Drs Trewin, Burton, Barron, Atherton & Brookes

Quality Report

Balance Street Health Centre
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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 inspected this service on 3 October 2014 as part of our new comprehensive inspection programme.

The overall rating for this service is good. 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:

- Patients were kept safe because there were arrangements in place for staff to report and learn from key safety risks. The practice had a system in place for reporting, recording and monitoring significant events over time.
- There were systems in place to keep patients safe from the risk and spread of infection.
- Evidence we reviewed demonstrated that patients were satisfied with how they were treated and that this was with compassion, dignity and respect. It also demonstrated that the GPs were good at listening to patients and gave them enough time.
- The practice had an open culture that was effective and encouraged staff to share their views through staff meetings and significant event meetings.

We saw several areas of outstanding practice including:

- The practice operated a one family one doctor policy, ensuring that every patient had a named GP, and family members were cared for by the same GP.
- Excellent levels of communication between the GPs facilitated through the informal daily pre morning surgery meetings.

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

The provider should:

Summary of findings

- Maintain a log of medicines alerts, medical devices alerts and other patient safety alerts received which details any action taken, if required.
- Have a designated infection control lead and carry out internal infection control audits.
- Carry out a risk assessment and a mercury spillage kit should be available to keep patients and staff safe in the event of a mercury spillage.

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 was rated as good for safe. There were effective systems in place to ensure patients were protected from the risk of abuse or avoidable harm. The practice had a system in place for reporting, recording and monitoring significant events. Lessons learnt were shared with all staff. Systems were in place to ensure medicines were managed appropriately, both within the practice and dispensary. Infection control guidelines were followed and the practice was clean and tidy. Systems were in place to respond to emergencies and major incidents within the practice.

Are services effective?

Good

The practice was rated as good for effective. Patients' care and treatment was planned and delivered in line with current guidance and best practice. Patients were supported to make choices and to give informed consent. Chaperones were offered and provided for patients who requested support during invasive or intimate procedures. Staff received training appropriate to their roles and further training needs had been identified and planned. The practice could identify all appraisals and development plans for staff. There was evidence of multidisciplinary working.

Are services caring?

Good

The practice was rated as good for caring. Data showed 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 care and treatment decisions. Everyone spoke highly of the doctors, nurses and reception/ administration staff. Patients were supported to make decisions about their care and were listened to. Emotional support was provided for those patients who had suffered bereavement.

Are services responsive to people's needs?

Good

The practice was rated as good for responsive. Patients reported good access to the practice and the one family one doctor policy ensured continuity of care. Patients could book an appointment with their GP on the day if they wished, or make a pre-bookable appointment. The practice offered extended hours each weekday. The practice had good facilities and was well equipped to treat patients and meet their needs. The practice provided co-ordinated and integrated care for the patients registered with them. There were a range of clinics to provide help and support for patients with long-term conditions and the practice also hosted clinics run by consultants from Queens Hospital, Burton.

Summary of findings

There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff.

Are services well-led?

Good

The practice was rated as good for well led. The practice had a strong and visible leadership which was well supported by the staff team. The practice had an open culture that was effective and encouraged staff to share their views through staff meetings and significant events meetings.

The practice had systems in place to learn from incidents and near misses. The practice actively sought and acted on feedback about the standard of services they provided. There was an active Patient Participation Group (PPG) in place, which met six times a year. PPGs are a way in which patients and GP practices can work together to improve the quality of the service provided. Systems and procedures were in place to monitor and improve the quality of the service provided. There was a vision and strategic plan in place which laid out future developments for the practice.

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 had a systematic approach to managing the health of older patients. The practice worked in partnership with the community nursing team to support housebound older patients. The practice maintained an 'admission avoidance register' and reviewed this register every month. Individual care plans had been developed for patients with complex needs, and copies kept at the practice and in the patient's own home. The practice provided an opportunity for older patients to access a range of health care including home visits when appropriate.

People with long term conditions

Good

We found that the staff had the knowledge, skills and competencies to respond to the needs of patients with a long term condition such as diabetes and asthma. We found robust systems in place to ensure that all patients with a long term condition received regular reviews and health checks. Staff were proactive in following up late or missed appointments for these essential checks as part of the patient's annual review.

Families, children and young people

Good

We saw that the practice provided services to meet the needs of this population group. All family members registered at the practice have the same named GP to provide continuity of care and reduce risk. There was excellent access which enabled patients to be seen that day, or if necessary, straight away. Staff were knowledgeable about how to safeguard children from the risk of abuse. There were effective screening and vaccination programmes in place to support patients and health promotion advice was provided. Midwives and health visitors saw patients in the same building as the practice, which enabled a good exchange of information. Information was available to young people regarding sexual health and family planning advice was provided by staff at the practice.

Working age people (including those recently retired and students)

Good

We saw that the practice offered a range of appointments which included pre-bookable appointments and same day appointments. The practice offered extended hours on a Monday morning from 7.45am to 8am and evenings each weekday from 6.30pm to 7pm. Diagnostic tests, such as electrocardiograms (ECG) and routine blood tests were carried out at the practice.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice had a register of patients with learning disabilities and their care was overseen by their named GP. We saw that patients with a learning disability were invited for appointments with the GP and / or the nurse for a complete health check and to update their individual care plan. There were systems in place to support non-English speaking patients to enable them to be involved in decisions about their care. Staff understood the need to involve carers when making best interest decisions for patients who lacked mental capacity and formal training in the Mental Capacity Act 2005 had been arranged.

People experiencing poor mental health (including people with dementia)

Good

The practice worked in partnership with other services to provide a service that met patients' needs. Appointments with psychiatric services, which included the visiting consultants and community psychiatric nurses, took place in the practice building. There was a system in place to ensure patients physical health needs were reviewed annually. Staff were aware of voluntary organisations they could signpost patients to for additional support.

Summary of findings

What people who use the service say

We spoke with 14 patients on the day of the inspection. Patients were extremely satisfied with the service they received at the practice. They told us they could always get an appointment at a time that suited them, including same day appointments. They told us they had confidence in the staff and they were always treated with dignity and respect.

We reviewed the 46 patient comments cards from our Care Quality Commission (CQC) comments box that we had asked to be placed in the practice prior to our inspection. We saw that almost all comments were extremely positive. Patients told us that staff were friendly and helpful. They also told us they felt listened to and did not have to wait for appointments. Eight comments were less positive but there were no common themes to these.

We looked at the national GP Patient Survey published in December 2013. The survey found that 93% of patients rated Drs Trewin, Burton, Barron, Atherton & Brookes as good or very good, which is among the best. 89% of patients said they would recommend the practice to someone new to the area. 95% of the patients who responded said that they had confidence and trust in the doctor and 88% had confidence and trust in the nurse they had seen last at the practice. The survey also showed 85% of patients thought their experience of making an appointment was good, and 94% said the last appointment they had was convenient.

Areas for improvement

Action the service SHOULD take to improve

The practice should maintain a log of medicines alerts, medical devices alerts and other patient safety alerts received which details any action taken, if required.

The practice should have a designated infection control lead and carry out internal infection control audits.

The practice should carry out a risk assessment and a mercury spillage kit should be available to keep patients and staff safe in the event of a mercury spillage.

Outstanding practice

There were examples of outstanding practice at Drs Trewin, Burton, Barron, Atherton & Brookes as follows:

The practice operated a one family one doctor policy, ensuring that every patient had a named GP, and family members were cared for by the same GP. The GPs developed an in-depth knowledge of their patients' health and social care needs.

Excellent levels of communication between the GPs facilitated through the informal daily pre morning surgery meetings.

Drs Trewin, Burton, Barron, Atherton & Brookes

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The lead inspector was accompanied by a GP specialist advisor, a second CQC inspector, and an expert by experience who had personal experience of using primary medical services.

Background to Drs Trewin, Burton, Barron, Atherton & Brookes

Drs Trewin, Burton, Barron, Atherton & Brookes is located in Uttoxeter and provides primary medical services to patients who live within a five mile radius of the practice.

The practice has six permanent GPs (four male and two female), a practice manager, a business manager, three practice nurses (one currently on maternity leave), three healthcare assistants, a reception team leader, reception and administrative staff. There is also a dispensary manager, dispensary purchasing manager and dispensary staff. There are 13710 patients registered with the practice (as at 22 September 2014). The practice is open from 8am to 7pm Monday to Friday. The practice offers extended hours on Monday mornings from 7.45 to 8am, and Monday to Friday evenings from 6.30 to 7pm. Patients can access the service for routine appointments from 9am. The practice treats patients of all ages and provides a range of medical services. Drs Trewin, Burton, Barron, Atherton & Brookes has a higher percentage of its practice population in the 65 and over age group than the England average.

The practice provides a number of clinics for example asthma, diabetes and healthy heart. It offers child immunisations, minor surgery, including vasectomies and travel health. The practice also provides a minor injury and phlebotomy service.

Drs Trewin, Burton, Barron, Atherton & Brookes has a Primary Medical Services contract.

Drs Trewin, Burton, Barron, Atherton & Brookes does not provide an out-of-hours service to its own patients but has alternative arrangements for patients to be seen when the practice is closed.

Why we carried out this inspection

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

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. 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.

Detailed findings

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 the time.

How we carried out this inspection

Before the inspection we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We received information from the Clinical Commissioning Group (CCG) and the NHS England Local Area Team.

We carried out an announced visit on 3 October 2014. During our inspection we spoke with five GPs, two practice nurses, two health care assistants, the practice manager, the acting dispensary manager, the data quality lead, one secretary and two reception staff. We spoke with 14 patients who used the service about their experiences of the care they received. We reviewed 46 patient comment cards sharing their views and experiences of the practice. We also spoke with a representative from the patient participation group.

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

We saw that the practice had robust systems in place to assess and monitor the consistency of their performance over time. We saw records which showed that multiple sources of information were used by the practice to check the safety of the service and action was taken to address any areas in need of improvement. These included significant events and complaints. We found clear procedures were in place for reporting safety incidents, complaints or safeguarding concerns. Staff we spoke with knew it was important to report incidents and significant events to keep patients safe from harm. Staff told us they were actively encouraged and supported to raise any concerns that they may have and were able to explain and demonstrate the process in place.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. The practice kept records of significant events that had occurred during 2014 and these were made available to us. We saw that staff were responsible for completing significant event forms, and significant event audits or analysis were carried out each time there was a patient safety incident. All incidents were recorded on a well maintained register, which recorded details of the incident, action taken and lessons learnt. The practice manager and GPs told us incidents were discussed at the weekly partners meetings and shared with all staff at the relevant meetings. We looked at minutes of these meetings which described the learning from incidents and any actions that staff needed to take. For example, we saw an error had occurred when the night service had not been switched on, so when patients telephoned the practice they did not get the out of hours telephone number. To prevent this occurring a checklist had been introduced for reception staff to complete at the end of each day. Senior staff reviewed the checklist weekly to ensure it was being actioned.

Staff told us that the accident book was kept in reception for staff to record minor incidents/accidents. Clinical staff were encouraged to report near misses to the head nurse. Staff confirmed that incident reports were discussed at clinical meetings. Information from safety alerts was also shared with them accordingly and clinical staff were required to sign the information sheets to confirm they had read these.

The lead practice nurse told us they received medicines alerts, medical devices alerts and other patient safety alerts, and took any appropriate action. However they did not keep a log of alerts received or details of action taken, if required.

Reliable safety systems and processes including safeguarding

Disclosure and Barring Service (DBS) checks had been completed for all staff who worked at the practice. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable adults and children. All staff had received training in safeguarding vulnerable adults and children. The training records demonstrated that the GP partners had completed training at level three (advanced) in safeguarding children and vulnerable adults, as had the practice nurses and health care assistants. Staff confirmed they were able to access policies and procedures through the practice's internet site. Staff explained to us the processes they would follow in the event they became concerned that a patient may be at risk of harm. Contact details were easily accessible. Staff demonstrated they were aware of the safeguarding lead for the practice with which they would share their concerns, and confirmed they had completed safeguarding training. Clinical staff gave an example where they previously had concerns about a patient that they had shared with the GP. The GP shared these concerns with the health visitor and found the patient to be known to them. As a result of this a visit to the patient was made by the health visitor and appropriate support was provided.

A chaperone policy was in place and visible on the reception desk, and included on the practice's website. Staff confirmed they had received chaperone training. One of the health care assistants told us they regularly acted as chaperone for the visiting consultants and clearly explained their role and responsibilities. Four member of reception staff had also requested to be chaperones and training had been arranged.

Good

Are services safe?

Medicines Management

Staff confirmed they knew how to respond to medical emergencies and told us where the emergency equipment and medicines were stored.

We found that medicines were administered and stored correctly. We were told that the lead practice nurse was responsible for managing the medicines held in the practice. We checked the storage and stock control of the medicines held in the practice. We found that medicines were well organised and kept in locked cupboards. We saw that there was an efficient system for stock rotation. A weekly stock check and monthly audit were completed to ensure all medicines remained in date and were safe to use.

Medicines that required refrigeration were stored in two refrigerators. We saw evidence that the temperature of the refrigerators used for storing these were checked twice daily ensuring they were stored within the manufacturer's guidelines. Staff accurately described the temperature range that medicines and vaccines should be stored at and the actions they would take if the refrigerator temperature had not been maintained. The practice had invested in new thermometers that alarmed if the temperature was outside of the recommended range. Guidance was available for staff on how to maintain the supply and storage of vaccines at the required temperatures. We saw there were signed Patient Group Directives (PGD) in place to support the nursing staff in the administration of vaccines. A PGD is a written instruction from a qualified and registered prescriber, such as a doctor, enabling a nurse to administer a medicine to groups of patients without individual prescriptions.

The practice offered a full range of primary medical services and was able to provide pharmaceutical services to those patients on the practice list who lived more than one mile (1.6km) from their nearest pharmacy premises. One of the GP partners had the role for overseeing the quality of dispensing of medicines. Controlled medicines were stored securely in the dispensary. The standard operating procedure for controlled medicines showed that they were handled in line with legal requirements. The dispensary used a computerised system for stock control and ordering of medicines. There were standard operating procedures in place relating to dispensing of prescriptions. Dispensing staff described the systems in place for the safe storage and monitoring of prescription pads to prevent them from being stolen and used inappropriately.

Cleanliness & Infection Control

All of the patients we spoke with during the inspection told us that the practice was always clean and tidy. We saw that the practice was clean and orderly. We saw hand sanitation gel was available for staff and patients throughout the practice including in reception.

An infection control audit had been completed by the local NHS trust in April 2014, and had highlighted issues with the cleanliness and infection control practices within the practice. Where issues had been identified, appropriate action had been taken to make changes to protect patients from potential harm. For example, carpets had been replaced with washable flooring, cloth curtains replaced with disposable paper curtains and a new cleaning company had been employed since May 2014. The standard of the cleaning was audited monthly and action taken to address any identified shortfalls.

Although staff had received infection control training, the practice did not have a designated infection control lead. No further infection control audits had been carried out since April 2014. We noted that infection control policies and procedures were available for staff to refer to. Staff confirmed they used single use equipment for most procedures, such as tourniquets used when taking blood from patients. Blood pressure cuffs were however not single use and clinical staff confirmed these were cleaned after each use.

The provider had taken reasonable steps to protect staff and patients from the risks of health care associated infections. There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We saw evidence that their disposal was arranged through a suitable company. There were guidelines informing staff what to do in the event of a needle stick injury. We saw evidence that staff had received the relevant immunisations and support to manage the risks of health care associated infections.

A legionella risk assessment had been completed in October 2012 and was due to be repeated the end of

Good

Are services safe?

October 2014. There was evidence to support that schedule of work developed from the risk assessment was actioned, for example hot and cold water temperature checks.

Equipment

The practice nurse confirmed that all equipment used in the practice was checked and calibrated each year. We saw that these were all up-to-date and in good order for the safety of patients and staff.

We saw there was equipment at the practice that contained mercury. Mercury is a hazardous substance and is subject to the Control of Substances Hazardous to Health Regulations 2002. We saw a risk assessment had not been carried out and a mercury spillage kit was not available to keep patients and staff safe in the event of a mercury spillage.

Staffing & Recruitment

Effective recruitment and selection processes were in place to ensure staff were suitable to work at the practice. We saw an up to date recruitment policy outlining the recruitment process to be followed for the recruitment of all staff. The policy detailed all the pre-employment checks to be undertaken before a person could start to work at the practice. Most staff had worked at the practice for many years. We looked in the file of the one member of staff who had recently been recruited. We saw that all of the appropriate checks had been carried out.

Patients were cared for by suitably qualified and trained staff. We saw evidence that health professionals, such as doctors and nurses, were registered with their appropriate professional body and so fit to practice. There was a system in place that ensured health professionals' registrations were in date.

Monitoring Safety & Responding to Risk

Health and Safety policies and procedures were available for staff to refer to. We saw that there had been a fire risk assessment carried out in February 2014 and those annual checks of fire extinguishers and electrical equipment had been completed. There was a contract in place for maintenance of the lift. The practice employed a caretaker who was responsible for checking the building on a daily basis and carrying out any routine maintenance tasks.

The GPs told us they were flexible with their hours, and would increase the number of hours they worked to accommodate the needs of the service. The practice nurses told us they were able to cover a colleague's maternity leave as one practice nurse had increased their hours. Other staff who worked in the practice were organised into 'hubs' for example reception staff, secretaries and administration staff. This enabled flexible staffing levels, whereby staff would cover any shortfalls. Staff told us that the practice manager would provide as and when required. Staff told us that when the practice was closed for training, reception was still open and manned, so that the patients could call in to make appointments.

The GPs and practice manager informed us there were sufficient appointments for patients. Patients were offered appointments that suited them, for example same day, next day or pre-bookable appointments with their own GP. There was a system in place to ensure that patients with long term conditions were invited for their reviews, and followed up if they did not attend.

Arrangements to deal with emergencies and major incidents

We looked at the equipment available at the practice for use in the event of an emergency, for example oxygen, the defibrillator and pulse oximeter. A defibrillator is an electronic device that provides a shock to the heart when there is a life threatening arrhythmia present. A pulse oximeter measures the amount of oxygen in the blood. We saw that the equipment was checked to ensure it was in working order and fit for purpose. Staff confirmed they knew how to respond to medical emergencies and told us where the emergency equipment was stored. They told us they had been trained in basic life skills including CPR, and that this training was done annually to ensure they were up to date with their knowledge and skills. Staff gave an example where a patient had become unwell having had their blood taken for testing, and talked through how they had responded to them to aid their recovery.

There were systems in place to respond to emergencies and major incidents within the practice. There was a business continuity plan available which identified potential safety risks including changes in service demand, the disruption to staffing levels and loss of domestic services. The business continuity plan provided action plans and important contact numbers for staff to refer to which ensured the service would be maintained during any emergency or major incident.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients' needs were assessed and care and treatment was delivered in line with current legislation and recognised best practice. The GPs confirmed they received information regarding the National Institute for Health and Care Excellence (NICE) guidelines via email. They told us that any new information was discussed at the informal morning meeting before morning surgery and also at the monthly clinical meetings. This was supported by the minutes of the clinical meetings and staff meetings. Information was also shared via the wipe board in the GPs communal work area.

GPs demonstrated adherence to local guidelines and protocols regarding clinical decisions such as changes in care pathways. The GPs attended educational meetings facilitated by the Clinical Commissioning Group (CCG), and engaged in annual appraisal and other educational support. The annual appraisal process requires GPs to demonstrate that they have kept up to date with current practice, evaluated the quality of their work and gained feedback from their peers.

Clinical staff told us they ensured best practice was implemented through regular training, networking with other clinical staff and regular discussions with clinical staff team at the practice. We were told that GPs were very approachable and that clinical staff would have no hesitation in asking for support or advice if they felt they needed it.

Management, monitoring and improving outcomes for people

The practice routinely collects information about patients care and outcomes. It uses the Quality and Outcomes Framework (QOF) to assess its performance and undertaken regular clinical audit. The QOF rewards practices for providing quality care and helps to fund further improvements. We saw there was a robust system in place to frequently review QOF data and recall patients when needed.

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included: appropriate prescribing of medication of loss of bone mass and prostate specific antigen (PSA) blood tests. The PSA audit demonstrated a completed audit and the practice was able to demonstrate patients had received the appropriate treatment. The audit relating to appropriate prescribing of medication of loss of bone mass was very recent and patient records were currently being reviewed.

Doctors in the surgery carried out minor surgical procedures in line with their registration and NICE guidance. We saw that the staff were appropriately trained and carried out regular clinical audits on their results which were used in their learning. Examples of audits seen included haematoma and infection rates following vasectomy.

Effective staffing

We found that staff were appropriately qualified and competent to carry out their roles safely and effectively in line with best practice. We checked two staff records and saw that appropriate checks took place when new staff were recruited.

Staff confirmed they received annual appraisals and the most recent of these were carried out in February 2014. They told us their training and learning needs were discussed during their appraisal sessions and that training identified was planned where possible for the forthcoming year. One member of staff we spoke with confirmed that there were opportunities for staff to undertake professional development in addition to the mandatory training. They told us that the GPs and practice manager were very supportive of requests for additional training.

We saw a staff training matrix in place which gave details of all training completed by all staff. Clinical staff and all reception staff and admin staff had completed safeguarding training to the appropriate level. We saw that data quality and prevalence training had been completed by all staff. The practice manager told us that staff training was being scheduled for 2015. There were plans to complete a team building course for all staff and GPs at the practice as there had been significant staff changes this past year at the practice.

We saw evidence that revalidation was taking place. Revalidation is the process by which all registered doctors have to demonstrate to the General Medical Council (GMC) on a regular basis that they are fit to practise and their knowledge is up to date. Systems were in place to ensure that the practice nurses remained registered with their professional body.

Good

Are services effective?

(for example, treatment is effective)

Working with colleagues and other services

We found that the practice worked with other service providers to meet patients' needs and manage complex cases. The practice provided a number of clinics run by professionals employed by other NHS organisations such as the local acute trust, community trust and the mental health team. These provided people with access to physiotherapy, counselling services and ante natal and post natal care. The practice had five consultants running outreach clinics in the building, offering monthly or bi-weekly appointments. These included ear, nose and throat, orthopaedics, general surgery and urology. The GPs recognised the need to consider patients' social needs alongside their medical needs and aimed to provide services as close to home as possible.

Information about patients from other services was received either electronically or as a paper copy. Each GP reviewed information from other services about their patients on the day it was received. Each GP was responsible for the action required and would either record the action or arrange for the patient to be contacted and seen as clinically necessary. Systems were in place to ensure that patient information was reviewed when GPs were on leave. One GP acted as a duty doctor each day, and dealt with any medical issues on the day, and the non duty GP dealt with any correspondence or results received.

The practice offered a Choose and Book option for patient referrals to specialists. The Choose and Book appointments service aims to offer patients a choice of appointment at a time and place to suit them. The GPs told us that they complete referrals to another service with the patient as part of the consultation. Referrals were completed either via electronic templates or audio file, and were usually processed by the secretaries on the same day.

The practice communicated with the out of hour's service about specific patients through the use of special notes. Special notes are used for patients who may need follow up intervention out of normal GP opening hours or cannot manage their healthcare themselves. The practice held monthly meetings with the community matrons and district nurses to discuss any patients considered to be at risk due to their health care needs. They also met quarterly with the multidisciplinary team to discuss patients on the palliative care register.

A number of other services were also located in the same building as the practice, for example, the district nurses, midwives and community mental health nurses. The practice staff told us this improved communication as community based staff were able to discuss any concerns about patients with the GPs as required as they were located in the building.

Information Sharing

All members of staff had done training about information governance to help ensure that information at the practice was dealt with safely with regard to patients' rights as to how their information was gather, used and shared.

We spoke with staff from three care homes whose patients were cared for by the practice. One member of staff told us they supported people to attend regular appointments for blood tests at the practice. They told us that if there were any abnormalities or changes in the blood results, the practice contacted them directly and arranged for further appointments.

One of the GPs told us that following discussion with the community staff they had identified that patient information was being completed by hand written forms prior to visits. As a consequence, an electronic form had been created that pre-populated the patient details, and saved community staff time. Any additional information from the visit would be updated electronically, ensuring that the patient records at the practice were up to date.

Consent to care and treatment

We saw that the practice had policies on consent, the Mental Capacity Act, and assessment of Gillick competency of children and young adults, and information around the Frasier guidelines. We saw examples of where the guidance had been put into practice and had been signed off by the GPs. Clinical staff told us that patients had a choice about whether they wish to have a procedure carried out or not. For example, a practice nurse told us that they were about to take a blood sample from a patient who then refused the procedure. The practice nurse described how they talked through the patient's anxieties with them. A mutually agreed decision was reached for them to return to the practice a few days later to try again when they felt they would be able to have this done.

Staff told us they had not yet completed training on the Mental Capacity Act and assessing patients' mental capacity. This had been arranged for staff the previous week but it had been cancelled and rearranged for two weeks' time. Mental capacity is the ability to make an

Good

Are services effective?

(for example, treatment is effective)

informed decision based on understanding a given situation, the options available and the consequences of the decision. People may lose the capacity to make some decisions through illness or disability. Staff told us if they had any concerns about a person's capacity to make decisions, they would ask their patient's GP to carry out an assessment.

Health Promotion & Prevention

New patients were required to complete a questionnaire providing details of their medical history. New patients were routinely offered a health check with a health care assistant or practice nurse.

The practice provided a range of support to enable patients to live healthier lives. Examples of this included, a weekly 'Healthy Heart' clinic, travel advice and vaccinations and weight management. We were also told that the practice carried out child immunisations and offered family planning advice and support. A range of leaflets were available in the reception area / waiting room.

The practice offered a full range of immunisations for children. The percentage of children receiving the vaccines was in line with average for the local clinical commissioning group.

The practice offered a full travel vaccination service including yellow fever.

Flu vaccination was offered to all over the age of 65, those in at risk groups and pregnant women. The percentage of eligible patients receiving the flu vaccination was slightly below the national average. The shingles vaccine was offered according to the national guidance for older people.

Information supporting national screening programmes such as Chlamydia screening was available as were the testing kits.

The practice offered the NHS Health checks to all patients aged 40 to 75.

The nurse we spoke with told us that health promotion information was available for all patients. The health care assistant told us that they discussed smoking, drinking and diet with patients when they carried out routine NHS health checks with patients.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a survey of 768 patients undertaken by the practice's patient participation group. The evidence from these sources showed patients were satisfied with how they were treated and that there was compassion, dignity and respect. For example, data from the national patient survey showed that the practice was rated as amongst the best for patients rating the practice as good or very good. The survey showed that patients generally felt that the doctor was good at listening to them. Over 95% of the patients who responded said that they had confidence and trust in the doctor they had seen last at the practice.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 46 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, polite and caring. They said staff treated them with dignity and respect. Eight comments were less positive but there were no common themes to these. We spoke with 14 patients on the day of our inspection. All told us they were satisfied with the care provided by the practice, and they said their dignity and privacy was respected. One patient told us the GP was very supportive and had contacted the consultant at the hospital on their behalf.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in the consulting and treatment rooms so that patients' privacy and dignity was maintained during examinations. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place could not be overhead.

Staff told us they ensured patient's dignity was maintained by making sure the door was locked and that screens were used to enable patients to undress in private. Patients were made comfortable and staff told us they offered a chaperone service if patients preferred. Staff confirmed they had received chaperone training. We were told that information was made available to patients in the event they requested a chaperone.

Throughout the inspection we saw and heard staff speaking with patients in a helpful and respectful manner. We asked patients about confidentiality and no one expressed any concerns. There was sign at the reception desk asking patients to stand back and respect the privacy of the patient at the desk. The practice switchboard was located in a separate room behind the reception desk, which kept patient information private.

We spoke with staff from a local care home which cared for people with a learning disability. They told us staff were understanding of their needs but also treated them in the same way as any other patient when they visited the practice. They said that the reception staff were very understanding if appointments were cancelled at short notice, when people chose not to be seen by the GP or nurse. They commented that the GPs were very knowledgeable about the people they cared for and always gave them time.

Care planning and involvement in decisions about care and treatment

Patients told us that they felt fully informed and involved in the decisions about their care. They told us they felt listened to and supported by staff and were given sufficient time during consultations to discuss any concerns. Patient comments on the comment cards we received were also positive and supported these views.

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions. For example, data from the national patient survey showed 87% of practice respondents said the GP was good at explaining treatment and results, and 84% felt the GP was good at involving them in decisions about their care. Both of these were above the average compared to the Clinical Commissioning Group area. Results from the practice's own satisfaction survey showed that 99% of patients said they were satisfied with the care provided by the GPs.

Staff told us that the population of the patients at the practice were mainly white, British people, with Eastern European seasonal land workers. There were also a small number of Indian and Chinese patients registered with the practice. Staff told us that support for people whose first language was not English tended to come from their own supporters, although an interpreter service was available. Leaflets in the patients preferred language were printed from the internet to help them understand their conditions.

Good

Are services caring?

Not all staff had received training in the Mental Capacity Act 2005 but demonstrated some knowledge regarding best interest decisions for patients who lacked capacity. They described that if a patient attended with a carer or relative, they would always speak with the patient and obtain their agreement for any treatment or intervention. The nurses told us that if they thought a patient lacked capacity, they would ask their GP to review them.

Patient/carer support to cope emotionally with care and treatment

The one family one doctor policy operated at the practice meant that the GPs knew the needs of their patients and families very well. Staff told us that families who had suffered bereavement were called and visited by their GP. Staff were aware that families could be sign-posted to other services for support. GPs were able to refer patients to the primary care mental health worker, who were based in the same building as the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The provider understood the different needs of the population it served and acted on these to design services. A phlebotomy service had been established at the practice so that patients did not have to travel to the local hospital. Clinical staff told us that patients who were prescribed warfarin (anti blood clotting medicine) were encouraged to attend for regular blood checks and monitoring of their conditions. Clinical staff described how they visited patients who were unable to get to the practice to check their warfarin levels. The blood results were available at the time of the test, and the dosage of warfarin could be amended and recorded at the same time. Staff told us this removed the need for staff to obtain the result from the hospital and inform the patient, and reduced the risk of losing the warfarin dosage booklet. Staff told us they had been doing this for some 18 months and they had been very successful in reaching patients they might not have seen regularly previously.

We saw there was a system in place that ensured patients with long term conditions such as asthma and diabetes received regular health reviews. Clinical staff told us they carried out regular and routine blood tests for patients with diabetes. They explained they also use these sessions to give dietary advice and support for patients on how to manage their conditions. We were told about an initiative whereby the practice nurse would visit housebound diabetic patients in their own home to carry out their diabetic review. The aim was to ensure their treatment was appropriate and avoid hospital admissions.

The practice had an active patient participation group (PPG) to help it to engage with a cross- section of the practice population and obtain patient views. We spoke with a representative of the PPG who explained their role and how they worked with the practice. They told us that the group had a good distribution of patients from different age groups. There was evidence of meetings with the PPG every two months throughout the year. The representative told us the PPG had a good working relationship with the practice, and felt that the GPs explained any changes in the health economy to them and listened to any concerns they had.

Tackling inequity and promoting equality

The practice proactively removed any barriers that some people faced in accessing or using the service. Staff we spoke with told us there was a small minority of patients who accessed the service where English was their second language. They told us the patient was usually accompanied by a family member or friend who would translate for them. Staff told us they could arrange for an interpreter if required. We did not see any leaflets in different languages for patients, although information could be translated via the website. There were two female GPs at the practice, who were able to support patients who preferred to have a female doctor. This also reduced any barriers to care and supported the equality and diversity needs of the patients.

There were arrangements to ensure that care and treatment was provided to patients with regard to their disability. There was a hearing loop system available for patients with a hearing impairment and clear signage informing patients where to go. There was a disabled toilet and wheelchair access to the practice for patients with mobility difficulties.

Access to the service

The practice had a one family one doctor policy. As a result of this, the patients we spoke with were very happy with the appointment system. Patients could book an appointment with their GP on the day if they wished, or make a pre-bookable appointment. None of the patients spoken with or the completed comment cards indicated any issues with obtaining an appointment.

The practice website outlined how patients could book appointments and organise repeat prescriptions online. Patients could also make appointments by telephone or in person to ensure they were able to access the practice at times and in ways that were convenient to them.

The practice opened from Monday to Friday from 8am to 6.30pm each week with morning surgery from 9am to 11.30am, and evening surgery from 4pm to 6.15pm. The dispensary opened at 8.30am to 6.30pm. All clinics were available by appointment and patients could book these on the telephone, online or at the reception desk at the practice. Extended hours were available on a Monday morning from 7.45am to 8am and evenings each weekday from 6.30pm to 7pm. These appointments were particularly useful to patients with work commitments.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Staff told us that patients who required urgent appointments could access services the same day. Reception staff told us that these appointment requests were brought to the GPs attention who responded to the request accordingly. Telephone consultations were also provided at times agreed with the patient.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. This was provided by an out of hour's service. If patients called the practice when it was closed, their call was diverted to the out of hour's service.

The practice was situated over five floors and accessible to patients. The waiting room at the practice was comfortable and spacious. Information was made available on the screen display, and leaflets for health promotion were available for patients to take away with them should they wish to do so.

The waiting room and corridors provided space for patients who used a wheelchair or walking aid to access the practice easily. One of the counters in the reception area had been lowered so that patients who used wheelchairs had access to speak with the receptionist directly. There were disabled toilet facilities with emergency alarms fitted, automatic entrance doors and disabled parking spaces were available. A lift was available for patients to access consultation rooms on the upper floors of the practice.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy is in line with recognised guidance and contractual obligations for GPs in England and there is a designated responsible person who handles all complaints in the practice. Accessible information was provided to help patients understand the complaints system on the practice's website.

We found that there was an open and transparent approach towards complaints. We saw that the practice recorded all complaints and actions were taken to resolve the complaint as far as possible. Three complaints had been received during 2014. We saw that these had been handled satisfactorily.

The GPs and the practice manager told us that complaints were discussed at the weekly management meetings. We saw that the outcome and learning from complaints was then shared with the staff team at team meetings.

None of the patients we spoke with had any concerns about the practice or had needed to use the complaints procedure.

Are services well-led?

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

Our findings

Vision and Strategy

There was a clear and visible leadership and management structure in place. Staff told us that there was now a positive culture and focus on quality at the practice. We saw examples where staff had been supported and encouraged to develop their skills through discussions at team meetings and through individual appraisals. We spoke with a GP who confirmed that there was an open and transparent culture of leadership, encouragement of team working and concern for staff well-being.

Staff told us that the practice was well led. We saw that there was strong leadership within the practice and the senior management team were visible and accessible. There was evidence of strong team working. Records showed that regular meetings took place for all staff groups. The practice manager told us that they met with the GPs each week and information from these meetings was shared with staff. Staff told us that the GPs, practice manager and team leaders were very supportive.

Throughout the inspection we saw and patients told us that staff treated patients with dignity and respect. All patients we spoke with confirmed that staff were compassionate and kind.

We saw that the practice had a set of core values, which included 'to be the best with quality of service and clinical care – shared views on how to achieve' and 'to be honest and have integrity in everything we do, and play to our strengths'. Staff we spoke with demonstrated their commitment to the core values and to providing a high standard of service for patients.

The practice manager told us that contingency plans included replacement of key members of staff. For example, where members of staff were likely to retire, the practice planned to recruit replacement staff within timescales that enabled suitable handover/learning opportunities. The practice manager said this would help to ensure a seamless transition and maintain existing standards of service.

The practice was proactive in its approach to develop the services provided. We were told by the practice manager that the practice was looking to improve patient access to the online booking services through the use of a mobile phone application.

Governance Arrangements

All staff had access to policies, procedures and clinical guidelines either through paper copies which were stored in files or through information available on the practice's intranet. Staff showed us the access arrangements on the computer system. All documentation on the intranet and the paper copy files were kept up to date with dates for reviews recorded. Staff told us they were able to access either when they needed information or were guided to read the latest information. We saw from staff meeting minutes that changes and updates were discussed and staff confirmed these discussions took place.

Staff told us they were clear about their roles and responsibilities and knew who they should refer to on occasions where their responsibilities were exceeded. We saw from policies and procedures available at the practice that clear processes were in place with lead staff identified. For example, lead safeguarding personnel and commissioning were identified utilising staff skills and expertise.

We saw evidence of Quality and Outcomes Framework (QOF) targets and action taken in relation to the consistent performance of the practice over the past 12 months. QOF is the NHS annual reward and incentive programme which awards practices achievement points including the management of chronic disease, such as asthma and diabetes. The practice had a designated data quality lead, responsible for checking the data to ensure there were no omissions or errors. Any omissions were discussed at the weekly GP meeting.

The practice also regularly carried out clinical audits internally, for example complications post vasectomy and PSA ranges (a blood marker for a certain type of cancer). Findings were shared with staff and actions and recommendations were recorded.

We saw that the practice worked to the identification of risks and risk management. We saw a risk assessment spreadsheet in which all risks identified within the practice and their current status had been recorded. For example, we saw a risk assessment completed for the reception office that identified the risk of injury to staff from holding the telephone between their shoulder and ear. We saw that action had been taken as a result of the risk assessment and the record showed that headsets had been purchased for each receptionist. We saw these headsets used by reception staff.

Are services well-led?

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

Leadership, openness and transparency

There was a clear leadership structure which had named members of staff in lead roles. For example one of the GP partners was the lead for safeguarding, and shared the role of Caldicott guardian with the senior partner. A Caldicott Guardian is a senior person responsible for protecting the confidentiality of a patient and service-user information and enabling appropriate information-sharing. We spoke with staff from different teams and they 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 saw from minutes that a range of meetings were held weekly, bi-weekly, monthly and quarterly. Staff told us there was an open culture within the practice and they had the opportunity and were happy to raise issues at the meetings. The practice manager told us that a whole team building event had been organised.

One GP partner had lead responsibility for human resources policies and procedures, supported by the practice manager. We reviewed a number of policies, for example the recruitment and induction policies which were in place to support staff. Staff we spoke with knew where to find the policies if required.

We found the practice to be open and transparent, and prepared to learn from incidents and near misses. Three monthly significant events meetings were held where these were discussed. Lessons learned from these discussions were shared with the team. We saw the system in place for the dissemination of safety alerts and National Institute for Health and Care Excellence (NICE) guidance. Clinical staff told us they acted on alerts and kept a record of the action they had taken.

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

The practice had gathered feedback from patients through patients' surveys and complaints received. We looked at the results and patient comments made in the annual patient survey and noted that 134 out of 768 patients commented adversely about the telephone system. We saw as a result the practice was planning to introduce a new telephone system later in 2014. The practice was carrying out the annual survey for 2014 at the time of this inspection.

The practice had an active patient participation group (PPG) which contained representatives from various population groups: including mothers, babies, children and young people, and working age people. The PPG meets every two months and two of the GP partners attended the meetings.

We saw from minutes that staff meetings took place every two weeks. Practice discussions and information sharing took place during these meetings. Staff told us that they felt able to make contributions and suggestions at all times, and their views were actively sought and acted upon. The practice manager told us three members of reception staff had requested to be trained as chaperones, and this training had been arranged for November 2014.

Management lead through learning & improvement

The practice held regular meetings that ensured continued learning and improvements for all staff. We saw minutes of staff meetings, clinical staff meetings and management team meetings that showed discussions had taken place on a range of topics. This included significant events, complaints and palliative care for patients, with actions to be completed where appropriate. In addition a heads of departments meeting was held each month by the practice. Staff told us that each department within the practice was represented at this meeting, where they looked at the development and the future of the practice.

We saw how the practice responded to areas that needed to be improved. For example, a management meeting took place on 26 August 2014 in which the premises had been discussed. A recent fire alarm had highlighted that some staff had not fire training and hadn't evacuated when the alarm had sounded. We saw that all staff had received fire training as a result of this.

The practice had identified the need for clinical staff training to improve the service provided for a vulnerable group of people considered to be at risk, people with learning disabilities. Training was scheduled to take place in October 2014 for all clinical staff.

The practice was able to evidence through discussion with the GPs and via documentation that there was a clear understanding among staff of safety and of learning from incidents. Concerns, near misses, Significant Events (SE's) and complaints were appropriately logged, investigated and actioned. For example, we saw that the outcome of

Are services well-led?

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

complaints received and resolved had been discussed at the management meeting held on 26 August 2014. We saw the practice significant events log for 2014 which gave details of the incident, who was involved, action taken and lessons learned.