Oakham Surgery

Quality Report

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Oldbury,
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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.

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Summary of findings

Overall summary

We inspected Oakham Surgery 213 Regent Road, Tividale, Oldbury, West Midlands, B69 1RZ which provides primary medical services for a local population of approximately 11595 patients. The practice is a training practice for GP Registrars (fully qualified doctors who wish to become general practitioners) and an approved teaching practice for medical students. At the time of our inspection the practice employed seven permanent GPs, two specialist nurse practitioners and two practice nurses. There were also two healthcare assistants, 16 administrative staff, and a practice manager.

We spoke with 13 patients including two members of the patient participation group (PPG). PPGs are a way in which patients and GP surgeries can work together to improve the quality of the service. We spoke with clinical, administrative staff and members of the management team. We also reviewed a range of information we hold about the service and we asked other organisations to share what they knew about the service.

Systems were in place to ensure patients were safe, this included effective safeguarding policies and procedures that were fully understood and acted on by staff. There was an open culture within the practice and staff felt they were able to raise and discuss any issues with the practice manager or the GP partners.

There was evidence of completed audit cycles undertaken to ensure patients' care and treatment was effective and which improved the quality of the service.

Patients described staff as caring and told us that their privacy and dignity was respected and they were involved in making decisions about their care and treatment.

The practice had suitable arrangements in place to respond to patients with a variety of health needs.

We determined that the practice was well-led as leadership roles and responsibilities were well established with clear lines of accountability. There was evidence that the practice had robust systems in place for assessing and managing risks and monitoring the quality of service provision.

Data that we reviewed showed that the practice population included around 12% of patients from a minority ethnic group and a higher percentage of the practice population than the England average were aged 18 or below. The data showed that the practice was one of a number of practices in NHS Sandwell and West Birmingham Clinical Commissioning Group (CCG) that had a high deprivation score than the England average with poverty affecting children and older people. A CCG is an NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services.

Patients over the age of 75 years had a designated GP and specific care pathways in place to ensure coordinated continuity of care.

Patients with long term conditions were reviewed by the GP, the practice nurse and at the chronic disease management clinic.

The practice had a midwife clinic three times a week to provide ante natal care and access to health visiting services so that children under the age of 5 years had access to the Healthy Child Programme.

There were late evening and weekend surgeries to accommodate the needs of working age patients.

The practice was part of the scheme to avoid unplanned admissions. This focused on coordinated care for the most vulnerable patients with the aim to avoid admission to hospital by managing their health needs at home.

The practice had joint working arrangements with local mental health services.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?
The service was safe.

There were systems in place to ensure patients received a safe service. There was evidence of regular checks of emergency medicines and equipment. There was information and guidance on local reporting arrangements for safeguarding children and vulnerable adults so that any concerns could be appropriately investigated and addressed.

Are services effective?
The service was effective.

There was evidence of completed audit cycles undertaken to ensure patients care and treatment was effective and achieved positive outcomes and improved the quality of the service. We found the practice had joint working arrangements with other health care professionals and services. The GP and practice nurses had a collaborative approach to working to ensure patients' care and treatment was managed effectively.

Are services caring?
The service was caring.

Patients were complimentary about the service that they received and said that staff at the practice listened to their concerns and were understanding. Patients told us that their privacy and dignity was respected and they were involved in making decisions about their care and treatment.

Are services responsive to people's needs?
The service was responsive to people's needs.

The practice had arrangements in place to respond to the needs of the practice population. These included services aimed at specific patient groups and ensured the service was accessible to a variety of patients with different health needs. The practice had a system in place to respond to complaints and concerns in a proactive manner.

Are services well-led?
The service was well-led.

Leadership roles and responsibilities were well established with clear lines of accountability. There was evidence that the provider

Summary of findings

had robust systems in place for assessing and managing risks and monitoring the quality of the service provision. There were arrangements for staff to learn and improve the service as result of incidents and complaints to reduce the risk of reoccurrence.

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
Patients over the age of 75 years, including those living in care homes had a designated GP. This was an accountable GP to ensure patients over the age of 75 years received co-ordinated care. There were specific care pathways appropriate for older patients such as the falls clinic. Home visits were available for those older patients who were unable to attend the practice. A GP undertook a surgery at the care home's every two weeks. These ensured patients' needs were reviewed.

People with long-term conditions
Patients with long term conditions were reviewed by the GPs, the practice nurses and at the chronic disease management clinic to assess and monitor their health condition so that any changes could be made. Patients on repeat prescriptions were reviewed to assess their progress and ensure that their medications remained relevant to their health need.

Mothers, babies, children and young people
The practice had a midwife clinic three times a week to provide ante natal care and a health visiting services for children under the age of 5 years so they had access to the Healthy Child Programme. Babies and children were offered same day appointments when they were unwell to ensure they were assessed promptly. The GPs undertook six week checks for babies and this was coordinated with the mother's post natal check. Immunisations clinics were held for childhood vaccinations.

The working-age population and those recently retired
There were late evening and weekend surgeries to accommodate the needs of working age patients. The practice was opened on an alternate Tuesday and Thursday from 6:30pm to 7:30pm and every third Saturday from 8:40am. This enabled patients who worked to attend in an evening or at weekend. NHS checks were available for people aged between 40 years and 74 years.

People in vulnerable circumstances who may have poor access to primary care
Patients who were vulnerable due to their health or social circumstances were offered health checks. Appropriate information was shared and referrals were made to relevant agencies and health

Summary of findings

care professionals to ensure their health and wellbeing. The practice had access to interpreting service for patients whose first language was not English and information on the practice website was accessible in 81 languages.

The practice was part of the scheme to avoid unplanned hospital admissions by providing an enhanced service. This focused on coordinated care for the most vulnerable patients with the aim to avoid admission to hospital by managing their health needs at home. An enhanced service is a service that is provided above the standard general medical service contract.

People experiencing poor mental health

The practice had joint working arrangements with local mental health services, a counsellor undertook a clinic at the practice twice weekly to support patients with mental health needs and there was a substance misuse worker who undertook a clinic once a month at the practice.

Summary of findings

What people who use the service say

We looked at results of the national GP patient survey carried out in 2013. Out of the 286 surveys sent 107 were completed and returned. Findings of the survey were based on comparison to the regional average for other practices in the local Clinical Commissioning Group (CCG). A CCG is an NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services. Areas in which the practice was doing well included patients waiting 15 minutes or less after their appointment time to be seen and the number of patients who would recommend the practice to someone new to the area. Areas for improvements identified included the accessibility of appointments, although the ranges were above the average in comparison to other practices in the CCG. This demonstrated that overall the feedback was positive.

We spoke with 13 patients including two members of the patient participation group (PPG). PPGs are a way in which patients and GP surgeries can work together to improve the quality of the service. Nearly all of the patients who we spoke with were satisfied with the service. All of the patients described the staff at the practice as caring and told us that their privacy and dignity was respected. Patients said that the GPs listened to their concerns and were understanding and they felt involved in making decisions about their care and treatment. As part of the inspection we sent the practice comment cards so that patients had the opportunity to give us feedback. We received nineteen completed cards all with positive feedback. The findings of the GP patient surveys and comment cards supported what patients told us on the day of the inspection which was that patients were happy with the service that they received.

We reviewed comments made on the NHS Choices website to see what feedback patients had given. We saw that most of the comments were very positive and the practice had responded to all of the comments including any negative comments in a constructive manner.

Areas for improvement

Action the service SHOULD take to improve

The practice should review the recruitment policy and procedure to ensure it fully reflects all areas of robust recruitment so that they can be consistently implemented. This includes risk assessing staff who do not have a Disclosure and Barring Service check (DBS). The DBS check is a criminal records check that helps identify people who are unsuitable to work with children and vulnerable adults.

The practice should put systems in place to ensure emergency medicines are kept within the recommended temperature ranges so they are safe and effective to use in the event of a medical emergency.

Oakham Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a second CQC inspector. The team also included a specialist advisor GP and a practice manager with experience of primary care services.

Background to Oakham Surgery

Oakham surgery has seven permanent GPs, two specialist nurse practitioners and two practice nurses. There are also two healthcare assistants, 16 administrative staff and a practice manager. The practice is part of NHS Sandwell and West Birmingham Clinical Commissioning Group (CCG) which has a membership organisation involving 110 GP practices serving around 530,000 patients. A CCG is an NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services.

The practice had opted out of providing out-of-hours services to their own patients. This service was provided by an external out of hours service contracted by the CCG.

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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

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

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health.

Before visiting, we reviewed a range of information we had received from the out-of-hours service and asked other organisations to share their information about the service.We carried out an announced inspection on 11 August 2014. During our inspection we spoke with a range of staff including managers, clinical and non clinical staff. We spoke with patients who used the service and family members. We observed the way the service was delivered but did not observe any aspects of patient care or treatment.

Are services safe?

Our findings

The service was safe.

There were systems in place to ensure patients received a safe service. There was evidence of regular checks of emergency medicines and equipment. There was information and guidance on local reporting arrangements for safeguarding children and vulnerable adults so that any concerns could be appropriately investigated and addressed.

Safe Track Record

There was evidence to support that the practice had a good track record on safety with no major incidents that had occurred. There was a lead GP responsible for checking safety alerts. Their role involved responding to any alerts and taking appropriate action. Safety alerts were then discussed with staff in practice meetings. Patient safety alerts are issued when potentially harmful situations are identified and need to be acted on. We saw evidence of a safety alert that had been acted on.

The practice had a system in place for reporting, recording and monitoring incidents and significant events and there were arrangements in place to share learning with staff. A significant event is any event thought by anyone in the team to be significant in the care of patients or the conduct of the practice. The practice had systems in place for identifying and managing risks to patients. Staff told us that an alert system was in place on patients' computerised records, for example where an individual was vulnerable, at risk of abuse, or at risk of being admitted to hospital. This ensured patients received appropriate support, and that relevant professionals were involved, where required.

The practice had a whistle blowing policy and staff told us that they felt confident to raise any concerns about poor care that could compromise patient safety. Whistleblowing is when staff are able to report suspected wrong doing at work, this is officially referred to as 'making a disclosure in the public interest'. Patients spoken with did not report any safety concerns to us.

Learning and improvement from safety incidents

There was evidence that staff were reporting incidents and these had been recorded. There was an extensive folder with detailed significant event audits which showed clear evidence of completed audit cycles, learning and dissemination of information to staff. A significant event is any event thought by anyone in the team to be significant in the care of patients or the conduct of the practice. A policy for significant events was in place and regularly reviewed. When a significant event occurred the practice manager would coordinate the investigation and the event would also be shared with staff in meetings, where they were discussed openly to promote shared learning. We were given an example of action taken as a result of a significant event to reduce the likelihood of reoccurrence.

Reliable safety systems and processes including safeguarding

There were arrangements in place for ensuring patient safety, this included clear safeguarding policies and procedures for staff to respond to any concerns. Most of the staff had attended training in vulnerable adults and safeguarding children. A GP trainee had only been in post a few days, and was due to receive training after six months in post. Clinical staff had completed level 3 safeguarding children training. This level of training helps develop knowledge, skills and the ability to work collaboratively on the processes for safeguarding and promoting the welfare of children.

Staff who we spoke with were able to demonstrate knowledge and awareness of safeguarding vulnerable adults and children and were clear and confident they would recognise and respond to any concerns. Staff were aware of the role of the safeguarding lead GP and said they would refer to them for advice and guidance. There was evidence that safeguarding concerns were identified and acted on in line with local safeguarding procedures. There were arrangements in place to share information of concern such as regular multi-disciplinary meetings with health care professionals.

The practice had a chaperone policy in place and a large number of staff had received training in this area. Staff who we spoke with were aware of their role and responsibilities when undertaking this duty.

Monitoring safety and responding to risk

Records showed that essential risk assessments had been completed, where risks were highlighted measures had been put in place to minimise the risks. Various risk assessments had been reviewed recently, including fire safety and the control of substances hazardous to health (COSHH).

Are services safe?

There were arrangements to deal with foreseeable emergencies. Staff had received training in responding to a medical emergency and fire awareness. There were emergency medicines and equipment available that were checked regularly so that staff could respond safely in the event of a medical emergency. The practice had an automated external defibrillator (AED). This is a piece of life saving equipment that can be used in the event of a medical emergency.

Medicines management

There were systems in place to ensure emergency medicine and equipment were safe and effective to use in the event of a medical emergency. We noted that information on most of the medicines stated that they should not be stored above a specified temperature range. However, staff confirmed that there was no system in place to monitor the temperature of the environment so that they could be confident that the medicines were stored within the recommended temperature range. Immediately after our inspection the practice manager told us that arrangements were in place to ensure the temperature of the environment where emergency medicines were stored was regularly monitored. We will review this again at our next inspection.

There were two dedicated secure fridges where vaccines were stored. There were systems in place to ensure that regular checks of both fridge temperatures were undertaken and recorded. This provided assurance that the vaccines were stored within the recommended temperature range and were safe and effective to use.

Prescriptions were stored appropriately to reduce the likelihood of misuse. A repeat prescribing protocol was in place and included guidelines for issuing repeat prescriptions to patients on monitored medicines. These were medicines that required patients to have their blood test undertaken regularly to ensure the dosage was correct.

There was a pharmacy based in the surgery independent of the practice. The pharmacy was open late into the evening. Some patients commented on how useful they found this.

Cleanliness and infection control

On the day of our inspection the practice was visibly clean and tidy. There were systems in place to reduce the risk of cross infection such as the availability of personal protective equipment (PPE) and colour coded cleaning equipment. Information about hand hygiene was on display to help promote good hand hygiene. Staff had received training in infection prevention and control and our discussion with staff demonstrated their understanding.

We found that suitable arrangements were in place for the storage and the disposal of clinical waste and sharps. Sharps boxes were dated and signed with the date of use to enable staff to monitor how long they had been in place.

Infection prevention and control policies and procedures were in place to guide staff and ensure staff adhered to good practice. The practice employed cleaners to carry out daily cleaning duties. Cleaning schedules were in place and records were kept of cleaning carried out. Regular cleaning audits were also completed to ensure standards of cleaning were monitored and kept under review.

Records showed that individual hand hygiene audits for staff had been recently completed. Staff told us that an annual infection control audit was completed. However, we were unable to view the most recent audit on the day of the inspection as the practice manager was unable to locate the audit. This was because the lead person was on leave.

A legionella risk assessment had been reviewed recently to ensure that any risks to patients from potential contaminated water was identified and acted on. Legionnaires' disease is a form of bacteria which can live in all types of water.

Staffing and recruitment

The practice had a relatively large patient list size of 11595 patients. The staffing establishment reflected the patient list size and consisted of seven permanent GPs, two specialist nurse practitioners and two practice nurses. There were also two healthcare assistants, 16 administrative staff and a practice manager.

There were systems in place to monitor and review staffing levels to ensure any shortages were addressed and did not impact on the delivery of the service. This included the practice being proactive and planning ahead, for example, limiting the number of GPs who could be on leave at any one time. The practice manager confirmed that most of the staff had worked at the practice for a number of years which provided stability within staff team that ensured patients received continuity in their care. The practice had no staff vacancies at the time of our inspection and any shortfall in GPs, nursing or administrative staff as a result of sickness or leave was covered by internal staff.

Are services safe?

There was evidence that some of the appropriate pre-employment checks were completed prior to staff commencing their post. All of the clinical staff employed at the practice had a Disclosure and Barring Service (DBS) check. The DBS check is a criminal records check that helps identify people who are unsuitable to work with children and vulnerable adults. However, non clinical staff did not have a criminal records check in place although some staff said that they undertook duties as chaperoning. There were no risk assessments in place to identify why these checks were not needed or to continually risk assess staff suitability to work with children and vulnerable adults. Following our inspection the practice manager told us that non clinical staff now had either a DBS check or risk assessment in place. We will review this again at our next inspection. We also identified gaps in the recruitment process. We looked at three staff files and found no information about any physical or mental health conditions, which were relevant to the staff member's ability to carry out their work. We discussed this with the practice manager at the time of the inspection. They explained that arrangements for occupational health assessment and screening were previously undertaken through a local occupational health team. This service had ceased as the funding had been withdrawn. They acknowledged that action was required to address the issue.

The practice had recruitment policies and procedures in place although we identified gaps and inconsistencies in the policy. For example, the recruitment policy stated that occupational health assessment should be completed before the job was offered and we found that this had not happened on all occasions There was also no reference to risk assessments for staff that were judged not to require a criminal records check.

We saw evidence that clinical staff had current registration with their professional body Membership of a professional body provides evidence that staff meet the standards required by their professional body and that they had the right to practice. A computer system was in place to monitor and oversee the renewal process.

All of the GPs employed at the practice were part of the local NHS Medical 'Performers List'. Any doctor who wishes to perform general medical services (GMS) must be on a performers list.

Dealing with Emergencies

The practice had a business continuity plan which covered a range of areas of potential risks relating to foreseeable emergencies such as adverse weather and the plan demonstrated how these risks could be mitigated to reduce the impact on the delivery of the service.

Equipment

Discussions with staff demonstrated and records showed that systems were in place to ensure that all equipment used in the practice was regularly maintained to ensure they were good working order and safe to use. The fire alarm system and emergency lighting was serviced and electrical appliances were tested. One of the nurses we spoke with told us that they regularly checked all single use items and stock supplies, to ensure that the supplies remained in date.

A schedule was set out, which listed all equipment available in each room, including when it required calibrating and servicing. Records showed that equipment had been calibrated and serviced at regular intervals.

Are services effective?

(for example, treatment is effective)

Our findings

The service was effective.

There was evidence of completed audit cycles undertaken to ensure patients care and treatment was effective and achieved positive outcomes and improved the quality of the service. We found the practice had joint working arrangements with other health care professionals and services. The GP and practice nurses had a collaborative approach to working to ensure patients' care and treatment was managed effectively.

Effective needs assessment, care & treatment in line with standards

The minutes of clinical staff meeting viewed showed a wide range of subjects were discussed affecting patient care and welfare. This included the need for a named GP for patients over the age of 75 years and emergency health care plans to help avoid unplanned hospital admissions. Clinical staff also attended regular meetings with relevant professionals and agencies to discuss and review patients who had complex needs, in vulnerable circumstances or were receiving end of life care. This ensured that their wishes were respected, and that they received appropriate support and treatment. Patients with a learning disability were offered annual health checks.

We spoke with local care home managers about the arrangements for reviewing patients who were unable to attend the practice. One told us that the practice had completed their own care plans, which took account of people's wishes, preferences and needs with the aim to help minimise unnecessary admissions to hospital. The GP allocated to the home had reviewed everyones' needs including a review of their medication and an up to date care plan was put in place.

The practice training records did not demonstrate that all of the staff had received formal training on the Mental Capacity Act (2005). The practice manager confirmed that staff had received 'in house' training. There was also a GP lead for mental capacity issues and staff could refer to them for advice and support. Information was available on the principles of the Mental Capacity Act (2005) on the practices intranet. Our discussions with staff and evidence reviewed on the day showed that if a patient lacked the capacity to consent to their care and treatment, staff would act in accordance with the legal requirements of the Mental Capacity Act (2005). We were given an example where a GP had referred to national guidance to determine whether a patient under the age of 16 years old was 'Gillick competent'. This guidance is helps assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions. There was up to date policy on consent to guide staff on best practice and ensure consistency in practice.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles, although we found that some audit cycles were incomplete as there was a lack of evidence to support that the findings had been acted on. Audits should be full cycle to show the initial audit, changes implemented and re-auditing to demonstrate the improvements made. There were examples of completed clinical audits that had resulted in changes to practice and improving outcomes for patients. For example the practice had a high prescribing rate for a specific medication, an audit was undertaken the findings analysed and this had resulted in a reduced rate of prescribing. An audit was also completed on palliative care patients to ensure that the patient list for the out of hours service (OOH) was updated, ensuring the OOH service provider had the information they needed to care for patients when their GP practice was closed. Audits were undertaken as part of GPs' appraisal and revalidation process. Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise medicine. Licensed doctors have to revalidate usually every five years, by having annual appraisal based on core guidance for doctors.

Some of the GPs in the practice undertook minor surgical procedures in line with their registration and best practice guidance. The GPs were appropriately trained and kept up to date.

There were arrangements in place to ensure women received cervical smear tests by staff that were appropriately trained. Samples were sent to a local NHS hospital to be analysed and reported on.

The practice carried out reviews as part of the Quality and Outcomes Framework (QOF). The QOF is the annual reward and incentive programme which awards practices achievement points for managing some of the most common chronic diseases, for example asthma and

Are services effective?

(for example, treatment is effective)

diabetes. Data that we reviewed showed that overall the practice was performing above average in comparison to other practices in the local Clinical Commissioning Group (CCG). A CCG is an NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services. For example to date for the year 2013-14 the practice performance for childhood Immunisation and vaccination score was 95%.

Effective Staffing, equipment and facilities

There were clear policies and procedures in place in regard to staff induction, training and appraisals. This ensured that staff working at the practice received appropriate training and support to carry out their work. We saw examples of completed induction checklists in staff files, which had been signed by the manager and the staff member. There was evidence of mentorship for a recently qualified nurse. The salaried GP at the practice was mentored to provide on going support and guidance by a GP who was also a partner at the practice.

Staff spoken with told us that they worked together as a team and felt well supported. They told us that they received time for learning and had attended appropriate training to enable them to carry out their work. For example a nurse practitioner who worked alongside the lead GP for sexual health at the practice attended a sexual health conference twice a year to update their knowledge and skills. Discussions with staff and records showed that staff had received supervision through peer support, mentoring and regular team meetings they attended. Regular clinical supervision sessions for nurses was in progress to enable nurses to share their experiences and discuss best practice. There was evidence of learning and development opportunities for staff and reviews of roles and responsibilities to fully utilise staff skills and expertise.

We saw evidence that staff had received training in core areas such as basic life support, infection prevention and control and safeguarding vulnerable adults and children. Staff training was recorded on a training record which provided a system to monitor staff training needs. The staff we spoke with on the day of the inspection said that they had received fire awareness training and were aware of the fire procedure .However, we saw that some staff were due refresher training in fire awareness. The practice frequency for this training was annually, and some staff last had the training in February 2013. The practice manager told us that this training was in progress. Training updates would ensure staff knowledge and skills remained current and reflected best practice.

All of the GPs who worked at the practice had undergone an external revalidation of their practice.

The GPs and nurses at the practice had various lead roles in areas such as mental health and elderly care. This provided the opportunity for staff to develop specialist knowledge and expertise.

Working with other services

Discussions with staff and records showed that the practice worked in partnership with other health and social care providers such as social services, local mental health teams and district nursing services to meet patients' needs in an effective way.

Clinical staff attended regular meetings with relevant health care professionals and agencies to discuss and review patients who had complex needs, in vulnerable circumstances or were receiving end of life care. This ensured that their wishes were respected, and they received appropriate support and treatment. For example there was a monthly meeting with the palliative care team and a nurse at the practice had the lead role for palliative care.

The managers of three care homes we spoke with told us that the practice responded promptly to patients' needs, and visited when required. They all praised the fact that a named GP held a surgery every fortnight at their care home, which ensured that patients were regularly reviewed.

There were effective arrangements to review test results, relevant letters, and referrals and follow ups for patients.

The practice had opted out of providing out of hours services (OOH). This had been contracted by the CCG to an external service provider. The practice received an electronic summary for patients who had accessed the OOH service. These patients were reviewed and followed up where necessary by the doctor who was on duty each day.

Health, promotion and prevention

There was information in the practice leaflet that showed the types of health services available at the practice. This included smoking cessation and sexual health services.

Are services effective?

(for example, treatment is effective)

These provided patients with the information they needed to maintain good health. There were clinics led by the specialist nurse practitioners such as the minor illness clinic which aimed to review patients with common illness and aliments and a diabetes clinic. Patients who we spoke with on the day commented on how effective this clinic was in ensuing timely assessment of their minor health needs. Other services available at the practice included minor surgery and phlebotomy (the taking of blood).

There were systems in place to ensure patients received a review of their medicines which were undertaken by the GPs. This ensured patients' medications remained relevant to their health needs and any changes could be made. A recall system was in place so that patients received timely follow up for any tests or investigations undertaken as well as general reviews for long term health conditions.

All new patients over the age of five who wished to register with the practice were offered a consultation for a registration/health check to effectively assess the patients current health needs.

There was evidence of effective collaborative working between the GPs and nurses. For example a nurse practitioner worked alongside the lead GP for sexual health and the practice held a specialised sexual health clinic once a week.

Are services caring?

Our findings

The service was caring.

Patients were complimentary about the service that they received and said that staff at the practice listened to their concerns and were understanding. Patients told us that their privacy and dignity was respected and they were involved in making decisions about their care and treatment.

Respect, dignity, compassion and empathy

We looked at the results of the national GP patient survey carried out in 2013. Of the 286 surveys sent 107 were completed and returned. Findings of the survey were based on comparison to the regional average for other practices in the local Clinical Commissioning Group (CCG). A CCG is a NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services. Areas in which the practice was doing well included 71% patients who said that they were satisfied with the level of privacy when speaking to receptionists at the surgery and 87% of patients who said the last GP they saw or spoke to was good at treating them with care and concern. As part of the inspection we sent the practice a box with comment cards so that patients had the opportunity to give us feedback. We received 19 completed cards. They all gave very positive comments about the practice. Patients described staff as being helpful and polite and said they were involved in their care planning. Patients spoken with on the day of the inspection gave examples of being treated with dignity and respect.

We asked staff about bereavement support for patients. They told us they would signpost patients to bereavement services. We saw that there were information leaflets in the patient waiting area with details of bereavement support groups. A GP at the practice would also call bereaved relatives to offer support. There were arrangements in place to refer patients to counselling services for emotional support. Clinical staff attended regular meetings with relevant professionals and agencies to discuss and review patients who were receiving end of life care. Systems were in place to ensure palliative care patients received appropriate care when the practice was closed by ensuring the out of hours service provider had the information they needed to care for patients.

We saw information displayed in the patient waiting area and consultation rooms informing patients about the availability of chaperones. We saw privacy curtains were available in treatment rooms; and patients confirmed curtains were used during physical examinations to ensure their privacy and dignity.

A closed circuit television system (CCTV) was in operation inside the premises in the communal areas such as the waiting room. We saw there were signs on display informing patients of this and stated why CCTV was in operation. This information helps patients to understand the purpose of the cameras such as staff safety, or crime prevention reasons.

The storage facilities for patient records ensured that they were held securely and remained confidential. We found from our observations whilst sitting in the patients' waiting area and our discussions with patients that systems were in place to ensure patient confidentiality was maintained. There was a sign informing patients that they could speak in confidence away from the patient waiting area. Staff had also received training in patient confidentiality to improve their awareness and understanding.

Involvement in decisions and consent

We saw information leaflets in the waiting area. The information included details of advocates, groups and agencies to contact should patients require advice and support. Patients told us they felt involved in planning their care and making decisions. Patient told us the GPs would always ask how they felt, and took time to explain their treatment and options. This made them feel involved and informed about their care. Patients said that staff always provided clear explanation about any tests or treatment, the reason for these, and why they were being done. This enabled them to make informed choices and give their consent to any care and treatment that they received. Discussion with staff and evidence reviewed on the day showed that if a patient lacked the capacity to consent to their care and treatment, staff would act in accordance with the legal requirements of the Mental Capacity Act (2005).

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

The service was responsive to people's needs.

The practice had arrangements in place to respond to the needs of the practice population. These included services aimed at specific patient groups and ensured the service was accessible to a variety of patients with different health needs. The practice had a system in place to respond to complaints and concerns in a proactive manner.

Responding to and meeting people's needs

The demographics of the patient population showed that around 12% of patients were from a minority ethnic group. The practice had arrangements for accessing interpreting services for patients whose first language was not English. We saw that there was a self-check in service in the patient waiting area that had information in alternative languages. We found there was no written information displayed in different languages and formats. The practice manager told us that the patient population mostly spoke English as their first language. However, where possible they obtained copies of information leaflets in other languages and formats. This included a braille and audio copy of the flu leaflet .We saw that the practice website had a translate function which at the click of button converted all of the information into the patients chosen language, with 81 languages to choose from. Some of the GPs at the practice told us they were able to speak other languages and where appropriate they would use their language skills to communicate with patients.

The practice provided a wide range of services to meet patients' needs. Further services and clinics were being provided to enable more people to be treated locally by the practice. For example, a new clinic was being introduced in October 2014 for annual checks for people with dementia. A nurse specialising in dementia was also in post to provide support and advice to people who had dementia, including their carers. This was in response to national recognition of an increasing number of people with dementia

There were three female GPs working at the practice as well as female nurses so that patients had the choice of receiving gender specific care and treatment.

The practice had arrangements in place for responding to the needs of patients with a variety of health needs. Antenatal care was provided by the midwife who attended the practice, this enabled the GPs and midwives to discuss any issues face to face. A mental health counsellor held regular clinics at the practice to support patients. The practice opened extended hours on an alternate Tuesday and Thursday and every third Saturday allowing patients who worked to attend an evening or at weekend. There were no formal meetings with Health Visitors, however, the practice had an allocated health visiting team so that children under the age of 5 years had access to the Healthy Child Programme.

There was sufficient seating for patients in the waiting area. We noticed that there were no toys in the waiting area. Two of the patients with young children who we spoke with commented that the availability of toys would help make the environment more children friendly and enable children to remain occupied whilst waiting.

Staff described the arrangements in place to ensure that essential information about patients was shared with their consent to relevant providers and agencies at the earliest opportunity. Clinical staff told us that they worked closely with the out-of-hours service (OOH). Staff providing emergency cover, had access to essential information about patients' needs, including end of life wishes and specific health issues to help avoid inappropriate hospital admissions.

There were systems in place to assess, monitor and review the needs of patients who needed end of life care .This included a care plan in place for patients, multi-disciplinary meetings and a patient register which highlighted patients that had a high level of dependency so that these patients could be easily identified and their support needs met.

Administrative staff were responsible for ensuring that completed referrals were sent to secondary care services in a timely manner including urgent referrals. The practice proactively followed up test results for patients who had been referred to secondary care services.

Access to the service

The practice leaflet and practice website included information on the types of services available at the practice, opening times and the contact details to obtain medical care when the practice was closed.

We looked at results of the national GP patient survey carried out in 2013. Out of the 286 surveys sent 107 were completed and returned. Findings of the survey were based on comparison to the regional average for other practices in the local Clinical Commissioning Group (CCG). A CCG is

Are services responsive to people's needs?

(for example, to feedback?)

an NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services. Areas for improvements identified included the accessibility of appointments, although the range was above the average in comparison to other practices in the CCG. There was evidence that the practice was improving the accessibility of appointments by adding additional appointment slots to the end of morning surgeries and where appropriate referring patients to the specialist nurse practitioners.

A triaging system was in place for urgent appointments with a duty doctor reviewing patients with urgent needs. We spoke with health and social care providers such as care home managers about the arrangements for reviewing patients who were unable to attend the practice. They told us that the practice offered a telephone triage service and where necessary the GPs would undertake home visits to ensure patients' needs were managed effectively.

The practice had a ramp designed for wheelchairs and pushchairs that lead up to the main surgery entrance. There were disabled toilet facilities and a Loop Induction System for patients with hearing impairment.

Concerns and complaints

We reviewed comments made on the NHS Choices website to see what feedback patients had given. We saw that most of the comments were very positive and the practice had responded to all of the comments including any negative comments in a constructive manner.

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. The practice managed complaints proactively with a policy in place to deal with them. The systems in place enabled the practice to record and monitor complaints and identify themes and trends so that improvements could be made. Learning from complaints and concerns was shared with staff to reduce the likelihood of reoccurrence.

Are services well-led?

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

Our findings

The service was well-led.

Leadership roles and responsibilities were well established with clear lines of accountability. There was evidence that the provider had robust systems in place for assessing and managing risks and monitoring the quality of the service provision. There were arrangements for staff to learn and improve the service as result of incidents and complaints to reduce the risk of reoccurrence.

Leadership and culture

At the time of our inspection the practice was going through a period of transition involving a merger with two other practices. We identified during the inspection that this merger had resulted in changes to the provider's registration with, the Care Quality Commission (CQC) of which we had not been informed. Following our inspection the practice submitted the necessary application to make changes to the provider's registration. The practice manager acknowledged that the failure to inform us had been an over- sight. The merger had resulted in some changes to the organisational structure within the practice. However, staff told us that these changes had been implemented with minimum disruption to the service and had also resulted in positive changes to roles and responsibilities and the delivery of the service.

The aims and values of the service were clearly set out, and these were shared with the staff members. Staff were committed to providing high quality care and services. They described the culture of the organisation as supportive and open. They also said that they felt that the service was well run, and that the practice manager and GP partners provided supportive leadership.

Staff were encouraged to report incidents and complaints to improve the quality of the service. This showed a culture where transparency and openness was encouraged.

Governance arrangements

Staff told us that there was visible and strong leadership. The management structure included the practice manager who was also head of operations, the outlet operations manager and administrative supervisors. Nurses and GPs had lead roles and responsibilities that supported the governance framework at the practice.

We saw that the practice had a formal process to support clinical governance. This included incidents and complaints management and reporting. Clear lines of accountability were in place to ensure that the service was well managed. This was evident from comments from staff and records that we looked at.

The practice had its own intranet site called 'The Tree' developed by a member of staff. All of the staff had access to the site. The practice policies, procedures and relevant templates were placed on the intranet. Some of the staff commented that they had read the policies and procedures to ensure they followed appropriate guidance. This ensured that information was kept up to date and accessible to staff to enable them to be implemented in practice.

Systems to monitor and improve quality & improvement (leadership)

The practice had undertaken audits in areas such as prescribing, infection prevention and control and the management of patients with chronic disease.

We found that arrangements were in place to ensure the continuous improvement of the service and the standards of care. Following the recent merger, the staff team now had a lead nurse whose role was to oversee the clinical standards and practice. The nurse practitioners and the practice nurses roles had been reviewed, to fully utilise their skills and expertise. For example, the nurse practitioners now spent more time seeing patients who were acutely ill or required treatment for minor injuries.

Regular clinical supervision sessions for nurses was being established to enable nurses to share their experiences and discuss best practice. We saw that meetings took place for clinical staff which provided a forum for discussing clinical issues and ensuring practice reflected national guidance. There were systems in place to support staff learning and development which included an annual training programme and staff appraisal. There was evidence of critically appraising systems in place that enabled improvements to take place. Procedures were in place for monitoring staff performance, and managing poor practice.

The practice carried out reviews as part of the Quality and Outcomes Framework (QOF). The QOF is the annual reward and incentive programme which awards practices achievement points for managing some of the most common chronic diseases, for example asthma and

Are services well-led?

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

diabetes. The practice was continually reviewing ways of improving the recording of QOF data to achieve improved ratings and outcomes for patients. There was evidence that performance was monitored through the year by the practice manager and a lead nurse for QOF. A member of staff in an administrative role also formulated reports on QOF data so that these could be analysed, monitored and acted on. For example we saw that data from QOF was used to target patients who required reviews of their long term health conditions. Overall the practice performance for QOF had to date increased in comparison to the previous year.

Patient experience and involvement

The practice had quarterly newsletters which kept patients up to date with changes as well as sharing important information about the service.

We looked at results of the national GP patient survey carried out in 2013. Of the 286 surveys sent 107 were completed and returned. Findings of the survey were based on comparison to the regional average for other practices in the local Clinical Commissioning Group (CCG). A CCG is an NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services. The overall feedback from the survey was positive.

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

We saw that the practice had an active and engaged patient participation group (PPG). PPGs are a way in which patients and GP surgeries can work together to improve the quality of the service There was evidence that the PPG group had acted on feedback from patients and customised the General Practice Survey to focus on the area of patient communication. The analysis of findings had resulted in action taken. For example a display for carers which provided information and contact numbers for a range of support groups was reinstated in the patient waiting area. As a result of patient feedback improvements had been made in the telephone system.

Regular staff meetings took place for administrative and clinical staff and this enabled staff to give feedback. There was evidence of clear decision making processes that involved collaboration with staff which gave them ownership of decisions that affected them and engaged them in any changes.

Management lead through learning & improvement

Records showed that a wide range of practice meetings were held that enabled decisions to be made about issues affecting the general business and clinical practice. For example, the minutes of a clinical staff meeting viewed included a wide range of subjects discussed affecting patient care and welfare including named GP for patients over the age of 75 years. All of the staff had opportunities to attend and contribute to relevant meetings. The minutes of meetings were recorded and actions that arose from these meetings were clearly set out and reviewed, to ensure that the required changes and improvements were made to the service.

Our discussion with managers and some of the GPs demonstrated a commitment to improving the quality of the service for patients through the process of engaging with patients and staff.

Identification and management of risk

A report on incidents and complaints was produced every year so the practice could establish themes, trends and manage risks. The practice manager had completed a fire and health and safety risk assessment to establish any potential risks and how these could be minimised. Risks were shared with staff as part of staff meetings.

Records showed that essential risk assessments had been completed, where risks were highlighted measures had been put in place to minimise the risks.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Our findings

Patients over the age of 75 years, including those living in care homes had a designated GP. This was an accountable GP to ensure patients over the age of 75 years received co-ordinated care. There were specific care pathways appropriate for older patients such as the falls clinic. Home visits were available for those older patients who were unable to attend the practice.

Nursing and residential care homes with patients registered at the practice had a designated GP who undertook a surgery at the home every two weeks, which ensured patients' needs were reviewed. There were emergency health care plans for patients over the age of 75 to help avoid unplanned hospital admissions. The practice had a notice board in the patient waiting area with details for elderly care services that patients could refer to for support and advice.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Our findings

The practice had a ramp designed for wheelchairs and that lead up to the main surgery entrance. There were disabled toilet facilities and a Loop Induction System for patients with hearing impairment.

Patients with long term conditions were reviewed by the GPs, the practice nurses and at the chronic disease management clinic to assess and monitor their health condition so that any changes could be made. This included a review of their medication, to assess their progress and ensure that their medications remained relevant to their health need. Referrals to specialists and other secondary services were made in an appropriate and timely way.

Clinical staff attended regular meetings with relevant professionals and agencies to discuss and review patients who had complex or long term conditions such as patients receiving end of life care. This ensured that their wishes were respected, and that they received appropriate care and support.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

The practice had a ramp designed for wheelchairs and pushchairs that lead up to the main surgery entrance. Antenatal care was provided by the midwife who undertook a clinic at the practice three times a week. The practice had an allocated health visiting team so that children under the age of 5 years had access to the Healthy Child Programme.

Priority was given to appointment requests for babies and young children to ensure they were assessed promptly. The GPs undertook six week checks for babies and this was coordinated with the mother's post natal check. Immunisations clinics were held for childhood vaccinations.

The practice offered contraceptive services, including advice on contraception and sexual health for young people. There was lead GP for sexual health and the practice held a specialised sexual health clinic once a week.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Our findings

There were late evening and weekend surgeries to accommodate the needs of working age patients. The practice was opened on an alternate Tuesday and Thursday from 6:30pm to 7:30pm and every third Saturday from 8:40am. Patients were able to book non urgent appointments around their working day by telephone, on line or using the 24 hour automated booking service. Patients could call and speak with a GP or a nurse where appropriate if they did not wish to or were unable to attend the practice.

There were late evening clinics available such as well woman, sexual health and smoking cessation to make them more accessible for patients of working age.

NHS checks were available for people aged between 40 years and 74 years.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Our findings

Patients who were vulnerable due to their health or social circumstances were offered health checks. The practice had access to an interpreting service for patients whose first language was not English and information on the practice was available in different languages. The practice was part of the scheme to avoid unplanned hospital admissions by providing an enhanced service. This focused on coordinated care for the most vulnerable patients with the aim to best support them at home. An enhanced service is a service that is provided above the standard general medical service contract.

Clinical staff attended regular meetings with relevant professionals and agencies to discuss and review patients who had complex needs and in vulnerable circumstances, to ensure that their wishes were respected, and that they received appropriate support and treatment. Patients with a learning disability were offered annual health checks. A substance misuse worker undertook a clinic once a month at the practice to review patients with drug dependency issues.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Our findings

Patients with serious mental illnesses were offered an annual review of their physical and mental health needs, including a review of their medicines. Staff worked closely with local community mental health teams to ensure patients' mental health needs were reviewed, and that appropriate risk assessments and a care plan was in place. A mental health counsellor held regular clinics at the practice to support patients.