Surrey Lodge Group Practice

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Surrey Lodge Group Practice on 5 August 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing, effective, caring, responsive and safe services. It was also good for providing services for the populations groups we rate. We found however the service required improvement in well led.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients feedback on accessing appointments with GPs and nurses was positive.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice had a clear vision which had quality and safety as its top priority. High standards were promoted and owned by all practice staff with evidence of team working across all roles; however the practice would benefit from clearer leadership in some clinical areas and meeting the needs of vulnerable patients.

There were areas of practice where the provider needs to make improvements.

Importantly the provider should

- Ensure checks are carried out on portable electrical equipment

Summary of findings

- Ensure where required clear staff leads are in place and this is clearly communicated to all staff.
- Ensure where required patients are provided with written management plans to support them in self managing conditions such as asthma and COPD.
- Ensure the staff appraisal plan is fully implemented, and appraisals for nurses are supported with clinical input.
- Ensure systems are in place to provide staff with up to date guidance on available internal and external health promotion services such as counselling and smoking cessation, and to ensure patients have access to support in a timely manner.
- Enable all clinical staff to have access to practice meetings.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. Staff had received training appropriate to their roles and any further training and updates had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans being in place for staff, however these were overdue.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice reviewed the needs of their local population and engaged with the NHS England Area Teams and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patient's reports varied in relation to accessing appointments. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for providing well-led services. The practice had clear aims to deliver good outcomes for patients. Staff were clear about the aims and their responsibilities in relation to the

Summary of findings

practice. There was a leadership structure in place; however this could be improved to include leadership in key areas such as mental health and learning disabilities. Staff felt supported by management. The practice had a number of policies and procedures to govern activity. There were systems in place to monitor and identify risk. The practice sought feedback from staff and patients. Staff had received inductions; some staff were able to access weekly meetings and although an appraisal system was in place these were overdue.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example in dementia, shingles vaccinations and end of life care. The care for patients at the end of life was in line with the Gold Standard Framework.

The practice was responsive to the needs of older people, meeting monthly with district nurses to enhance communication regarding patients with complex needs.

Nurses visit house-bound patients to do health promotion, perform physical health checks, blood tests and ECGs.

The practice had achieved 78% vaccination rate for the influenza vaccine for those over 65.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. Emergency processes were in place and referrals made for patients in this group who had a sudden deterioration in health. When needed longer appointments and home visits were available. The practice has an electronic register of patients with long term conditions and has a recall system in place to ensure patients are called for a review annually so their condition could be monitored and reviewed.

The national Quality Outcome Framework (QOF) 2014/15 showed the majority of clinical and public health outcomes had been achieved, with improvements being made on the previous year for conditions such as chronic obstructive pulmonary disease (COPD) and hypertension. The practice were able to initiate insulin for diabetic patients where required, enabling all treatment to be provided in house.

The practice worked alongside the Community COPD team to maximise health and prevent hospital admissions. Emergency medication was supplied in advance if necessary, for example COPD rescue pack.

Patients at high risk of emergency admission had care plans in place and were contacted regularly. Patients at high risk had same day access to a GP to avoid emergency admission into hospital.

Summary of findings

For those people with the most complex needs GPs worked with relevant health and social care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Systems were in place for identifying and following-up vulnerable families and families who were at risk.

There is a weekly Midwife clinic and drop-in baby clinic at the surgery. Immunisation rates were high for all standard childhood immunisations. Where children and babies failed to attend for immunisations these would be followed up by the practice nurse.

All reports from Accident and Emergency (A&E) for all patients under 16 years are sent to relevant GPs for review to assist in identifying any recurring attendance at A&E and/or any possible safeguarding issue.

Appointments were available outside of school hours for children and all of the staff were responsive to parents' concerns and would ensure parents could have same day appointments or telephone consultations for children who were unwell.

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 practice have a high proportion of young adults and university students, they provide so a range appointment times and are flexible in using telephone appointments if patients are unable to attend in person.

The practice offered online services as well as a range of health promotion and screening which reflects the needs for this age group, however not all staff were familiar with in house or external healthy lifestyle support services on offer for patients.

Appointments and prescriptions could be booked online in advance.

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 offered annual health checks for people with learning disabilities and offered longer appointments for people when required. The practice have patients from three residential homes for people with learning disabilities, and they maintain links with the carers and managers of the different homes. Home visits are available where required.

Summary of findings

For patients where English was their second language, an interpreter could be arranged.

Type Talk is used to communicate with deaf patients. This is a national telephone relay service which enables people who are hard of hearing, deaf or speech impaired to communicate with hearing people using the telephone.

The practice worked with multi-disciplinary teams in the case management of vulnerable people.

Staff knew how to recognise signs of abuse in vulnerable adults and children.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice maintained a register of patients who experienced mental health problems. The register supported clinical staff to offer patients an annual appointment for a health check and a medication review at the practice or in patients' homes.

Special care alerts were placed on vulnerable patients notes to alert reception staff. Same day appointments were offered where required.

The practice had access to the local mental health gateway service, a screening tools with detailed referral information, in which staff could gain access to counselling, psychotherapy and psychiatric input for patients, however not all staff were familiar with the service.

Patients who experienced difficulties attending appointments at busy periods would be offered appointments at the beginning or end of the day to reduce anxiety.

Summary of findings

What people who use the service say

During our inspection we spoke with four patients. We reviewed 50 CQC comment cards which patients had completed leading up to the inspection.

The comments were positive about the care and treatment people received. Patients told us they were treated with dignity and respect and involved in making decisions about their treatment options.

Feedback included individual praise of staff for their care and kindness and going the extra mile. We reviewed the results of the GP national survey carried out in 2014/15 and noted 91% described their overall experience of this surgery as good and 95% had confidence and trust in the last GP they saw or spoke to, above both the local and national average.

Areas for improvement

Action the service SHOULD take to improve

- Ensure checks are carried out on portable electrical equipment
- Ensure where required clear staff leads are in place and this is clearly communicated to all staff.
- Ensure where required patient are provided with written management plans to support them in self managing conditions such as asthma and COPD.
- Ensure the staff appraisal plan is fully implemented, and appraisals for nurses are supported with clinical input.
- Ensure systems are in place to provide staff with up to date guidance on available internal and external health promotion services such as counselling and smoking cessation, and to ensure patients have access to support in a timely manner.
- Enable all clinical staff to access to practice meetings.

Surrey Lodge Group Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector. The team included a GP specialist advisor, practice nurse specialist advisor and an expert by experience. Experts by Experience are members of the public who have direct experience of using services.

Background to Surrey Lodge Group Practice

Surrey Lodge Group Practice provides primary medical services in Central Manchester, from Monday to Friday. The practice is open between 8.00am – 6.30pm Monday to Friday, with a range of appointments available between 8:20am and 6:00pm

Surrey Lodge Group Practice is situated within the geographical area of NHS Central Manchester Clinical Commissioning Group (CCG).

The practice has a Personal Medical Services (PMS) contract. The PMS contract is the contract between general practices and NHS England for delivering primary care services to local communities.

Surrey Lodge Group Practice is responsible for providing care to 8126 patients of whom 53% were male and 47% were female, with 65% of patients between the ages of 14 and 44 years, of which a high proportion are university students. The practice population included 26% black and minority ethnic (BME) patients.

The practice consists of six GPs, two male and four female, a nurse practitioner, practice nurse and health care assistant. The practice was supported by a managing partner, receptionists and secretaries.

When the practice is closed patients were directed to the out of hour's service GoToDoc.

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.

How we carried out this inspection

Before visiting, we reviewed a range of information about the practice. We asked the practice to give us information in advance of the site visit and asked other organisations to share their information about the service.

We carried out an announced visit on the 05 August 2015. We reviewed information provided on the day by the practice and observed how patients were being cared for.

Detailed findings

We spoke with four patients and ten members of staff. We spoke with a range of staff, including the GPs, practice manager, nurse practitioner, practice nurses and reception staff.

We reviewed 50 Care Quality Commission comment cards where patients and members of the public had 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 living in vulnerable circumstances
- 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. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and spoke with staff who confirmed incidents were routinely discussed. This showed the practice had managed these consistently over time and demonstrated a safe track record over the long term.

We saw staff had access to multiple sources of information to enable them to maintain patient safety and keep up to date with best practice.

The practice investigated complaints and responded to patient feedback in order to maintain safe patient care.

Learning and improvement from safety incidents

The practice had a system in place for reporting and recording significant events. We saw from the practice significant events records and speaking with staff investigations had been carried out. All staff told us the practice was open and willing to learn when things went wrong.

Staff told us they received updates relating to safety alerts they needed to be aware of via meetings and emails. The nurses told us they received regular updates as part of their ongoing training. They also undertook self-directed learning and attended learning events.

Reliable safety systems and processes including safeguarding

The staff we spoke with were able to tell us how they would respond if they believed a patient or member of the public were at risk. Staff explained to us where they had concerns they would seek guidance from the safeguarding lead or seek support from a colleague as soon as possible.

We saw the practice had in place a child protection and vulnerable adults' policies and procedures. Where concerns already existed about a family, child or vulnerable adult, alerts were placed on patient records to ensure information was shared between staff to ensure continuity of care.

The GP who was the safeguarding lead had completed adult and children's safeguarding training to appropriate levels and was due to attend additional training linked to the Mental Capacity Act. All other staff had completed safeguarding training and provided evidence and examples of having a clear understanding of their safeguarding responsibilities.

Chaperones were available for patients with notices informing patients of their rights to ask for a chaperone within the waiting area and clinic rooms.

Medicines Management

The practice held medicines on site for use in an emergency or for administering during consultations such as administering of vaccinations.

The nurse practitioner was qualified as an independent prescriber and received support in her role from GPs, as well as updates in the specific clinical areas of expertise for which they prescribed. The nurse and nurse practitioner administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that the nurse and advanced practitioner had received appropriate training to administer vaccines.

We saw emergency medicines were checked to ensure they were in date and safe to use. We checked a sample of medicines and found these were in date, stored safely and where required, were refrigerated. Medicine fridge temperatures were checked and recorded to ensure the medicines were being kept at the correct temperature.

Speaking with reception staff they explained to us the system in place to ensure where changes to prescriptions had been requested by other health professionals, such as NHS consultants and/or following hospital discharge, the changes were reviewed by the GP daily and the changes implemented in a timely manner. We were shown the safety checks carried out prior to repeat prescriptions being issued and where there were any queries or concerns these were flagged with the GP before any repeat prescriptions were authorised.

Good

Are services safe?

We saw prescriptions for collection were stored behind the reception desk, out of reach of patients. Reception staff we spoke with were aware of the necessary checks required when giving out prescriptions to patients who attended the practice to collect them, i.e. date of birth, address of patient.

Cleanliness & Infection Control

The practice was seen to be clean and tidy. The manager was the named lead for infection control.

Contract cleaners were in place and attended the practice every day. There was a cleaning schedule in place to make sure each area was thoroughly cleaned on a regular basis and the practice held a copy. We looked in several consulting rooms. All the rooms had hand wash facilities and work surfaces which were free of damage, enabling them to be cleaned thoroughly.

There were the dignity curtains in each room. We saw in the treatment room a disposable curtain which was labelled showing when they required replacing. The practice had ordered disposable curtains for all clinical rooms and fabric curtain were systematically being replaced.

All the patients we spoke with were happy with the level of cleanliness within the practice.

We saw policies and procedures were in place. The policy included protocols for the safe storage and handling of specimens and for the safe storage of vaccines. These provided staff with clear guidance for sharps, needle stick and splashing incidents which were in line with current best practice. The policy stated infection control training would take place annually for staff and an annual audit would take place. We noted new staff had undertaken infection control as part of their induction and all other staff completed updates as part of an e-learning package. An audit had not taken place.

All staff we spoke with were clear about their roles and responsibilities for maintaining a clean and safe environment. We saw rooms were well stocked with gloves, aprons, alcohol gel, and hand washing facilities.

The practice only used single patient use instruments and we saw these were stored correctly and stock rotation was in place.

Equipment

The manager ensured all equipment was effectively maintained in line with manufacturer's guidance and calibrated where required. We saw maintenance contracts were in place for all equipment.

All staff we spoke with told us they had access to the necessary equipment and were skilled in its use.

Checks had not been carried out on portable electrical equipment. Speaking with the manager they told us they would clarify requirements for equipment and ensure where required appropriate checks would take place.

A panic alarm system was in place in consulting rooms and behind reception for staff to call for assistance.

Staffing & Recruitment

There were formal processes in place for the recruitment of staff to check their suitability and character for employment. The practice had a recruitment policy in place which was up-to-date. We looked at the recruitment and personnel records of two staff including the most recently recruited staff. We saw for staff recently recruited checks of the person's skills and experience through their application form, personal references, identification, criminal record and general health had been carried out. We were satisfied that Disclosure and Barring Service (DBS) checks had been carried out appropriately for all clinical staff to ensure patients were protected from the risk of unsuitable staff.

Where relevant, the practice also made checks to ensure that members of staff were registered with their professional body and on the GP performer's list. This helped to evidence that staff met the requirements of their professional bodies and had the right to practice.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. The practice had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative. All health and safety information was available to practice staff via the internal computer system.

The practice had clear staffing levels identified and procedures in place to manage expected absences, such as

Good

Are services safe?

annual leave, and unexpected absences through staff sickness. Staff told us they worked together to manage staff shortages and plan annual leave so as not to leave the practice short of staff.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and resuscitation equipment. When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

We saw emergency procedures for staff to follow if a patient informed staff face to face or over the telephone if they were experiencing chest pains, this included guidance form the Resuscitation Council and calling 999 for patients where required. Staff were able to clearly describe to us how they would respond in an emergency situation.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of the CCG and associated health and social care professionals.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nurses we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that they completed thorough assessments of patients' needs in line with NICE guidelines.

The GPs and nurses we spoke with explained how they reviewed patients with chronic diseases such as asthma on an annual basis. The national Quality Outcome Framework (QOF) 2013/14 showed that the majority of clinical outcomes were below the local CCG and national average. For example 36.5% of outcomes for patients with chronic obstructive pulmonary disease (COPD) had been achieved, 57% below the local average and for patients with hypertension 66% of outcomes had been achieved, 21% below the local average. The practice was aware of the lower than average outcomes, a result of staff sickness, the introduction of a new computer system and staff not allocating the correct clinical codes to patient's notes. The practice had worked to improve the outcomes during 2014/15.

Looking at data provided by the practice for 2014/15 we saw that outcomes for patients had improved for example 97% of outcomes had been achieved for patients with COPD and 100% of outcomes had been achieved for patients with hypertension. The practice were continuing in the current year to look at ways of improving outcomes for all patients in line with QOF and initial in year data showed on-going improvement.

The practice had patients registered with them from four mental health nursing homes, GPs and nurses visited the homes as and when patients required treatment or health reviews. GPs carried out annual physical health reviews for patients diagnosed with mental health needs, including those with schizophrenia, bi-polar and psychosis, as a way of monitoring their physical health and providing health improvement guidance. The QOF 2013/14 showed lower than average outcomes were being achieved, for example 21.6% had a comprehensive care plan documented 65.5% below the local average. The practice identified following these outcomes, that majority of patients had care plans in place; however these records had not been appropriately coded within the computer system. Data for 2014/15 showed 96% of all outcomes for patients with poor mental health had been achieved.

We saw from QOF that 100% of child development checks were offered at intervals that were consistent with national guidelines and policy.

We saw from information available to staff and by speaking with staff, that care and treatment was delivered in line with recognised best practice standards and guidelines. Staff told us they received updates relating to best practice or safety alerts they needed to be aware of via emails and the nurses told us they received regular updates as part of their ongoing training.

Majority of clinical staff were able to describe to us how they assessed patient's capacity to consent in line with the Mental Capacity Act (MCA) 2005, with GPs due to attend training to ensure MCA was embedded into practice.

The practice worked within the Gold Standard Framework for end of life care, where they held a register of patients requiring palliative care. Multi-disciplinary palliative care review meetings were held monthly with other health and social care providers. Individual cases were discussed weekly between clinical staff to ensure patients and relatives needs were reviewed on a regular basis to meet patient's physical and emotional needs and ensured that whenever possible patients die in the place of their choosing. An audit of end of life care carried out in June 2015 showed, end of life care was well planned and enabled in majority of cases for patients to end their life in a place of their choosing such as their own home.

We were told for patients where English was their second language an interpreter could be booked in advance or accessed via the telephone. This was in line with good practice to ensure people were able to understand treatment options available.

Management, monitoring and improving outcomes for people

Speaking with clinical staff, we were told assessments of care and treatment were in place and support provided to enable people to self-manage their condition, such as diabetes and COPD. We noted there were GP leads in place

Good

Are services effective?

(for example, treatment is effective)

for some long term health conditions, such as Chronic heart disease (CHD), however speaking with staff and GPs during the inspection we were provided with conflicting information as to who took the lead for different clinical areas and were told in some areas there were no leads, for example mental health to help ensure all staff were following the most up to date care and treatment. The practice told us they were looking to introduce monthly education sessions to address this and would look at where required having named leads.

A range of patient information was available for staff to give out to patients which helped them understand their conditions and treatments. The nurses provided patients with verbal management plans to support them in self managing conditions such as COPD and asthma, but did not provide written plans. We were told templates were in place for nurses to provide written plans for patients to support them in self managing their conditions and the practice would ensure these were used in the future.

Staff said they could openly raise and share concerns about patients with colleagues to enable them to improve patient outcomes.

The practice showed us how they monitored patient data which included full clinical audits taking place which demonstrated changes to patient outcomes. Clinical audit is a process or cycle of events that help ensure patients receive the right care and the right treatment. We were saw audits including end of life care and prescribing of Amoxicillin in children (Amoxicillin is used to treat infections caused by bacteria). We were told the practice were keen to carry out more audits in the future to enable them to reflect and review patient care is in line with the most up to date guidance.

The practice was also ensuring childhood immunisations were being taken up by parents. NHS England figures showed in 2013, 93% of children at 24 months had received the measles, mumps and rubella (MMR) vaccination.

Information from the QOF indicated the practice had below average level of achievement with 71% of outcomes achieved. This was 22% below those of other practice within the local CCG area in 2013-2014. Reviewing data provided by the practice for 2014-2015 we saw an overall improvement in outcomes. We saw 94% of outcomes had been achieved as a result of improved process and systems in re-calling patients and improvement in record keeping.

Patients told us they were happy with the way doctors and nurses at the practice managed their conditions and if changes were needed they were fully discussed with them before being made.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw evidence staff had attended mandatory courses such as annual basic life support and safeguarding. We noted a good skill mix among the GPs and nurses with a number having additional training and qualifications. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practice and remain on the performers list with NHS England).

Speaking with staff and reviewing records we saw all staff were appropriately qualified and competent to carry out their roles safely and effectively. The practice had an appraisal system in place for all staff, however for some staff these were overdue and we noted nursing staff did not receive clinical appraisals. The manager was aware appraisals were overdue and had plans in place to ensure all staff received an appraisal in year. We also saw plans were in place for nursing staff to receive joint appraisals with a GP and manager.

The nurses were expected to perform defined duties and were able to demonstrate they were trained to fulfil these duties. For example on administration of vaccines, cervical cytology and treating minor ailments. Staff told us they received updates and new guidance during team meetings.

All staff we spoke with told us they were happy with the support they received from the practice and spoke of an open door policy. Staff told us they received updates and new guidance during team meetings or via email. We saw the GPs and nurses had access to training as part of their professional development, attending training and education events in which updates on key issues were provided.

Working with colleagues and other services

The practice worked with other agencies and professionals to support continuity of care for patients and ensure care

Good

Are services effective?

(for example, treatment is effective)

plans were in place for the most vulnerable patients. Multi-disciplinary meetings were arranged with other health and social care providers, for example monthly meetings took place between GPs, district nurses, active case managers and Macmillan nurse. Communication took place on a daily basis with community midwives, health visitors and district nurses by telephone and fax.

The practice worked with other service providers to meet patients' needs and to manage patients with complex needs. They received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The GPs took the lead responsibility for reading and acting on any issues arising from communications with other care providers on the day they were received and disseminating to appropriate staff for action such as reception staff to arrange appointments or home visits. All staff we spoke with understood their roles and felt the system in place worked well.

Information Sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. The practice sent referrals directly to hospitals and secondary care providers, those referrals such as two week wait referrals were sent electronically. We were told the practice were soon to begin using a central booking service for referrals.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system to coordinate, document and manage patients' care. A new system had been introduced in October 2014 and all staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

The GPs described how the practice provided the out of hours service with information to support, for example, end of life care. Information received from other agencies, for example accident and emergency or hospital outpatient departments were seen and actioned by the GP on the same day. Information was scanned onto electronic patient records in a timely manner.

The practice worked within the Gold Standard Framework for end of life care (EoLC), where they provided a summary care record and EoLC which was shared with local care services and out of hour providers.

Consent to care and treatment

A protocol was in place for staff in relation to consent. The policy incorporated implied consent, how to obtain consent, recording consent, consent from under 16s and consent for immunisations, however the protocol did not provide guidance for staff, where assessing capacity in line with the Mental Capacity Act 2005.

Speaking with staff they were clear about their responsibility to gain and, where required, to record consent. We found the majority of staff were aware of the Mental Capacity Act 2005, the Children's Acts 1989 and 2004 and their duties in fulfilling it. Majority of clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice, this included best interest decisions and do not attempt resuscitation (DNACPR). The GPs were due to attend training to ensure MCA was embedded into practice.

All clinical staff we spoke with made reference to Gillick competency when assessing whether young people under 16 were mature enough to make decisions without parental consent for their care. Gillick competency allows professionals to demonstrate they have checked the person understands the proposed treatment and consequences of agreeing or disagreeing with the treatment. Where capacity to consent was unclear staff would seek guidance prior to providing any care or treatment. Nursing staff told us they would see patients under 16 without parents consent for contraception if patients were Gillick competent, however for other conditions such as asthma reviews and or management of long term conditions they would require a parent present.

Health Promotion & Prevention

New patients looking to register with the practice were able to find details of how to register on the practice website or by asking at reception. New patients were provided with an appointment for a health check.

The practice had a range of written information for patients in the waiting area which could be taken away on a range of health related issues, local services health promotion and support for carers.

Good

Are services effective?

(for example, treatment is effective)

We were provided with details of how staff promoted healthy lifestyles during consultations. During discussions with GPs and nurses, overall they were supporting patient's physical, emotional and social needs to enable healthy lifestyles, however not all were aware of the services offered locally or internally to refer patients for example smoking cessation.

The clinical system had built in prompts for clinicians to alert them when consulting with patients who smoked or had weight management needs.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice had achieved 78% vaccination rate for the influenza vaccine for those over 65 and 62% rate for those at risk under 65 years of age including children.

A children's immunisation and vaccination programme was in place. Data from NHS England showed the practice was achieving high levels of child immunisation including the MMR a combined vaccine that protects against measles, mumps and rubella. We saw from QOF 100% of child development checks were offered at intervals that are consistent with national guidelines and policy. There was a clear policy for following up non-attenders by the practice nurse.

The practice's performance for cervical smear uptake in 2013/14 was 59%, 18% below the local average. Speaking with the practice they had introduced a clearer prompt system, produced leaflets for patients in different languages to help women understand the need for cervical smears, but also looked at patient eligibility. As a result data showed 67% uptake during 2014/15.

The practice was proactive in following up patients when they were discharged from hospital. When the practice received a discharge letter from the hospital, details were passed onto the GP and where any follow up was required staff would arrange an appointment or home visit.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

During our inspection we observed staff to be kind, caring and compassionate towards patients. We saw reception staff taking time with patients and trying where possible to meet people's needs.

We spoke with four patients and reviewed 50 CQC comment cards received the week leading up to our inspection. All were positive about the level of respect they received and dignity offered during consultations.

The practice had information available to patients in the waiting area and on the website that informed patients of confidentiality and how their information and care data was used, who may have access to that information, such as other health and social care professionals. Patients were provided with an opt out process if they did not want their data shared.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located at reception and a back office. Staff told us and we observed where any private conversations were required these were transferred to the back office to maintain privacy.

We observed staff speaking to patients with respect. We spent time with reception staff and observed courteous and respectful face to face communication and telephone conversations. Staff told us when patients arrived at reception wanting to speak in private; they would speak with them in a private area.

Patients we spoke with gave positive feedback about the helpfulness and support they received from the reception staff. Looking at the results from the GP national survey, 90% of respondents found the receptionists at this surgery helpful, above the local and national average.

Staff were able to clearly explain to us how they would reassure patients who were undergoing examinations, and described the use of chaperones and modesty sheets to maintain patients' dignity.

We found all rooms had dignity curtains and lockable doors in place to maintain patients' dignity and privacy whilst they were undergoing examination or treatment.

Care planning and involvement in decisions about care and treatment

Patients told us they were happy to see any GP or nurse as they felt all were competent and knowledgeable.

Majority of patients we spoke with told us the GP and the nurses were patient, listened and took time to explain their condition and treatment options. The results from the GP national survey, 95% had confidence and trust in the last GP they saw or spoke to and 92% had confidence and trust in the last nurse they saw or spoke to.

The practice had formal care plans in place for patients and they included care plans for vulnerable patients over 75 year of age and those patients at risk of unplanned hospital admissions.

We noted where required patients were provided with extended appointments. For example reviews with patients with learning disabilities, those who required an interpreter or had multiple conditions to ensure they had the time to help patients be involved in decisions.

Patient/carer support to cope emotionally with care and treatment

All staff we spoke with were articulate in expressing the importance of good patient care and also had an understanding of the emotional needs as well as physical needs of patients and relatives.

From the GP national survey 88% of respondents stated the last GP they saw or spoke with was good at listening to them, 82% say the last GP they saw or spoke with was good at giving them enough time and 84% said the last nurse they saw or spoke with was good at giving them enough time.

Patients who were receiving care at the end of life were identified and joint arrangements were put in place as part of a multi-disciplinary approach with the palliative care team.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The practice were aware of the diverse population, including the student population, but had also reflected as part of the inspection process on the vulnerable groups they support. For example three residential homes for people with learning disabilities and four mental health nursing homes. We noted there were no leads within the practice for the vulnerable groups and data provided by the practice showed only 60% of patients with learning disabilities had had a formal review of care. We were told all patients had been reviewed but not formally. Following our inspection the practice agreed on a lead and told us they would work to improve the systems and existing relationships with residential and care homes to meet the needs of patients.

The practice worked with patients and families and also worked collaboratively with other providers in providing palliative care and ensuring patient's wishes were recorded and shared with consent with out of hours providers at the end of life.

The practice made reasonable adjustments to meet people's needs. Staff and patients we spoke with provided a range of examples of how this worked, such as opportunistic screening and reviews, accommodating home visits, booking extended appointments and arranging translators.

We saw where patients required referrals to another service these took place in a timely manner.

A repeat prescription service was available to patients via the website and a box at reception or requesting repeat prescriptions with staff at the reception desk. We saw patients accessing repeat prescriptions at reception without any difficulties.

The practice did not currently have a patient participation group (PPG), however they continued to explore methods of engaging patients and we noted details of how to join the PPG was displayed in the waiting areas.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example longer appointment times were available for patients with learning disabilities or those who required an interpreter.

The practice was able to book face to face translators for Non-English speaking staff in advance of appointments or access interpreters over the telephone if required.

The practice was accessible for patients with disabilities. A disabled toilet was available as were baby changing and breast feeding facilities.

There were male and female GPs in the practice therefore patients could choose to see a male or female doctor.

Access to the service

The practice is open between 8.00am – 6.30pm Monday to Friday, with a range of appointments available between 8:20am and 6:00pm. All consultations were by appointment only and were pre-bookable up to four weeks in advance. For patients requiring same day access or a telephone consultation the practice operated a triage system, in which brief details of the patients' needs would be taken by reception, a GP or nurse practitioner would then review patients and where required offer a same day appointment. We were told patients were never turned away. We were told vulnerable patients for example those at risk of unplanned hospital appointments would be offered urgent appointments with the on call GP and children would be offered same day appointments.

Patient's views on the appointment system were mainly positive. We saw from the GP national survey 81% of respondents described their experience of making an appointment as good and 96% were able to get an appointment to see or speak to someone the last time they tried; above the local CCG and national average.

Information was available to patients about appointments on the practice website. This included information about the triage system, home visits and provided details of the days GPs worked should patients wish to see a specific GP.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed and this information was detailed on the practice website. If patients called the practice when it was closed an answerphone message gave the telephone number they should ring depending on the circumstances.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Longer appointments were available for patients who needed them. For example those with long-term conditions, patients with learning disabilities or patients who required a translator.

Listening and learning from concerns & complaints

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

We saw there was a complaints procedure in place. We reviewed complaints made to the practice over the past twelve months and found they were investigated with actions documented. Lessons learned were shared with staff at team meetings.

Patients we spoke with told us they knew how to make a complaint if they felt the need to do so. Reception staff told us they would give patients the option of speaking with the manager at the time for any verbal complaints or issues they felt could be resolved informally.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the practice aims and objectives within their practice statement of purpose, for example, 'To provide quality services to our patients that are safe, caring, responsive, effective and well-led' and

'To ensure that our services are provided equitably and without discrimination'.

We spoke with ten members of staff and they all expressed their understanding and commitment to the practice aims and objectives and we saw evidence of the latest guidance and best practice being used to deliver care and treatment.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff electronically. We looked at several of the policies and saw these reflected current guidance and legislation.

There were named members of staff in lead roles for some areas, for example infection control and a GP partner was the lead for safeguarding. However when speaking with staff we were provided with conflicting information as to who took the lead for different clinical areas and were told in some areas there were no leads, for example mental health and learning disabilities to help ensure all staff were following the most up to date care and treatment.

We spoke with ten members of staff and they were all clear about their own roles and responsibilities. They all told us they knew who to go to in the practice with any concerns.

We saw the practice made use of data provided from a range of sources including the clinical commissioning group (CCG) and General Practice Outcome Standards (GPOS) to monitor quality and outcomes for patients such as services for avoiding unplanned admissions.

The practice used the range of data available to them to improve outcomes for patients and work with the local CCG. The practice also used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF 2013/14 data for this practice showed it was a below average performing practice compared with other local practice in the CCG area, 22% below the local average. The practice were aware of the data, we were told this was due to a range of factors including changes to their IT system had impacted on the data. We saw in 2014/15 the practice had addressed the issues and data showed an improvement in outcomes with 94% of outcomes achieved.

The manager and GP partners and nurse practitioner met weekly to discuss practice issues, significant events, complaints, new clinical guidance and practice development; these were held on a Monday which meant that the three salaried GPs and practice nurse were unable to attend. We were told minutes of meetings were shared via the intranet and those not able to attend were able to feed into the meetings via email. Full practice meeting were held annually and these were minuted and accessible to staff via the computer system.

From the summary of significant events we were provided with and speaking with staff we saw learning had taken place. The GPs within the practice conducted a small number of individual clinical audits, in which outcomes were shared at practice meetings. Speaking with GPs and the manager they told us they were looking at increasing the number of audits carried out and the quality of audits taking place to maximise learning and outcomes for patients.

The practice had arrangements for identifying, recording and managing risks associated with the premises and equipment. The manager provided us with details of maintenance and equipment checks which had been carried out in the past twelve months. We noted checks on portable electrical equipment had not been carried out. The manager told us they would clarify requirements for equipment and ensure where required appropriate checks would take place.

Leadership, openness and transparency

Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues with GPs or the practice manager. Staff told us there was never a time when there was no one available to seek support, advice or guidance. Speaking with the nurses they told us whenever they required support during a consultation GPs were available and a secure IT system was in place to allow the nurse to message GPs regarding patient care and seek guidance.

The manager was responsible for human resource policies and procedures. We reviewed a number of policies and procedures. For example a recruitment policy and

Are services well-led?

Good

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

induction programme was in place to support staff. We were shown evidence that staff, as part of induction, had access to policies and procedures. All staff were able to access policies and procedure via the policies and procedure electronic file, which included sections on health and safety, equality, leave entitlements, sickness, whistleblowing and bullying and harassment. Staff we spoke with knew where to find these policies and new members of staff confirmed they formed part of the induction process.

Practice seeks and acts on feedback from users, public and staff

The practice had gathered feedback from patients through the national patient survey, internal surveys, The NHS friends and family test, compliments and complaints.

We saw that there was a complaints procedure in place for formal complaints. We reviewed complaints made to the practice over the past twelve months and found they were investigated with actions documented with lessons learnt shared with staff.

We reviewed the results of the GP national survey carried out in 2014/15 and noted 91% described their overall experience of the practice as good, above the local CCG average of 80% and 88% would recommend this surgery to someone new to the area, again above the CCG average of 72%.

There was currently no patient participation group at the practice, but this was an area the practice continued to work towards and had looked at a number of options including Facebook and virtual groups.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff electronically on any computer within the practice.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us that the practice was very supportive of training and development opportunities. An appraisal system was in place for staff. The manager was aware these were overdue and had plans in place to ensure all staff received an appraisal in year. We also saw plans were in place for nursing staff to receive joint appraisals with a GP and manager.

The practice had reviewed significant events and other incidents and shared with staff.