Dr Pryke and Partners

Quality Report

Winyates Health Centre,Winyates
Redditch, B98 0NR

Tel: **01527 513888**
Website: www.winyateshc.co.uk

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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 of this practice on 6 November 2014.

We have rated this practice as 'good' overall. We found the practice to be 'good' in the safe, effective, caring, responsive and well-led domains. We found the practice provided good care to older people; people with long term conditions; families, children and young people; the working age population and those recently retired; people in vulnerable circumstances and people experiencing poor mental health.

Our key findings were as follows:

- Every patient we spoke with was positive about the care they received. They told us they were treated with kindness, consideration and respect by all staff.
- The care and treatment provided by Dr Pryke and Partners was safe overall. However some systems to ensure that everyone learned from significant events at the practice were not being used as stated in the practice policy.
- GPs audited the care and treatment they provided to ensure that patients received high quality care which was compatible with the latest guidance for GPs.
- Staff understood the needs of their patient population. They used social prescribing to improve the overall well-being of their patients.

There were areas of practice where the provider should make improvements. They should:

- Review policies and procedures to ensure that complaints and significant events are escalated and followed up consistently and appropriately and that subsequent learning is disseminated to all relevant staff.
- Ensure all staff appraisals are undertaken in a thorough and consistent way.
- Review the use of manual record keeping for patients with a learning disability who attended health reviews. This did not support robust monitoring.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Most information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents. However it was not clear to us that information arising from significant events and complaints was always communicated widely to support learning and improvement for all staff.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from NICE and used it routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs have been identified and planned. The practice could identify all appraisals and the personal development plans for all staff. Staff worked with multidisciplinary teams, including community nurses and mental health workers.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS Area Team and 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 named GP and that there was continuity of care, with urgent appointments available the same day.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain

Summary of findings

was available and easy to understand and evidence showed that the practice responded to issues raised. However the practice should ensure that there is a consistent process in place to learn and improve from complaints.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. 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 were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, performance reviews and attended staff meetings and events. The practice could improve its system for staff appraisals.

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 patients. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

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

Families, children and young people

Good

The practice is rated as good for the care of families, children and young patients. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age patients (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 patients whose circumstances may make them vulnerable. The practice held a register of patients with a learning disability. It had carried out annual health checks for people with a learning disability. It offered longer appointments for people with a learning disability.

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 patients experiencing poor mental health, including people with dementia. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

During our inspection we spoke with 11 patients and a carer. Every patient we spoke with was positive about the care they received. They told us they were treated with kindness, consideration and respect by all staff. They said that GPs and nurses were supportive and understood their concerns. The carer we spoke with told us that the patient they cared for was happy with the services provided by the practice and said that as a carer they were shown the same level of consideration and respect as patients. Patients said they were involved in decisions about their treatment and that details about their condition and treatment choices were explained clearly. Although some patients told us they might have to wait to see a preferred doctor, every patient confirmed that when they needed to see a GP they could get an appointment the same day.

We asked the patients and the carer we spoke with about privacy during consultations. Each one told us that they had no concerns about the privacy during consultations and confirmed that their dignity was maintained at all times. They told us they knew how to make a complaint should they need to and they were aware that a chaperone service was available. They said that clinicians encouraged healthy living to promote good health. Patients were generally aware of the practice website and some used it to book appointments and to order repeat prescriptions.

Thirty-six patients had completed comment cards to tell us about their care. We reviewed their comments and found that the majority of patients were positive about the care and treatment they received. They told us they found reception staff to be welcoming, helpful and efficient. They said that their dignity and respect were maintained. Their comments included references to GPs and nurses listening to patients and being focused, professional and attentive. Most patients were satisfied with the appointments system, although a small number of patients told us it could take too long to see a GP of their choice. One card referred to disinfectant hand gel dispensers being empty on occasion; this patient expressed concern that conversations with GPs were audible in the waiting room. We checked this. Patients we spoke with told us they had never overheard private conversations and inspectors did not overhear these either.

Areas for improvement

Action the service SHOULD take to improve

- Review policies and procedures to ensure that complaints and significant events are escalated and followed up consistently and appropriately and that subsequent learning is disseminated to all relevant staff.
- Ensure all staff appraisals are undertaken in a thorough and consistent way.
- Review the use of manual record keeping for patients with a learning disability who attended health reviews. This did not support robust monitoring.

Dr Pryke and Partners

Detailed findings

Our inspection team

Our inspection team was led by:

The inspection team was made up of a GP special advisor, an expert by experience and a CQC inspector who led the inspection. An expert by experience is a person who has developed their knowledge of health and social care through using services.

Background to Dr Pryke and Partners

This practice serves a population who live in Redditch, a town which has experienced rapid expansion. The practice has identified that the majority of its patient population, 65%, is aged between 16 years and 65 years; with 20% aged under 16. Services reflect the needs of a relatively 'young' population.

The Clinical Commissioning Group (CCG) area of Redditch and Bromsgrove has deprivation levels which are close to the England average. Within the CCG however, the practice population for Winyates Health Centre experiences levels of deprivation which are higher than the CCG average and England averages. The practice also has the largest patient list within the CCG area with over 15,000 registered patients. Practice staff told us that their list was continuing to expand.

The practice has eight GP partners and two salaried GPs; seven are women and three are men. It is a training practice where qualified doctors may complete part of their specialist GP training as a registrar. The practice employed five nurses, two healthcare assistants and a dedicated phlebotomist who specialised in taking blood sample from patients. Seven of these staff were women. A practice manager led a team of reception and administrative staff.

The practice has a contract to provide general and enhanced medical services to the practice population.

This practice does not provide out of hours care to its patients. The Redditch and Bromsgrove CCG contracts with providers to provide out of hours care for all patients living in the area. The practice website and leaflet advise patients to telephone 111 if they need urgent medical care when the surgery is closed.

Why we carried out this inspection

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

This provider had not been inspected before.

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.

Detailed findings

How we carried out this inspection

Before inspecting, we reviewed a range of information we hold about the practice and asked other organisations, including the Clinical Commissioning Group (CCG) for Redditch and Bromsgrove, to share what they knew.

We carried out an announced visit on 6 November 2014. During our visit we spoke with a range of staff at the practice including six GPs, the practice manager, the deputy practice manager, four members of the nursing team and administrative and reception staff. We spoke with 11 patients and one carer. We observed how people were being cared for and reviewed a range of documents. We reviewed comment cards left for us by patients.

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)

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety, including national patient safety alerts and information from the Clinical Commissioning Group (CCG). GPs told us that when safety alerts regarding medicines came through, they searched the patient records system to identify patients who were affected, reviewed their care and made changes to prescribing accordingly. For example, they had recalled all their patients who had had a stroke to check that their medication followed the most recent guidance.

The staff we spoke with were aware of their responsibilities to raise any concerns they had and they knew how to report safety incidents, near misses and significant events. For example a nurse had raised their concern about taking blood samples from patients when this was causing them discomfort. The lead nurse told us that this had led to a review of the practice policy and protocol for taking blood samples and they showed us evidence of the changes that were made to improve patient care.

The practice manager at Winyates Health Centre had developed a 'toolkit' to use in response to significant events. The aim of the significant event process was to identify potential risks to patients, staff or the systems used by the practice. The toolkit provided information about what might constitute a significant event and described the process for reporting such events. It included a template for recording and reviewing events. We saw that significant events were an agenda item for the monthly practice meeting.

The practice manager showed us the log of significant events for 2014. We saw that 13 events had been recorded as significant. These included patient complaints and concerns about medication. The log provided brief outcome details to show how the events had been resolved.

We reviewed available data in respect of identified risks for patients who used Dr Pryke and Partners Surgery. We found that no risks to patient safety had been identified.

Learning and improvement from safety incidents

Although the practice had a system for reporting, recording and monitoring significant events, incidents and accidents, we found this was not managed in a consistent way. When we looked at the log of significant events for 2014 we found that analysis and subsequent management of the events was not always recorded in a concise way with clear timelines, lessons learned or information about disseminating learning to staff.

One of the GPs showed us an example of a significant event from 2013. The details had been thoroughly documented and actions had been determined. However the template which had been devised for significant events had not been used and there was no evidence of monitoring to confirm that the actions specified had taken place.

When we looked at records of education meetings attended by GPs. We saw that there was a strong focus on identifying clinical themes and sharing knowledge to improve outcomes for patients. However when we looked at the records of practice meetings, we saw that information about the outcomes of significant events was brief and we did not see robust arrangements for disseminating learning to all staff.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children, young people and vulnerable adults. The senior GP was the lead for safeguarding. We looked at training records which showed that the lead safeguarding GP and two other GPs had completed advanced level training in safeguarding in the current year. We saw that all of the GPs had dates set for this training. In our discussions with GPs it was evident that they were familiar with local safeguarding policies and protocols for sharing information when one of their patients was at risk of harm. They were aware of the impact of particular types of abuse and ensured that information about this was appropriately recorded.

The lead nurse at the practice showed us records which confirmed that the practice nurses, healthcare assistants and the phlebotomist had all completed an appropriate level of safeguarding training within the last three years. Training records showed that half of the administrative and reception staff had completed online training in safeguarding with the remaining staff scheduled to complete this.

We found that the staff we spoke with understood their responsibilities in respect of safeguarding both children

and vulnerable adults. The staff we spoke with knew who to contact in the practice if they had concerns and they had access to the contact details for the relevant external agencies.

We saw that the practice offered a chaperone service if patients requested this or if the nature of an examination made this best practice. The chaperone service was provided by nurses.

Patient records were written and managed in a way to help ensure safety. Records were kept on an electronic system, EMIS, which collated all communications about a patient including electronic and scanned copies of communications from hospitals.

Medicines management

One of the GPs was the lead clinician for medicines management at the practice. We saw that they maintained a well-ordered system for this. We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures. The policy described the action to take in the event of the fridge temperatures being outside the recommended range. A senior nurse told us that practice staff followed the policy. We found that fridges used to store vaccines and other medicines were set to operate within the appropriate temperature range. We saw that daily checks were made to monitor the fridge temperatures and weekly checks were made to ensure the fridges were accurately calibrated.

Processes were in place to check medicines were within their expiry date and suitable for use. We saw records which indicated that medicines were checked weekly. All the medicines we checked were within their expiry dates. We were told that expired and unwanted medicines were disposed of in line with waste regulations.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw evidence that nurses had received appropriate training to administer vaccines.

GPs told us they had recently begun to use electronic prescribing. They said they reviewed all prescriptions before they were sent to a pharmacy. This had improved safety for patients because they had immediate access to patient notes if any concerns arose.

We spoke with the pharmacist who managed the pharmacy located in the health centre. They confirmed that electronic prescribing was safer for patients in that opportunities for error were minimised. The system ensured that patients received their medicines sooner than previously. If a particular medicine was out of stock, they were able to speak with GPs about changing a prescription and issuing an alternative medicine without delay. The pharmacist told us that the GPs focused on safety when there was a need to check a prescription.

Cleanliness and infection control

We observed the practice building to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice nurse was the clinical lead for infection control. They had undertaken training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role; the dedicated phlebotomist who was employed to take blood samples from patients confirmed that they had repeated infection control training when they joined the practice. We saw that all members of the nursing team had received updated training in infection control.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Sterile instruments were packaged for single use. There were policies for needle stick injury and for spillage of body fluids, which was visible in each treatment room. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

Good

Are services safe?

We saw that nurses cleaned the equipment they used in the treatment rooms after every use. We saw that sterile equipment was marked with a tag to indicate it was ready for use. Clinical waste was disposed of appropriately in locked containers.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

We saw that infection control audits were completed by a nurse consultant for infection prevention and control from Worcestershire Health and Care NHS Trust, on behalf of the Clinical Commissioning Group (CCG). When they visited the practice in April 2014 they had made recommendations about some treatment rooms where there had been water leaks. The lead nurse for infection control at the practice told us the practice had invested in a new roof for the building. They showed us the internal changes which had been made in response to the advice they received.

Equipment

The GPs we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly. We saw records which confirmed that all portable electrical equipment was tested annually and all medical equipment was recalibrated annually.

Staffing and recruitment

We saw that the practice had a comprehensive recruitment policy which set out the standards it followed when recruiting clinical and non-clinical staff. The policy clarified the need for certain groups of staff to be checked against police and criminal record lists. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks.

We looked at the employment files for a GP, a nurse and a receptionist. We saw that all appropriate checks had been made to ensure that staff had the qualifications, professional registration, skills and attributes they needed to provide safe care for patients within their job role.

The practice manager and GPs told us they continually reviewed the level of demand for the service from patients. They conducted a staff capacity assessment every day, to be sure they could balance the two in order to have safe staffing levels. They used locum GPs when they needed to and used a check list to ensure locums were appropriate to work at the practice.

Monitoring safety and responding to risk

The practice had a comprehensive file for health and safety. We saw that it contained a log of risks relevant to the practice and the practice building with guidance for staff in reducing or managing risks. Risks included those for staff who were pregnant and incidents regarding patients. We saw that all new staff at the practice received a welcome leaflet which included a strong focus on health and safety.

Arrangements to deal with emergencies and major incidents

A detailed business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice, including the loss of the premises and the loss of essential data. Each risk was clarified and a series of actions to reduce or manage risks were clearly described for staff to follow. The document also contained an appendix with relevant contact details for staff to refer to. For example, contact details of the electricity provider should the supply of electricity fail. The contact numbers for all staff were kept with the plan plus a chart outlining how information would be cascaded to staff. Copies of the plan were held outside the practice building by key staff.

We checked emergency medicines and saw that they were all within expiry dates. We looked at records which confirmed that checks were made of the emergency medicines to ensure they were always in date. They were stored securely where they could be accessed quickly when they were needed. The medicines included treatment for heart attack and severe shock.

We saw that a defibrillator, which is used to restart a person's heart if it should stop, was accessible and in good working order. Oxygen was stored appropriately.

Good

Are services safe?

We looked at training records which showed that staff received training in emergency life support and that this was updated annually. All staff were trained in dealing with fire and seven staff had received additional training to act as fire wardens.

Practice staff told us they had prepared an action plan, should the need arise to support patients with / suspected with the Ebola virus.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance and accessed national guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The GPs told us they discussed the implications of these for patients at their monthly education meetings. They reviewed the care of patients affected by changes promptly and ensured their treatment was consistent with the most recent guidance.

We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines. Assessments were reviewed at appropriate intervals, in line with guidance. We saw that there were detailed practice protocols for the management of patients with specific conditions. For example we looked at the protocol for diagnosing high blood pressure which had been written by the senior nurse at the practice. We saw that it was part of a set of comprehensive guidance about diagnosing and managing high blood pressure and high cholesterol in line with national standards.

We saw that GPs used comprehensive templates for recording information about patients and that the templates were based on current best practice. We were told that patients who had complex health needs had enhanced care plans. We saw that GPs referred patients who needed secondary care promptly and followed up their care afterwards with appropriate treatment.

The GPs told us they took lead roles in specialist clinical areas such as diabetes, heart disease, women's health and minor surgery. We saw that the partner GPs had achieved a range of higher level qualifications in general practice and in specialist areas. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. We were told that two GPs had a particular interest in patients with diabetes and were supported by nurses trained in diabetes care. The practice provided regular diabetes clinics and was able to provide 'insulin starts' so that patients who progressed to using insulin could do so with support from the primary medical care team rather than transfer to hospital care. They also provided specialised clinics for patients with heart disease and asthma and those needing family planning and immunisations. Their overall Quality and Outcome Framework (QOF) score was over 98 points. The QOF describes a range of expectations of GP practices and measures how well they perform. Their high score indicated that they managed their patients will long-term conditions well.

The lead GP for medicines management showed us a comprehensive file for medicines guidance and it was clear that the GPs held regular education sessions to disseminate and discuss new information about medicines. We saw a range of records which confirmed that clinicians reviewed their patterns of prescribing to ensure they were following the most recent guidance, for example in respect of medicines for diabetes and for antibiotics.

The GP partners told us they recognised their challenges. For example they had a relatively high level of prescribing antibiotics and through audits, reviews and sharing information with one another, they were actively seeking to reduce this. They also had a higher than average number of patients who accessed hospital accident and emergency care. The local community hospital was very close to the practice and convenient for many patients. The practice staff sought to counteract this with clear messages about the value of primary medical care in their leaflets and on their website.

We saw no evidence of discrimination when clinicians made care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and ethnicity were not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. We saw that the GPs at the practice were regularly completing audits of their clinical practice and reviewing other aspects of their work in a systematic way. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from QOF. We looked at a range of clinical audits.

Good

Are services effective?

(for example, treatment is effective)

One audit reviewed the causes and circumstances of patient deaths over two time periods. It concluded that the practice overall managed the deaths of patients in appropriate ways. The practice maintained a register of patients who needed end of life care and they provided care and treatment in line with the Gold Standard Framework (GSF). The GSF sets standards in end of life care and promotes the involvement of the patient and their family in making decisions about their care for as long as possible. Doctors and nurses, including Macmillan nurses worked together with patients and families to ensure those patients' wishes were adhered to and that they receive the best possible care. The audit had however identified that a small number of patients who died had not received end of life care as part of the GSF but might have been considered for this pathway. We saw that the outcomes of this audit had been shared at a GPs' education meeting in order to raise awareness of the findings.

Another audit we looked at measured compliance with guidance issued by the National Institute for Health Care Excellence (NICE) in prescribing for patients with type 2 diabetes. Overall we looked at 16 audits and reviews. We found that the audits demonstrated how the practice monitored their adherence to national and local guidance. We found that recommendations for improving patient outcomes were made consistently and that there was evidence that learning was shared.

The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, the practice met all the minimum standards for QOF in diabetes care, asthma care and chronic obstructive pulmonary disease (lung disease) care. This practice did not fall outside the expected range for any QOF (or other national) clinical targets. We saw that QOF scores for the practice were consistently high, which reflects their clinical effectiveness. We saw that their total QOF score was above the score for all practices in England at over 98%.

Staff spoke positively about the culture in the practice around audit and quality improvement. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved.

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. They also checked that all routine health checks were completed for patients with long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example in relation to child immunisations.

The practice manager told us that every quarter, the codes used in patient records to define their medical condition or needs were reviewed to ensure that patients received care appropriate to their needs and that the statistics they produced accurately reflected patients' health needs. This was monitored through the Clinical Commissioning Group (CCG) using specialist software which identified where patient records had been wrongly coded.

The practice was participating in a local enhanced scheme with the CCG in using a risk assessment tool to identify patients who might have dementia.

Effective staffing

The practice team included medical, nursing, managerial, administrative and reception staff. We reviewed staff training records. We saw that all staff had received a range of training appropriate to their role including disability awareness for nurses and information governance for reception staff.

We noted a good skill mix among the GPs and nurses. They ran a range of clinics including for minor surgery, chronic disease, anti-coagulation and family planning. They were able to provide specialist care in orthopaedics, dermatology and gynaecology. All the GPs were up to date with their yearly continuing professional development requirements and all had been revalidated or had a date for revalidation, to ensure they remained fit to practice. Only when revalidation has been confirmed by GMC can the GP continue to practise and remain on the performers list with the NHS England..

Good

Are services effective?

(for example, treatment is effective)

Dr Pryke and Partners is a training practice. It provided specialist training places for qualified doctors undertaking GP training as registrars. GP registrars were given extended appointments with patients and had access to a senior GP throughout the day for support.

We saw that a nurse practitioner and practice nurses held a range of qualifications appropriate to their roles in the practice, including diplomas in diabetes care and asthma care. We saw that nurses held other qualifications which included family planning and cervical cytology.

Training records confirmed that all staff were up to date with core and role specific training such as annual basic life support, infection control and safeguarding. All staff had participated in a training session during their protected time which had focussed on dementia.

We were told that all staff had annual appraisals. When we checked the appraisals for administrative and reception staff we noted there were some gaps in the records; with some staff appraisals unsigned and not dated. Some appraisals we looked at did not identify aims for staff to take forward into the next year.

Working with colleagues and other services

Administrative staff and GPs held a range of referral forms to access other services for patients. We found that the GPs at this practice recognised the value of referring their patients to support services within the area. A single 'social prescribing' form was used to access services which promoted mental wellbeing and support or befriending for older people. It included services which encouraged physical and creative activities; learning and self-development and advice services which focused on benefits, debt management and employment concerns. The single point of referral was part of a local pilot scheme and we found that the GPs welcomed it as an important supplement to their own work as clinicians.

They also told us about a valuable local initiative to monitor child health in the area and provide additional support for families through the Sure Start programme.

The pharmacist based in the health centre described staff at the practice as helpful and communicative. They told us the GPs were always willing to support patients in getting the most appropriate medicine in an efficient way.

A counsellor who saw patients at the practice two days each week described the staff at Winyates as a good team to work with.

Information sharing

The out of hours service commissioned for the area by the Clinical Commissioning Group (CCG); the district hospital Accident and Emergency department and some community services used the same computer system, EMIS, for recording information about patients. The different services were able to access shared records, if patients had agreed to this. Patient information including test results, hospital discharge summaries and information from the out of hours service came to the practice through the EMIS patient record system. We were told that if information arrived as a letter it was scanned and added to the system. We saw that any action needed was undertaken promptly. For example, medicines were amended by a GP or by administrative staff and then checked by a GP; and appointments for investigations or follow up were arranged quickly.

Consent to care and treatment

We found that GPs were aware of the Mental Capacity Act 2005 and of 'best interest' decisions. They were able to describe how they followed the law in respect of patients with dementia and patients with a learning disability who might not have the capacity to understand treatment options and make decisions in their own best interests. Patients with a learning disability and those with dementia were supported to be involved in developing care plans which set out their health and social care needs and checked that they were not being harmed or exploited in any way.

In respect of children and young people consenting to treatment, GPs must be certain that they are 'Gillick competent'. This means they can understand information about any medical condition they might have or develop and are able to make decisions about their care and treatment based on that understanding. All clinical staff we spoke with understood 'Gillick competence' in respect of children and young people.

Health promotion and prevention

GPs told us it was practice policy to invite all newly registered patients for a health check. They offered 'lifestyle' advice to help patients maintain physical and

Good

Are services effective?

(for example, treatment is effective)

mental health and wellbeing. For example, nurses had been trained to provide smoking cessation advice. Patients could be referred on to other health providers for information about exercise, healthy eating and responsible use of alcohol.

The practice offered NHS Health Checks to all its patients aged 40 to 75 years. The practice invited patients for cervical smear testing in line with the national recall system. They had achieved a 93% take up rate, which is higher than the national average. Patients aged over 75 years had access to a named GP. The practice was participating in a national initiative to reduce hospital admissions by identifying patients at risk of unplanned admissions and providing detailed care plans for the 2% of the patients who had complex needs and were most vulnerable. They provided flu vaccinations to vulnerable groups of patients.

We saw that the practice used a newsletter which was displayed in the practice and published on the practice website to keep patients informed, for example the newsletter we looked at had information about seasonal flu vaccinations for patients in vulnerable groups, preventive flu treatment for young children, shingles vaccinations for older patients. There were details about booking appointments online, communications using text messages, the electronic prescription service and the support service for carers. We found this was an effective way of updating patients' knowledge about health matters.

The practice kept a register of its patients who had a learning disability. We saw that there were 75 patients on the register. Staff had developed a detailed template for completion by a GP and a healthcare assistant. A 'double' appointment was offered by the GP so that there was enough time to review patients' needs thoroughly. When we counted, we found that nine patients had attended their reviews during 2014 and 12 patients had not attended a scheduled appointment. We were told that follow up of patients who missed two appointments was organised by a lead nurse for people with a learning disability through the Clinical Commissioning Group (CCG). We saw that the call and recall system for inviting patients to attend their reviews was managed manually by one member of the staff team. We noted that patient record systems were not fully used to support the monitoring of this group of vulnerable patients.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the Clinical Commissioning Group (CCG).

We saw a wide range of information for patients in the waiting areas but we found that information relating to mental illness was not displayed. However when we spoke with GPs we found that each one was involved in caring for patients who were vulnerable because of mental illness and that they worked closely with other health care providers and support organisations to increase patients' well-being.

GPs cared for patients who were pregnant. Community midwifes and health visitors held clinics at the practice and provided immunisations for children. There was a clear policy for following up patients who did not attend.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

In its Statement of Purpose, the practice described its aim to provide privacy and dignity for all patients where there was potential for embarrassment or for a patient to feel ill at ease. We saw that the full version of their privacy and dignity policy was held within their electronic document system. During our inspection we spoke with 11 patients and a carer. Every patient we spoke with was positive about the care they received. They told us they were treated with kindness, consideration and respect by all staff. They said that GPs and nurses were supportive and understood their concerns. The carer we spoke with told us that the patient they cared for was happy with the services provided by the practice and said that as a carer they were shown the same level of consideration and respect as patients.

Thirty-six patients had completed comment cards to tell us about their care. We reviewed their comments and found that the majority of patients were positive about the care and treatment they received. They told us they found reception staff to be welcoming, helpful and efficient. They said that their dignity and respect were maintained. Their comments included references to GPs and nurses listening to patients and being focused, professional and attentive. One card referred some conversations with GPs being audible in the waiting room.

We asked the patients we spoke with about privacy during consultations. Each one told us that they had no concerns about the privacy during consultations and confirmed that their dignity was maintained at all times. We observed how patients were treated by receptionists. We saw that the reception staff were pleasant and welcoming to every patient and spoke with them in a discrete manner. We saw that staff respected patients' rights to privacy and confidentiality. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. The proportion of respondents to the GP patient survey who stated that in the reception area other patients can't overhear was above the national average.

We reviewed the most recent data available for the practice on patient satisfaction. Information from the national patient survey showed that 82% of patients would recommend the practice to others. This is higher than the England average. Eighty-eight per cent described the overall experience of their GP surgery as 'fairly good' or 'very good' which is just above the England average. The proportion of respondents to the national survey who stated that the last time they saw or spoke to a GP or a nurse, 'the GP or nurse was good or very good at treating them with care and concern' was 82% for GPs and 89% for nurses. These percentages are close to the national average.

The practice patient survey for 2014 had included a question about the length of clinical appointments. We saw that most of the two hundred patients who had responded had expressed satisfaction with the length of appointments.

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection told us that health issues were discussed with them in ways they could understand and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

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 patents this service was available. Patients told us they knew how to make a complaint if they were dissatisfied with their care or treatment. They said they were aware that a chaperone was available if this was helpful for them.

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 78% of patients who responded said the GP involved them in care decisions and 81% reported that nurses involved them in care decisions. Both these results were slightly lower than the average for practices across England but were within the range where concerns were not raised.

The annual survey for the practice did not seek information about this topic in 2014.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection and the comment cards we received told us that staff responded compassionately when patients needed help.

We saw that the practice had a register of patients who needed end of life care. They provided care for those patients which met the Gold Standard Framework (GSF). The GSF sets standards in palliative care to ensure that GPs and nurses, including community nurses and Macmillan nurses review patients' needs with them in order to provide the best possible care and support. It aims to that patients and their families are involved in decisions about their treatment for as long as possible.

In addition, GPs had undertaken an audit of deaths in their practice population. They knew that their patients included a high number of young families and one outcome of the audit was increased awareness of the needs of this group when they were bereaved. The practice team worked closely with a counsellor who saw their patients at the practice and was able to provide additional support for patients at a difficult time in their lives.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice understood its patient population and were responsive to their needs. Practice staff engaged with other staff in practices within the Clinical Commissioning Group (CCG) to discuss local needs and work in partnership to meet them.

The practice had a patient participation group (PPG). The main aim of a PPG is to ensure that patients are involved in decisions about the range and quality of services provided by the practice. When the practice completed its most recent patient survey in 2014 the PPG had been involved in selecting the areas to focus on. Over two hundred patients had responded. The practice manager told us that the extended hours now offered by GPs were a result of patients asking for this in annual surveys from previous years. A representative of the PPG told us that the practice was continually looking to improve services for patients and that the practice manager was always responsive to patients' views.

The practice had a patient participation group (PPG). The main aim of a PPG is to ensure that patients are involved in decisions about the range and quality of services provided by the practice. We saw that in 2014 a patient survey had been conducted. We noted that when asked whether they would like to have longer appointments, most patients were satisfied with the appointments as they were.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The surgery was accessible to patients who used a wheelchair and there were consulting rooms on the ground floor of the practice building. Four parking spaces in the adjacent car park were available for disabled patients.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. The practice used a loop system to support patients who had hearing problems.

The practice had access to online and telephone translation services.

GPs told us about the care they provided for vulnerable patients, including patients who were alcohol dependent. They used social prescribing and made referrals to local specialist services to improve the well-being of this group of patients.

We saw that local support services for carers used a dedicated noticeboard in the practice to display information including contact numbers.

Access to the service

Appointments were available from 8am to 1pm and 2pm to 6.30pm every week day. On two days each week, the practice offered some later appointments until 7.30pm. Patients could book appointments by telephone, in person at the surgery or through the website. They could book appointments up to one month in advance. Full information was available to patients about appointments in a practice leaflet and on their website. This included how to arrange urgent appointments and home visits.

There were 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 patients we spoke with and those who had left comment cards for us were generally happy with the appointments system. They confirmed that they could see a doctor on the same day if they needed urgent attention and they could see another doctor if there was a wait to see the doctor of their choice.

Although some patients told us they might have to wait to see a preferred doctor, every patient confirmed that when they needed to see a GP they could get an appointment the same day.

Patients were generally aware of the practice website and some used it to book appointments and to order repeat prescriptions. This increased the choices available to patients. Practice staff told us they were testing making test results available to patients through the website.

Most patients were satisfied with the appointments system, although a small number of patients told us it could take too long to see a doctor of their choice.

Listening and learning from concerns and complaints

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice had a system in place for handling complaints and concerns. Information available in the practice leaflet and on the practice website advised patients to talk to staff about any concerns they had. They were advised that if complaints were not dealt with as they would have wished, they could take this further.

The practice manager and the deputy practice manager maintained a log of complaints. When we looked at the complaints log, we found that the details of any investigation or analysis were not always in place. We were told that any investigation was managed in the team where the focus of the complaint was. For example we reviewed a written complaint about a member of staff. We were told that the details about the investigation of the complaint would be held by the lead nurse. We went to the lead nurse who described their investigation but told us they had not recorded the discussions which took place. The action which had been agreed in a letter to the patient had not yet taken place.

We were told that complaints were reviewed at practice meetings. We followed this complaint through to a practice meeting. We saw that there was a brief reference to the complaint with a note that no further action was required. This was at a time when there was no recorded investigation and the follow up action had not taken place. The practice could not provide evidence of learning from this or other complaints.

When we reviewed the practice 'toolkit' for managing significant events, we found that the nature of the complaint was such that it met the practice's criteria for re-categorising as a significant event, but this had not happened.

We looked at another complaint about GPs which had been managed as a significant event. This had been thoroughly recorded and there was a clear action plan to achieve patient satisfaction.

We found the complaints management system was fragmented and that there was no overall monitoring to ensure that records were thorough and that actions were followed through. We did not see evidence of learning from complaints.

Some but not all of the patients we spoke with told us they were aware of the process to follow if they wished to make a complaint. Most told us they would ask at reception for this information. None of the patients we spoke with had ever needed to make a complaint about the practice.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. Clear aims were recorded in the Statement of Purpose for the practice: to improve the health of registered patients by using the educational and health promotion tools available; to provide a consistent and caring approach to patients and to provide a comprehensive range of services.

We saw that a Patients' Charter was available in a leaflet displayed in the waiting areas. The leaflet outlined patients' rights and described what patients could expect of the practice. A practice booklet provided full information about the range of services for patients and how to access them. Another leaflet provided information for patients about fees for services not provided by the NHS. The information was available to pick up at the surgery and online.

From our conversations with staff and patients, we found that the practice acted consistently to live up to its aims.

Governance arrangements

Within the practice there was a leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a GP was the lead for safeguarding. The staff we spoke with were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

We were told that the practice held regular business and governance meetings. GP partners used the Quality and Outcomes Framework (QOF), a national measurement tool, to measure its performance. The QOF data for this practice showed it had achieved 98 QOF points which is higher than the average score for practices in England. Overall, it was performing in line with national standards. We saw that QOF data was regularly discussed at clinical meetings and action plans were produced to maintain or improve outcomes.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, an audit of the care of patients who had contraceptive implants made reference to the importance of counselling the patient to help them understand some of the side effects in order to reduce requests for removal of the implant; an audit of patients who also attended a service which managed drug-misuse clarified the importance of developing a new communication protocol following changes to that service.

The practice had robust arrangements for identifying, recording and managing risks. Risks to the practice building, computer systems and staff absence were outlined in the business continuity plan with clear guidance for staff to follow if an incident arose. We saw that procedures were in place to ensure that all areas of the service provided were carried out in accordance with national guidance, including health and safety policies to support the safe running of the practice.

We saw that specific policies were in place to manage clinical conditions, for example diabetes. These were available electronically. All the policies and procedures we looked at had been reviewed recently and were up to date.

Leadership, openness and transparency

The GP partners had developed a clinical learning culture. They were open about their own work and the need to review and challenge their practice. There was an emphasis on continuous improvement.

The nurses had also developed a team approach to maintaining up to date training and development.

Other staff told us that the GP partners and other managers were very approachable. They said that they met regularly with their own staff group and that staff training meetings for the whole practice team were held.

The practice manager was responsible for human resource policies and procedures. We reviewed the policy for induction which ensured staff were welcomed to the practice and received appropriate information to do their job role.

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

The practice had a patient participation group (PPG). The main aim of a PPG is to ensure that patients are involved in decisions about the range and quality of services provided by the practice. The practice obtained feedback from patients through annual surveys and they used this information to improve their services for patients. A representative of the PPG told us that extended opening hours reflected the views put forward by the PPG. We

Are services well-led?

Good

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

looked at the analysis of the last patient survey, which had been considered in conjunction with the PPG. The results and actions agreed from annual surveys were available on the practice website.

The practice gathered feedback from staff through staff meetings and routine discussions. Staff told us they would discuss any concerns or issues with colleagues and managers. We were told of an example when a member of the nursing team reported their concerns about taking blood from some patients. Following discussion, it was decided to change the policy relating to taking blood samples so that nurses did not make more than two attempts at taking blood in order to prevent discomfort or distress to patients.

We saw that some appraisals for non-clinical staff had not been carried out in a thorough way. A thorough appraisal would maximise opportunities to gather feedback from these staff.

The practice had a whistleblowing policy which was available to all staff.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at training records and saw that staff in the different teams had had opportunities to develop their knowledge and skills through training.

The practice was a GP training practice which meant that qualified doctors who wished to complete specialist training to become GPs could work at the practice as a registrar under supervision. When patients saw the registrar, they were offered longer appointments and a supervisor was always available for advice when it was needed.