked to register independently for online access to the system. We spoke with GPs who advised us of a structured approach for assessing competence in young patients.

- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment. We were informed that a specialist learning disabilities community nurse could be approached to assist in obtaining consent if a particular patient was identified as requiring this assistance.
- The process for seeking consent was monitored. We saw examples which included a consent form given to a patient when they sought acupuncture therapy and were told about other written consent routinely obtained for procedures such as ear irrigation.

Health promotion and prevention

The practice identified patients who may be in need of extra support.

- These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on smoking. Patients were signposted to the relevant service, for example, Carers Direct and New Leaf, a local smoking cessation service.

The practice's uptake for the cervical screening programme was 86.3%, which was comparable to the CCG average of 86.2% and the national average of 81.8%. The practice had identified that there were currently 309 patients who had not had a smear test out of a total number of 2248. There was a policy to offer reminders for patients who did not attend for their cervical screening test. Patient records indicated when a test was overdue so a GP or nurse could discuss this with the patient when next seen.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were comparable to CCG averages. For example, childhood immunisation rates for the vaccinations given to under two

Are services effective? (for example, treatment is effective)

year olds ranged from 83.5% to 97.5% within the practice. The CCG rates varied from 91.7% to 96.5%. Five year old vaccinations ranged from 83.3% to 98.9% at the practice. The CCG rates varied from 88.1% to 98.1%.

Flu vaccination rates for the over 65s at the practice were 72.83% comparable with the national average of 73.24%. At risk groups rates at the practice were 47.11% comparable with the national average of 52.29%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed that members of staff were courteous and very helpful to patients and treated people with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private area to discuss their needs.

We reviewed seventeen patient CQC comment cards, fifteen of which were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring, put patients at ease and treated them with dignity and respect. We also reviewed one comment made to HealthWatch which was positive about the service provided and mentioned that home visits had been provided.

- We also spoke with three members of the patient participation group. (PPG) The PPG are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them. They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. The PPG members felt able to raise any issues with the practice openly and their comments were listened to. The Practice PPG had organised speakers from Alcoholics Anonymous and the Alzheimer's Society to attend the practice to raise awareness on these health related matters.

Comment cards highlighted that staff responded compassionately when they needed help and provided support when required. Several comment cards made reference to particular doctors, nursing staff including a healthcare assistant and receptionists as always being ready with a smile and understanding of their individual health related issues.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with doctors and nurses. For example:

- 94% said the GP was good at listening to them compared to the CCG average of 88% and national average of 89%.
- 89% said the GP gave them enough time (CCG average 86%, national average 87%).
- 99% said they had confidence and trust in the last GP they saw (CCG average 95%, national average 95%)
- 97% said the last GP they spoke to was good at treating them with care and concern (CCG average 84%, national average 85%).
- 97% said the last nurse they spoke to was good at treating them with care and concern (CCG average 92%, national average 90%).
- 88% said they found the receptionists at the practice helpful (CCG average 87%, national average 87%)

Care planning and involvement in decisions about care and treatment

Patients told us that they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. One patient told us that they were never rushed during their consultation with their named GP even when they had presented with more than one health issue to discuss. Patient feedback on the comment cards we received was also positive and aligned with these views.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were above local and national averages. For example:

- 92% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 86% and national average of 86%.

Are services caring?

- 92% said the last GP they saw was good at involving them in decisions about their care (CCG average 81% , national average 81%)

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. The practice website contained google translate which enabled people to review the contents of the pages in a language of their choice.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations. These included support for carers and patients with

dementia. The practice had an electronic noticeboard which included health awareness information. This was developed in collaboration with the patient participation group (PPG).

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 136 carers on their patient list. One of the receptionists was nominated as a carers lead and would signpost patients to a local carers hub.

Staff told us that if families had suffered bereavement, their usual GP would make contact with them to offer additional support. This contact was either followed by a card or patient consultation at a flexible time and location to meet the family's needs and by giving them advice on how to find a support service.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

- The practice offered extended hours clinics on weekday mornings which started at 7.30am. Appointments could also be obtained up until 6.30 pm or 7.00pm Mondays, Tuesdays, Wednesdays and Friday evenings. These were for patients who could not attend during normal opening hours.
- There were longer appointments available for people with a learning disability and those who had mental health related issues. These patients' records were highlighted so receptionists could allocate a double appointment time with an appropriate clinician.
- The practice responded to the needs of its vulnerable population. This included allocating future appointments to reoccur at the same time and day of the week/month as this encouraged some of it's more vulnerable patients to remember to attend.
- The practice told us they had paid for a taxi service to enable those with multiple long term conditions and parents with small children to attend the surgery when their transportation was limited.
- Home visits were available for older patients and patients who would benefit from these.
- Same day appointments were available for children and those with serious medical conditions.
- There were disabled facilities, hearing loop and translation services available. The practice had a Guide dogs policy and reception staff would assist those patients with visual impairments.
- British Red Cross provided a Crisis Intervention Community Support Service to support vulnerable adults in times of crisis. This was a service commissioned by the Clinical Commissioning Group (CCG) and had directly benefitted some of the patients registered at the practice. We obtained data from the Clinical Commissioning Group (CCG) which showed that from April to June 2015, 11 patients registered at the practice had been referred to the service by GPs, district nurse, and community psychiatric nurse.

Access to the service

The practice was open Monday to Friday at 7.30am. It closed at 6.30pm Tuesday to Friday and at 7.00pm on Mondays. Morning appointments were from 7.30am to 12.30pm Monday to Friday. Afternoon appointments were from 2.00pm to 7.00pm on Mondays and 2.00pm to 6.30pm on Tuesdays, Wednesdays and Fridays. Appointments were not available on Thursday afternoons so patients were redirected to the out of hours service. A receptionist was available during Thursday afternoons. The practice was closed during weekends.

In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available for people that needed them. Online booking was also available which included the facility to amend or cancel appointments.

Results from the national GP patient survey showed that patients' satisfaction with how they could access care and treatment was similar to local and national averages with the exception of access to the surgery by phone. This result was significantly lower than the local and national average.

- 87% of patients were satisfied with the practice's opening hours compared to the CCG average of 74% and national average of 75%.
- 48% patients said they could get through easily to the surgery by phone (CCG average 72%, national average 73%).
- 78% patients described their experience of making an appointment as good (CCG average 74%, national average 73%).
- 63% patients said they usually waited 15 minutes or less after their appointment time (CCG average 64%, national average 65%).

The practice told us that they had experienced technical problems with their phone system over the past few months since they had had a new system installed. Attempts to resolve this issue with the contractor were ongoing.

The practice informed us that telephone consultations were available on request and patients had been informed about this service through letters sent out. An audit of telephone consultations was undertaken over a one month period which showed that twenty three of the thirty telephone consultations resulted in prescriptions being issued or advice being provided. The practice were keen to continue to promote this service.

Are services responsive to people's needs?

(for example, to feedback?)

The practice told us that they were planning on starting a minor illness clinic in December 2015 where sixteen appointments could be allocated per day to the advanced nurse practitioner for patients who required minor illness advice.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- The practice manager was the designated responsible person who handled all complaints within the practice.
- We saw that information was available to help patients understand the complaints system. This was available in the practice waiting area and on their website.

We looked at 13 complaints received in the past 12 months. These included both verbal and written complaints recorded. We found that complaints were satisfactorily handled, dealt with in a timely way and the process was transparent. Lessons were learnt from concerns and

complaints and action was taken to as a result to improve the quality of care. For example, a patient complaint was received which stated that a practice clinician had not shown enough consideration toward the patient prior to a medical procedure being performed. This resulted in the practice manager discussing the matter with the clinician and the patient. Apologies were made to the patient and they confirmed they were satisfied with the outcome. Learning points were noted by the clinician.

We also reviewed NHS Choices website where patients posted their reviews of the service. Since March 2014, we found five positive comments which included that an exceptional service was provided from all at the practice and that doctors did their best, were friendly and approachable. Seven negative comments were posted which included that one patient felt put off complaining after a prescription miscommunication, there was a lack of dignity and privacy from reception staff and several comments were made regarding making and obtaining an appointment. The practice had responded to all of the comments posted on the website and advised patients of the ways in which they could make appointments and of the extended hours appointments available.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. They stated their purpose was to provide people registered with the practice with personal healthcare of high quality and seek continuous improvement in the health status of the practice population overall.

- The practice's mission statement was displayed in the waiting area and staff knew and understood the values.
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. Staff were supported through regular one to one sessions, meetings, training programmes and appraisals to monitor performance and identify further opportunities.
- Practice specific policies were implemented, up to date and were available to all staff. These were available on the staff intranet and new staff were made aware of policies through their induction programme.
- A comprehensive understanding of the performance of the practice. This was discussed during practice meetings held and performance was analysed, for example, CCG and QOF data.
- A programme of continuous clinical and internal audit which was used to monitor quality and to make improvements. Learning was shared amongst practice clinicians.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. We were provided with a risk assessment document which identified operational risks and proposed actions to address them.

Leadership, openness and transparency

The partners in the practice have the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care. The partners were visible in the practice and staff told us that they were approachable.

The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents. For example, following an error on a prescription, a patient did not receive an item they required. This led to further training in a reception staff meeting and times being set aside for reception staff to process prescriptions without distraction.

When there were unexpected or unintended safety incidents:

- The practice offered affected people reasonable support, truthful information and a verbal and written apology. The practice manager sought to meet with all patients who made a verbal or written complaint to address their concerns. Learning outcomes were noted where improvements were made to systems and processes.
- They kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

- Staff told us that the practice held regular team meetings. These included weekly practice meetings, monthly nurses meetings and reception staff meetings every two to three months. We were told that the partners also met when time permitted.
- Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings, were confident in doing so and felt supported if they did.
- Staff said they felt respected, valued and supported by management in the practice. Staff we spoke with said they felt part of a friendly, caring, inclusive and cohesive team. One said that a non-hierarchical approach was in place.

Seeking and acting on feedback from patients, the public and staff

Are services well-led?

Good 

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- It had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was an active PPG which met on a regular basis, carried out patient surveys and submitted proposals for improvements to the practice management team. The practice produced a topical newsletter and practice information leaflet in collaboration with the PPG which were distributed amongst patients. At the request of the PPG, one of the GPs had written an article about antibiotic prescribing in one of the newsletters produced. Discussions held with the PPG demonstrated they felt empowered to openly discuss matters with the practice where they felt this was appropriate. For example, we were told that they would like the practice to raise more awareness with the public regarding local health issues such as nutrition and the potential for social contact with vulnerable groups.
- The practice had also gathered feedback from staff through informal discussions held and through practice meetings and staff appraisals. Staff told us they would provide feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.