The Wellspring Surgery, Dr Teed & Partners

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 The Wellspring Surgery on June 2 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, safe, effective, caring and responsive services. It was good for providing services for the older people, people with long term conditions, families, children and young people, working age people (including those recently retired and students), people whose circumstances may make them vulnerable and people experiencing poor mental health (including people with dementia).

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

- Staff knew how to report significant events and we found that action had been taken in response to safety alerts. Actions were taken following investigations in to significant events and we saw evidence that these were re assessed to consider the impact they had on patients. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Information about safety was recorded, monitored appropriately, reviewed and addressed.
- The practice worked with other agencies to ensure the care and support provided to children and vulnerable adults was coordinated and effective.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff were aware of how to support patients whose capacity to understand and make decisions may be limited, for example for patients with dementia.
- 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. Complaints were dealt with appropriately and in a timely manner.
- There was a clear leadership structure and staff felt supported by the management. The practice proactively sought feedback from staff and patients, which it acted upon.

Summary of findings

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff knew how to raise concerns, and to report incidents and near misses. Lessons were learned and changes were made to improve practice. Staff had undertaken training in safeguarding children and vulnerable adults and there were arrangements in place to respond to any safeguarding concerns. This was supported through multi-disciplinary working with partner agencies. For example, the practice had regular quarterly meetings with Health Visitors to ensure high quality care. There were enough staff to keep patients safe. Arrangements were in place to respond to medical emergencies

Are services effective?

Good

The practice is rated as good for providing effective services. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. The practice had achieved 96% of their available points in respect of the Quality Outcomes Framework. This was above the national average. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long term conditions and for the implementation of preventative measures.

Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified. There was evidence of appraisals and personal development plans for all staff. Areas of specialism were led by different clinicians in the practice, for example there was both a lead GP and lead nurse who took responsibility for managing individual long term conditions.

Are services caring?

Good

The practice is rated as good for providing caring services. The patients we spoke with were positive about the care they received, and told us they felt respected and listened to by staff. We saw that staff treated patients with kindness and that patient confidentiality was maintained. In the national GP patient survey published in January 2015 82% of respondents stated that the GP involved them in decisions about their care. This was above the CCG National average of 86%. This view was supported by the patients and professionals we spoke with during our inspection.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The staff were aware of their patient's needs. For example, the practice has a high proportion of individuals with mental health needs. Therefore the practice employed a specialist community psychiatric nurse and worked closely with a psychiatrist who held regular weekly clinics at the practice to enhance the quality of patient care provided for these patients

Patients expressed mixed views about access to appointments. The national GP patient survey published in January 2015 demonstrated that this was an area in which the practice performed lower than the CCG average. The practice had an online appointment booking system but there was only a 0.4% uptake, so this was an area where the practice was raising patient awareness. The practice had employed the services of a consultant agency to review its appointment system and as a result planned to introduce a telephone triage system during 2015.

We spoke with representatives of three care homes who told us that the GPs were responsive to the needs of people living in the homes. The practice was equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded appropriately to issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led. There was a clear leadership structure and staff felt supported and valued by the management. The practice had a number of policies and procedures to govern activity and held a range of clinical and staff meetings. There were systems in place to monitor and improve the quality of services using the data available. The practice proactively sought feedback from staff and patients through the use of suggestion boxes. The practice acted upon this feedback. The patient participation group (PPG) was active, and members we spoke with told us they felt valued. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

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.

Patients over the age of 75 years had a named GP, and there was a nominated GP for each of the three care homes in the practice area. The practice had identified the most vulnerable 2% of its older population and had care plans in place.

Home visits were available and the practice nurses visited care homes to provide flu vaccinations. The practice held multi-disciplinary meetings to ensure the care provided to older people was coordinated with other care providers. The practice maintained a register of frail older people which it regularly updated. The practice was purpose built with accessible rooms and lifts. The practice had introduced a falls prevention scheme to meet the needs of patients prone to falls.

People with long term conditions

Good

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

The practice had a high proportion of patients with long term conditions. Nursing staff and named GPs had lead roles in chronic disease management. The practice was achieving patient outcomes in respect of QOF which were above the CCG and National England Average in most areas. For example the practice was 1.8 percentage points above the CCG and 2.8 percentage points above the England average with regard to monitoring patients with asthma. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long term conditions and for the implementation of preventative measures.

The practice had a system in place for the early identification of patients with diabetes. There was a high prevalence of patients with a diagnosis of diabetes in the practice. Longer appointments and home visits were available when needed. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

Summary of findings

There were systems in place to identify and follow up children living in disadvantaged circumstance who were at risk. The practice worked with and was responsive to partner agencies to ensure care was co-ordinated. Appointments were available outside of school hours and the premises were suitable for children and babies.

In line with the Healthy Child programme, the practice offered an eight week check for new babies. Staff were aware of the Gillick competencies which are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Childhood immunisation rates were lower than the CCG average in those children under the age of five years. The practice had been working with the CCG to try and find ways to improve these rates. However the practice was aware of factors such as a high number of patients who were only registered at the practice for a short period of time which could influence this uptake.

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.

Following feedback from a patient PPG survey, the practice had taken recent action to increase awareness of their online appointment booking system. The practice had a system to offer telephone consultations to improve access and offered flexible appointments to accommodate individual patient needs.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

The practice held a register of patients who had a learning disability and offered annual health checks to this group of patients. At the time of our inspection 35 out of 50 patients had been invited to attend for an annual health check and all had been completed.

Staff were working to ensure that all clients from this group had their health checks completed.

The practice has a high transient population and was responsive to the needs of those who were; asylum seekers, homeless and overseas immigrant

The practice used interpreter services for those patients whose first language was not English. It offered double appointments a number of patients whose circumstances may make them vulnerable to

Summary of findings

promote equitable patient care. Staff at the practice were aware of the arrangements in place to safeguard their patients, and how to respond to concerns. Information about how to access support services was available in the practice.

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).

Patients experiencing poor mental health were invited for annual health reviews. The practice worked with multi-disciplinary teams to support people experiencing poor mental health including those with dementia. The practice worked closely with a specialist community psychiatric nurse and a psychiatrist who held regular weekly clinics at the practice to enhance the quality of patient care provided for these patients. Information about MIND which is a weekly support group for people experiencing mental health problems was available in the patient waiting room.

Summary of findings

What people who use the service say

Data from the national GP patient survey published in January 2015 identified that 90% of patients reported that their GP was good at listening to them (compared with a CCG average of 87% and a national average of 89%), and 82% of respondents said the last GP they saw or spoke to were good at involving them in decisions about their care (compared with a CCG average of 80% and a CCG average of 82%).

Prior to our inspection, patients were invited to complete comment cards about their views of the practice. We reviewed the comments on the 35 cards completed by patients. The majority of patients who completed the cards were positive about their experience of the care they received at the practice. Comments were mainly positive about the staff, referring to both their kindness and helpfulness. Those who commented reported that they felt they were listened to and involved in decisions about their care. We received three negative comments from patients about the appointment system. These comments included the wait for a non-urgent appointment, particularly if the appointment was with the same GP to ensure continuity of care. Patients reported that they found the practice was clean and hygienic.

We spoke with six patients on the day of our inspection; this included three patients who were members of the Patient Participation Group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

Patients told us they were treated with dignity, respect and felt listened to. They told us that they were happy overall with the service provided at the practice. Patients told us that they could get an emergency appointment on the day. However, we received mixed comments with regards to waiting times for seeing the patients' GP of choice and the ease of obtaining a non-urgent appointment.

We spoke with representatives of three care homes for older people in the area. People living in these care homes received their primary medical service from the practice. We received positive comments about the support provided by the GPs, and how they related to people living in the care home.

The representatives of the PPG with whom we spoke, told us that they felt the practice both listened to and acted on their views. They told us that they were involved in discussions about the actions the practice planned to take following suggestions made by patients.

The practice had recently carried out the NHS Friends and Family test (FFT). This showed that 100% of all patients who completed the FFT would recommend the practice to others.

The Wellspring Surgery, Dr Teed & Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector. The team included a GP specialist advisor, a practice manager specialist advisor and an expert by experience. Experts by experience are members of the inspection team who have received care and experienced treatments from a similar service.

Background to The Wellspring Surgery, Dr Teed & Partners

Wellspring Surgery is situated in St Anne's which is one of the more deprived areas of the country. The percentage of adults and children affected by income deprivation is above the national average. The practice has a patient list of 9008 patients with a current annual list growth and turnover of 12% per year.

There are seven GP partners and one salaried GP working at the practice. This equates to 4.75 WTE. The practice had three male and four female GPs. The practice is a training practice and provides work placements for doctors in training (GP registrars) and medical students. GP registrars are qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine. There is a team of two nurses and one healthcare assistant. There is both a practice manager and a deputy practice manager.

The Wellspring Surgery holds a Primary Medical Services Contract to provide primary medical services. This is a contract between NHS England and general practices for delivering general medical services. The practice has opted out of providing out of hours services, which is provided by Nottingham Emergency Medical Services.

Opening Hours are from Monday, Tuesday, Wednesday and Friday from 8.30am to 12.30pm and 1.30pm to 6.30pm. The practice closes on a Thursday afternoon at 1pm. The practice does not offer extended hours.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 (Regulated Activities). Regulations 2014 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 (Regulated Activities). Regulations 2014 to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

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

Detailed findings

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before carrying out our inspection, we reviewed a range of information that we held about the practice and asked other organisations to share what they knew including commissioners, the area team from NHS England and Healthwatch. We carried out an announced inspection on 2 June 2015. During our inspection we spoke with a range of staff, including doctors, nurses and administrative staff. We spoke with patients who used the service, and members of the practice's patient participation group. We reviewed the policies, protocols and other documents used at the practice. We reviewed 35 completed comment cards and spoke with representatives of three care homes with patients registered at the practice.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. Clinical meetings were used to discuss safety alerts. For example National Patient Safety (NPSA) and Medicines and Healthcare Regulatory Authority (MHRA) alerts. Staff could describe a recent alert and explained that alerts were discussed at clinical meetings. There was a safety alerts protocol in place for staff to refer for support and guidance. During our inspection we that action had been taken by the practice in line with this protocol.

Staff we spoke with confirmed that safety alerts were received by email and that different clinicians in the practice took responsibility for different alerts. For example one clinician was responsible for managing risk alerts with regard to medical equipment.

We saw meeting minutes which demonstrated that the practice worked with a member from the medicines management team in the audit of medicines following alerts received. We saw evidence of the changes made to patients' prescriptions in terms of these medicines.

The evidence we saw assured us that the practice had a safe track record over time.

Learning and improvement from safety incidents

The practice had a system in place for the reporting and recording of significant events. Staff used forms which were available on the staff intranet. We saw a summary of the 34 reported significant events for 2014-2015, which were a combination of both positive and negative events.

There was evidence that significant events were logged and investigated thoroughly. We found evidence of learning from all significant events. Action plans were put in place with a review date to monitor that any changes made had been effective. Staff we spoke with knew how to report significant events, and we saw records which demonstrated that significant events were discussed at significant event meetings. Staff we spoke with were able to tell us about a recent significant event.

The practice had not reported any critical incidents or near misses in the last year, but were able to demonstrate what constituted a critical incident and how this should be managed, The practice reported all deaths to the Clinical Commissioning Group(CCG) as a matter of course and we saw evidence which confirmed this.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children, young people and vulnerable adults. The practice had a high level of deprivation and a high number of safeguarding concerns with regards to children. Safeguarding policies were available to staff. Contact details of key staff in partner agencies were available in the consultation/treatment rooms.

The practice had two lead GPs for both safeguarding vulnerable adults and children. Staff we spoke with were aware of actions to take if they had safeguarding concerns, and knew who the lead persons were for safeguarding in the practice. Reception staff we spoke with told us that if a patient attended for an appointment, and they were concerned they would put an alert on the system for the GP to note when they saw the patient. The practice nurse we spoke with provided two examples where she had alerted GPs and other members of the multidisciplinary team of safeguarding concerns she had identified during her clinics.

The lead GPs for safeguarding in the practice were trained to the appropriate level. All of the nursing staff had received training in child protection to the level appropriate to their role. All staff had received the appropriate level of vulnerable adult safeguarding training.

Where there were concerns related to children's safeguarding these were noted on the patients' records using a red card system. Multidisciplinary safeguarding children meetings took place every 3-6months, or more frequently depending on risk or clinical needs. We saw evidence of these "red card" meetings. The lead GPs for safeguarding told us that these meetings were helpful in identifying shared concerns. The practice had plans to improve working with school nurses in the local area to enhance their safeguarding practice.

The practice monitored children's attendance at the accident and emergency department and these patients were reviewed accordingly.

The practice had a chaperone policy which included details about who could chaperone and the action to take if a

chaperone were not available. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. Several administrative staff had been trained as chaperones. These staff had Disclosure and Barring Service (DBS) checks in place to allow them to fulfil their duties as chaperones safely. Information about the availability of chaperones was available in the practice waiting room.

Medicines management

Patients ordered repeat prescriptions in person or on line. There was a team of receptionists and administration staff who had been trained in managing repeat prescriptions. We saw evidence that the receptionist checked the name of the patient, their date of birth and how many times the medicines had been dispensed before requesting a GP to authorise the repeat prescription.

Managers reported that the arrangements for managing prescriptions and undertaking medicines reviews for people living in the three care homes that the practice visited worked well.

There were systems in place to manage the stock control of vaccinations. The expiry dates of medicines were routinely checked and we saw documented evidence of this on a spread sheet. We saw evidence that appropriate staff had access to the keys to the vaccines fridge which were locked and not accessible to the public at any time. All of the vaccines we checked were in date, stock was rotated and the expiry dates were clearly recorded.

Records were kept of the temperature of the three vaccine fridges. Temperatures were within the required temperature range. The fridges were hardwired, had an external thermometer and a USB data probe which monitored the fridge temperature. However there was not a thermometer which measured the temperature of the clinical rooms where medicines were stored. It is best practice to have a thermometer in the clinical rooms as the efficacy of some medicines is affected when the temperature reaches over 25 degrees C.

The nurse we spoke with was able to discuss how the staff had safely managed a breakdown in the cold chain when a fridge was not working properly. We saw evidence of a cold chain policy and the ice packs and cool bags used to transport vaccinations to local nursing homes. These steps ensured vaccines were kept at the right temperatures to ensure they were effective.

The medicines we saw were in date and we saw evidence of a spread sheet where these expiry dates were recorded.

There was an audit trail for the use of prescription pads and blank prescription pads were kept securely.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. Patients we spoke with told us they found the practice clean and had no concerns about cleanliness or infection control. We saw evidence of a cleaning schedule completed by a company which was independent of the practice. We saw that nurses cleaned their; desks, couches, computers and telephone equipment on a daily basis, but the documentation to evidence this took place could be strengthened.

The practice had an infection prevention and control policy. We saw an infection control audit had been undertaken in July 2014 by an independent company. The audit identified actions required by the practice and we found action had been taken in response to the audit which is good practice.

The surgery had a lead in infection prevention and control. Other staff received role specific training in infection prevention and control, and there were plans to include this in the induction policy.

Whilst hand gel was not available in the reception area on the day of our inspection, we saw evidence that this was available in all clinical rooms, staff and public toilets. We saw that spillage kits for blood, vomit and body fluids were available. This is important as spillages of contaminated body fluids can lead to individuals being placed at risk of developing infections. The curtains in the consultation and treatment rooms were changed every six months. A waste management contract was in place.

A legionella risk assessment had been carried out by an independent provider in January 2013. (Legionella is a particular bacterium which can contaminate water systems in buildings). There were regular tests undertaken to ensure the water system was free from harmful bacteria.

Both clinical and non-clinical staff had received training in recognising the signs and symptoms of the Ebola Virus. We saw evidence of prompt cards that clinical and non-clinical staff could use if they were dealing with telephone calls/ face to face consultations with individuals who may

present with symptoms of the virus. If any service user was suspected of having the Ebola virus there was a room which could be used to segregate the patient, protecting others from harm.

Records were kept of hepatitis B vaccinations of all clinical staff. This included when the vaccination was next due. This vaccine offers protection to staff.

Equipment

We saw that portable appliance testing (PAT) took place at the practice and all equipment had been tested as required. PAT testing had been carried out in February 2015. We saw that equipment had been calibrated in May 2015. Sufficient equipment was available for staff to enable them to carry out diagnostic examinations.

Staffing and recruitment

The practice had a comprehensive recruitment policy. Criminal records checks had been carried out through the Disclosure and Barring Service (DBS). We were informed that all clinical staff and any non-clinical member of staff who had contact with patients, including those involved in chaperoning had been subject to a criminal records check.

When needed, the practice used locum GPs who were known to the practice as a consequence agency staff were rarely used. We saw evidence that the practice received, copies of the checks carried out on any locum GP for example their criminal records check, their CV, medical registration information and insurance details. There was a locum pack in each clinical room which contained a form that all locums completed at the end of their shift with regards to any referrals made to other healthcare professionals for example secondary care. The use of this form helped to manage the risk of missed referrals.

The practice had considered potential increased demand for patients to register with them and had discussed the potential need to increase staffing levels with the CCG and the Landlord of the building to address issues with the building lease.

The practice had a low staff sickness rate and low staff turnover and there were arrangements in place to manage staff absences.

Monitoring safety and responding to risk

The practice had a health and safety statement policy which set out the responsibilities of the provider and staff in ensuring the health, safety and welfare of patients, staff and any others on the premises. A health and safety risk assessment had been undertaken and a Health and Safety Law poster was displayed. The practice had a lead member of staff for health and safety.

Arrangements to deal with emergencies and major incidents.

The practice had arrangements in place to manage emergencies. Records showed that staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator. This is a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. All staff we asked knew where to access this equipment and the evidence we saw showed that this emergency equipment was checked on a weekly basis to ensure it was working.

Emergency medicines were kept in an emergency drug bag for each GP. We saw three emergency anaphylaxis drug containers within the vaccination fridges in case a patient suffered a major immune reaction to any medicine. We saw evidence during the inspection of a computerised spread sheet of each GPs emergency medicines and nurses medicines with expiry dates clearly recorded. These medicines were all in date.

Two members of staff could describe the actions they would take in the event of a medical emergency at the practice.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. These included lack of access to the premises, loss of electricity or gas supplies, failure of the IT system and loss of medical records amongst others.

A fire risk assessment had been undertaken. Fire safety equipment was available and maintained. Staff confirmed that the fire alarm is tested every Thursday at 3 pm and all staff we asked, knew the procedure for safe evacuation during a fire.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nurses were familiar with current best practice guidance for example with guidance from the National Institute of Care and Health Excellence (NICE). Guidelines were discussed at clinical meetings which were attended by all clinicians at the practice and was disseminated to staff both electronically and as a hard copy.

Areas of specialism were led by different clinicians in the practice, for example there was both a lead GP and lead nurse who took responsibility for managing individual long term conditions.

New patient healthcare checks were offered and we saw evidence that 76 health checks had been carried out. We saw evidence that there were health checks for all people registered with learning disabilities at the practice and for those with mental health needs. For example 98.3% of patients diagnosed with depression in the practice had received an annual review and health check.

The practice has a higher than the Clinical Commissioning Group (CCG) average for the proportion of patients attending accident and emergency (A&E) departments. Staff told us that the area had a large diverse population with many different expectations of access to medical advice in a hospital setting. The practice had tried to encourage patients to access the right services by developing information displays in the practice including sections on minor illness, minor injuries and sign-posting patients to the most appropriate service for medical attention when it was required.

Referral letters to secondary care were usually passed to the administrative staff the same day the patient was seen. Reception staff and other administrative staff in the team were trained in managing this task, so that if a member of staff went off sick the task was still covered. This made it less likely for referrals to be delayed which could have a significant impact on clinical outcome.

The practice referred to Quality Outcome Framework (QOF) data to monitor their performance and we saw evidence that the practice had a higher than average number of patients with long term conditions. However the practice was achieving patient monitoring both above the CCG and National England Average in most areas. For example the practice was 1.8 percentage points above the CCG and 2.8 percentage points above the England average with monitoring their patients with asthma.

The practice had a high proportion of patients diagnosed with diabetes, due to the diverse population and high levels of obesity amongst the patient population.

The QOF data indicated that the percentage of patients with diabetes on the register whose cholesterol was high, was higher than the CCG average. The practice was aware of this and had responded by offering health promotion advice which was tailored to suit their multi-cultural population. This dietary advice was designed to help patients eat fewer foods/smaller portions which were high in fat, thus reducing their cholesterol levels. The health promotion aimed to reduce the risk of these patients developing coronary heart disease.

Data we received from the CCG showed that the practice was performing in line with the CCG area average and below the national average for the prescribing of a range of different medicines. However the data revealed that the practice had a high number of patients who received specialist antibiotics used to treat a broad range of infections. The practice staff told us that they had several patients who were diagnosed with prostatitis (a condition where the prostate gland becomes inflamed) which would only respond to treatment with this type of antibiotic.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs and nurses showed that the culture in the practice was that patients were cared for and treated based on need. For example nurses told us that if they saw a patient who had a learning disability or mental health problem for a minor health complaint, they used that time to carry out a full health check to ensure holistic care.

Management, monitoring and improving outcomes for people

The practice undertook audits to monitor and improve outcomes for patients. We saw evidence of 15 audits carried out between 2013 and 2015. The cycles were completed.

The practice had a 5% prevalence of diabetes amongst the practice population which was higher than the CCG average. A significant event in 2013 led the GPs to carry out

Good

Are services effective?

(for example, treatment is effective)

an audit to ensure that patients newly diagnosed with diabetes were coded, given dietary advice and a follow up appointment arranged. Both audits identified that the GPs were following local and NICE guidelines for the management of diabetes.

We saw examples of three audits of minor surgery had been undertaken by individual GPs. This was in line with their registration and National Institute for Health and Care Excellence guidance.

One of the audits showed that; the complication rate following minor surgery was below one percent, and below the national average of 2%. All excised lesions were sent for histology and the subsequent results noted both in the patient's own notes and the minor surgery log

The practice had a protocol for repeat prescribing, which could be requested by the patient online or in person. The protocol included a review of the number of times the medicines had previously been dispensed to avoid the risks of patients developing side effects.

Effective staffing

Practice staffing included medical, nursing, and administrative staff. There was a practice manager and an assistant practice manager employed.

All GPs 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 practise and remain on the performers list with NHS England).

The practice employed two practice nurses, and there was evidence to show the practice manager had undertaken regular checks on the status of the nurses' registration with their professional body; the Nursing and Midwifery Council. The nurses we spoke with were aware that they required to undertake revalidation.

Staff appraisals took place; those of the administrative staff were carried out by the practice manager. The practice manager and the lead GP undertook the appraisals of the nursing staff. The practice manager had their appraisal with the senior GP partner

Staff training was based on need, and was intended to support improved outcomes for patients. We saw evidence that the training was recorded using an online training base tracker, which provided comprehensive evidence of training needed and undertaken. Nurses worked within their scope of practice. The health care assistant was supervised by a GP in the administration of flu vaccines, and was mentored by the lead practice nurse. There was evidence that staff were given feedback on their performance and areas for development.

We saw examples of evidenced based protocols which nurses used to diagnose patients with minor illness. These included a section which stated that nurses needed to refer any patient they felt were outside their scope of practice, or required any prescribed medication (none of the nurses were non-medical prescribers) to the GP on call during that given clinic to ensure safe patient care.

The locum and GP registrar confirmed that they had had an induction when they started work at the practice. An induction pack was available to new medical staff on the practice's computer system. This included the organisational structure, a staff list including roles, the code of conduct including confidentiality and safeguarding arrangements.

Staff had access to online training as well as attendance on training courses. The training records we saw showed that all staff had received adequate training in safeguarding. We saw evidence of a training file belonging to one of the nurses with relevant certificates confirming attendance at study days for asthma management and diabetes.

Where there were concerns about performance of staff this was addressed.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. All patient hospital discharge letters and any patient who had attended an out of hours setting or a walk in clinic were seen by the GPs, scanned in to the practice system on the day of receipt, and distributed electronically to the GPs. If a GP was absent any incoming letters and results would be reviewed by a colleague GP.

The practice held monthly multidisciplinary team meetings to discuss adult patients with complex needs, those who

were frail and patients who had attended accident and emergency or who had had contact with the out of hours service. These meetings were attended by the community matron, social worker, (if available), care co-ordinator GPs practice nurses and one of the practice managers. Regular multi-disciplinary meetings were held to share information about children at risk. Staff reported that these arrangements for multi-disciplinary working were effective and worked well.

We were told by a representative of a care home that the practice worked with patients with a learning disability, empowering them to manage their healthcare needs where appropriate. The practice had a high proportion of individuals experiencing poor mental health and they worked with the community psychiatric nurses and the relevant psychiatrist.

Information sharing

The practice used an electronic system 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. If a patient called 111 the detail of the call was passed back to the practice by email or fax and followed up by a GP on the day. The GP contacted the patient to follow up on their call to 111 if they felt this was required.

Electronic systems were in place for making referrals, and the practice used the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Unless the patient was elderly or vulnerable patients were responsible for arranging their appointments at secondary services. If a patient was elderly or vulnerable this was done for them by the practice staff.

Feedback we had from patients on the day of our inspection reflected that the system for referrals to secondary or specialist services worked well. For example one patient told us that their experience had been very good, they received their appointment in the required timeframe and the GP received the relevant results from the specialist service.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. The nurses we spoke with had both received training in the Mental Capacity Act 2005. One of the nurses gave an example of how she had used this act when providing an influenza vaccine to a patient with a diagnosis of dementia. The same nurse was aware of the importance of patients with dementia having power of attorney for both health and finance.

Care home staff we spoke with confirmed that the GPs involved people living in the care home about decisions about their care, and were aware of when people may lack capacity, for example people with dementia. In these situations the GPs liaised with the care home staff who knew the patients and their families well

Staff were familiar with Gillick competencies. (Gillick competencies are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.) We found the clinical staff we spoke with understood the key parts of the legislation and were able to describe, using the different scenarios, how they implemented it in their practice.

The nursing staff we spoke with were aware of the arrangements for gaining parental consent before issuing a vaccine. They were clear that childhood vaccinations would not be given if the child were brought in by a person other than the parent, for example by a grandparent or child-minder. The nursing staff were aware of the importance of obtaining informed consent from patients. They told us they described the examination or treatment to the patient in advance and obtain consent before proceeding to gain informed consent. We were informed by one of the GPs how they made sure information was available to patients prior to giving consent to any minor surgery. We saw an example of a consent form that had been completed for a patient who had undergone a minor surgical procedure.

Information about advocacy services was readily available in the patients' waiting room. Staff we spoke with were aware of advocacy services and some told us they accessed this information using the practice's computer system. For example patients who had problems with alcohol dependency were signposted to a service known as "Last Orders".

Health promotion and prevention

Good

Are services effective?

(for example, treatment is effective)

The practice kept a register of patients with a learning disability and invited these patients to attend for an annual health check. At the time of our inspection 35 out of 50 patients had been invited to attend for an annual health check and all had been completed. Staff were working to improve in ensuring all clients from this group had their health checks.

The practice identified that 75.3% of all patients over the age of 15 years who smoked had been referred for smoking cessation advice run by "New Leaf" service. We asked the practice manager and the nurses if there was any data which provided success rates, but we were told that the independent provider had not made this available.

The practice's performance in respect of the percentage of women who had attended for cervical screening was 81.9% which was higher than the national target of 80%. The practice performance for bowel cancer screening was only 42.1% uptake which is significantly lower than the CCG Average of 53.8% Breast screening uptake was recorded as 67.6% which was lower than the CCG average of 70.4% The practice had responded to these low figures by working with the CCG to try and find ways to improve screening uptake. We saw evidence in the library which had a section dedicated to health promotion and screening.

The practice had performed in line with other local practices in respect of the number of patients with long term conditions who had received a flu vaccine. Ninety six point two percent of patients with a diagnosis of diabetes, 97.1% of patients with chronic obstructive pulmonary (COPD) disease and 96.7% of patients who had experienced a stroke had this vaccine. .

Childhood immunisation rates were lower than the CCG average in those children under the age of five years. The practice had been working with the CCG to try and find ways to improve these rates. However the practice was aware of factors such as a high number of patients who were only registered at the practice for a short period of time which could influence this uptake.

The practice offered an eight week check for new babies which included a post natal check for the mother and vaccination/development check for the baby. A medical questionnaire was available for new patients to complete as part of the registration process. This was available online. New patient checks were available with the healthcare assistant for new patients. The website reflected that the online registration services are available for 19 groups of patients whose first language was not English.

The practice website offered comprehensive health promotion advice on family planning and minor illness with more besides.

Health promotion information was available in the patients' waiting room. This included, for example, information about weight loss, eating well with diabetes, traveller health including travel to the Middle East, dental care and sexual health. There was information about common viruses and how to treat them. The practice website provided a search facility for services such as opticians and dentists.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Our observation of patients attending the reception area of the practice was that they were treated with respect. There had been previous concerns raised by the Patient Participation Group (PPG) with regards to maintaining patient confidentiality. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

However the practice had reorganised the seating in the waiting room to improve the situation and patients had reported that this is working well.

Patients we spoke with were positive about how they were treated by staff. One patient we spoke with said that they felt the GPs had a good understanding of patients with dementia. Another patient we spoke with described the reception staff as friendly. Other patients we spoke with were positive about their experiences at the practice.

Before our inspection we left comment cards for patients to complete to give their views on the practice. We received 35 completed comment cards. The majority of comments we received were positive about their treatment by staff. They described staff as friendly, respectful and helpful. One person commented on how staff at the practice took time to listen and they did not feel rushed.

In the national GP patient survey published in January 2015 90% of the patents reported that the last GP they saw or spoke to was good at listening to them which was above the local CCG average of 87%.

We reviewed those comments to Health watch and NHS Choices over the preceding 12 months. Some comments were positive about their experience at the practice and others less so; referring negatively to the availability of appointments. The practice responded to these comments on the website.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. We noted in the staff training records that some staff had been trained in handling difficult conversations.

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection told us that they felt involved in decisions about their care. They told us that they did not feel rushed and that the staff took time to explain things to them.

Those patients, who commented, using our comment cards, did not raise any concerns about their involvement in their care.

Data from the NHS GP patient survey from July 2014 identified that 87% of respondents said that the last GP they spoke to was good at explaining tests and treatments which was slightly above the local CCG average of 85%. This finding was supported by data from the NHS Friends and Family test comment cards where patients described that they felt GPs listened to them which helped them to cope with their illness. Eighty two percent of respondents indicated that the last GP they saw or spoke to was good at involving them about their care, this was above the CCG average of 80%.

Representatives of the care homes we spoke with told us that they found the GPs at the practice were courteous and involved people in discussions about their care.

During our discussions with staff we were provided with examples where staff had assisted more vulnerable patients to make decisions about their care arrangements.

Patient/carer support to cope emotionally with care and treatment

Notices in the patient waiting room and on the practice's website told patients how to access a number of support groups and organisations. Information was available about support groups and organisations. For example to support patients with asthma, patients experiencing poor mental health and those who had had a stroke.

The practice had a carers' identification protocol which included how to identify a carer, recording on the patients records and maintaining a register of carers. The practice had information about referral to the local carer support group. Information for carers was available on the waiting room noticeboard.

We spoke with one patient who described positively their experience of the emotional support provided by the practice when they were a carer. They said they were given advice on other services available to support them. One patient described the staff as very caring and committed to their patients.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had considered the potential for increased demand for patients to register with Wellspring Surgery. For example the practice had discussed the potential need to increase staffing levels with the CCG and the landlord of the building to rectify issues with the building lease.

The practice understood the needs of its diverse patient population which included members of the travelling community and individuals who were homeless. We saw evidence interpreters were booked for patients where English was not their first language and that appointment times were extended to 20 minutes to accommodate their needs.

A care home representative told us that they found the practice was responsive to patients' needs with the GPs responding promptly if a person living in the home became acutely unwell. . We were informed that the GPs supported people to remain at the care home and reduce any need for a hospital admission.

The practice had a comments box in the patient waiting room area. Representatives of the patient participation group (PPG) told us that any suggestions made were discussed at the PPG meetings. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.)

PPG representatives told us of changes made by the practice following discussions with them, which included a review of the appointment system for patients attending for phlebotomy (blood testing) appointments. The PPG acknowledged that the membership did not reflect the local population with a lack of members representing mothers with young children. The PPG were working with the practice to actively try and recruit such individuals. We saw evidence in the meeting minutes from the last PPG meeting in March 2015 that there was one mother who was interested in joining the PPG and was to be approached.

Tackling inequity and promoting equality

There was a high proportion of patients whose first language was not English registered with the practice; translation services were available to support them in their consultation We saw evidence of how the practices clinical system flagged the patients who required the services of an interpreter when they called in for an appointment.

We saw evidence on the electronic booking system that patients were able to make appointments with male or female GPs.

The practice had 50 patients with dementia who were registered with the practice and we saw evidence on the electronic booking system that these individuals were offered extended appointment times to accommodate their needs.

The premises had lift access meaning that they were accessible to patients who had a physical disability or mobility difficulties. We saw a dedicated room was available for mothers who were breast feeding. During the inspection we observed that adequate baby changing facilities were available.

The practice had a loop system for patients who had a hearing impairment.

The practice registered patients who did not have an fixed abode and took the lead in providing clinical care for a nearby homeless hostel. Members of the travelling community were registered at the practice. The practice was aware of their patients who did not remain in the practice area and their figures showed a yearly 12% turnover rate.

Access to the service

The national GP patient survey published in 2015 noted that 65% of respondents described their experience of making an appointment by phone as good. This was below the Clinical Commissioning Group average of 75%. The practice had advertised that patients could make appointments on line. However to date there has only been a 0.4% take up with this service.

Appointments with the GP were available on Monday, Tuesday, Wednesday and Friday from 8.30am to 12.30pm and 1.30pm to 6.30pm. The practice closed on a Thursday afternoon at 1pm. The practice did not offer extended hours.

Any patient who called the surgery for an appointment on the day to see any GP was invited to attend the Sit and Wait clinic.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Thirty out of 90 patients who completed the PPG patient survey commented that they could get through on the phone quite easily. Thirty six out of 90 patients who completed the same survey commented that they were able to see a GP quickly, or within two days if necessary.

The practice staff were aware of the heavy demand for appointments and data provided by the practice demonstrated that in one week 576 patient appointments were offered plus 41 home visits. The data highlighted that the practice had seen 70 extra patients during that one week. These figures demonstrated a high number of patient appointments were provided.

The Practice had employed a consultancy firm to analyse their appointment system and plan to make decision as to whether a telephone triage system was necessary to cope with the increasing demand. We saw evidence that this issue was to be addressed at the next PPG meeting in June.

Three patients we spoke with said they found it was easy to get a non-urgent appointment. One patient commented positively on the arrangements to get an emergency appointment.

Some patients, in their comment cards, reflected that it could be difficult to get a non-urgent appointment, but commented that the practice was doing something about this situation. In addition one patient who completed our comment cards reported that they were not always able to see the same GP.

The practice website provided contact details of the 111 service which was available outside of the practice opening times. The practice leaflet provided contact details for the nearest NHS Walk In Centre and provided a telephone number for the local out of hour's service when the practice was closed.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

Information about how to complain was displayed in the practice for patients. We saw evidence of a poster in the waiting area to this effect. The practice leaflet provided information for patients as to how to complain.

During our inspection we found that all patient complaints were investigated and appropriately responded to in a timely manner. All the complaints we reviewed offered the patient an apology. We found that complaints were discussed during the weekly clinical meetings. This was reflected in the minutes of the February and March 2015 clinical meetings which we reviewed. We were informed by the practice manager that the learning from any complaints was discussed with any staff directly involved and we saw evidence of this in a complaint we reviewed which related to an incident regarding poor infection control with one of the nursing staff.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a mission statement which had been developed with staff. We saw a business plan which addressed the financial aspects and other potential business to move the practice forward in the next year.

All the staff we asked, including administration, receptionists and nurses described the practice ethos as one where they aimed to treat patients with respect, and equal treatment of all patients; that the practice was patient focussed.

It was evident that the practice had considered the future needs of its population and was taking steps to address this. We saw evidence of correspondence between the practice and the Clinical Commissioning Group (CCG) in an attempt to address the situation of the building lease which was preventing any further expansion, which is beyond the practice control.

Governance arrangements

We reviewed five policies and procedures and found that all were up to date and detailed future review dates. The policies and procedures were available on the practice's computer system.

Different staff had lead roles with in the practice, and every GP partner had a lead role. Examples included a lead member of staff for safeguarding, one GP was the IT lead, with one GP leading on the Quality and Outcomes Framework (QOF) and managing the practice nurses. Individual GPs took responsibility for the different long term conditions. This was reflected in the practice minutes where we saw evidence of actions to be taken from safety alerts, significant events and patient complaints.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures.) We found that the QOF data was used to help drive improvements in the services provided. Staff told us that QOF data was regularly discussed at the general practice meeting. The minutes we saw reflected that all areas of performance were discussed and included forward planning and any outstanding areas of work to be addressed.

Leadership, openness and transparency

The practice held regular monthly practice meetings. Staff described the meetings as a forum for a two way conversation. The practice manager told us that staff requested informal one to one sessions. Staff told us they felt valued and listened to. The practice manager told us that the management team had an "open door policy" and we witnessed this during our inspection.

The nursing staff we spoke with reflected that they felt the senior staff were approachable. Although there was a designated lead GP for the nursing team, we were told by one of the nurses with whom we spoke that they could approach any of the GP partners.

A staff whistleblowing policy was in place in the practice.

Seeking and acting on feedback from patients, public and staff

The practice had a PPG that met together. The PPG representatives we spoke with told us that they received feedback on patient and public suggestions submitted using the suggestion box in the waiting areas of the practice. They told us that they felt that feedback they gave was taken account of by the practice. We saw that the practice considered areas for improvement arising out of complaints; for example improving the telephone system to improve access and the use of the consultancy firm to address the appointment issues.

The practice, supported by the PPG, carried out an annual patient survey. The most recent patient survey was carried out in February 2015, following consultation with the PPG as to the questions to be included. This survey highlighted some concerns with the turnaround time for prescriptions. However the practice responded by suggesting that when they change to the Electronic Prescription service, this situation should improve.

Management lead through learning and improvement

We found that staff had regular appraisals which included a development plan. There was evidence that staff were supported to attend training to improve the services

Are services well-led?

Good

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

provided to patients. Staff we spoke with confirmed that the practice was pro-active in respect of training. This included both online learning as well as other courses dependent on need.

The practice was a training practice. The trainee GP we spoke with was positive about their experience at the practice. The practice had medical students from the local University however we were not able to speak to a student as they were not working on the day of the inspection. However GPs commented that the students provided good evaluations of their learning experience during their placement at the surgery.

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