Chelmer Village Surgery

Quality Report

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Date of inspection visit: 7 January 2016
Date of publication: 25/02/2016

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?	Requires improvement
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 Chelmer Village Surgery on 07 January 2016. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for all of the population groups.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received most training appropriate to their roles and any further training needs had been identified and planned.
- Patients we spoke to said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a leadership structure and staff felt supported. The practice sought feedback from staff and patients, which it acted on.

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

Summary of findings

Importantly the provider must

- Ensure all DBS checks are completed for staff carrying out chaperone duties

In Addition, the provider should

- Carry out an up to date infection control audit

Have suitable arrangements in place to deal with bereavement

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?

Requires improvement

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and managed. There were enough staff to keep patients safe. There had not been an infection control audit carried out since 2013. Staff recruitment checks were well documented, however DBS checks were not completed for non-clinical staff acting as chaperones, immediate action was taken on this matter on the day of inspection.

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 and used it routinely. 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 and appropriate training planned to meet these needs. There was evidence of completed clinical audit cycles and that audit was driving improvement in performance to improve patient outcomes. There was evidence of appraisals for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice lower than others for some aspects of care. However, patients we spoke with were very positive about their care and treatment and told us they were treated with dignity and respect. We also received very positive comment cards on the day of our inspection. Information for patients about the services was available and easy to understand. The practice did not have a bereavement policy in place to support families.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good

Summary of findings

facilities and was well 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 quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. Staff were clear about the practice's vision and their responsibilities in relation to this. There was a leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was a virtual group with limited interaction. Staff had received inductions, regular performance reviews and attended staff meetings.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered personalised care to meet the needs of the older people in its population, offered phlebotomy services to this patient group as well as flu jabs at home if required. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and an annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were in line with averages for the CCG for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances those with a learning disability. It offered annual health checks for people with a learning disability and but these patients had not accepted this offer. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). 91.67% of people experiencing poor mental health had an agreed care plan documented in their record, this was above the national average of 88.47%. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results published in July 2015 had a response rate of 32.3%. 344 survey forms were distributed and 111 were returned. The responses were as set out below:

- 69.4% found it easy to get through to this surgery by phone compared to a CCG average of 64.7% and a national average of 73.3%.
- 89.1% were able to get an appointment to see or speak to someone the last time they tried compared to a CCG average of 85.9% and a national average of 85.2%.
- 95.2% said the last appointment they got was convenient compared to a CCG average of 92.1% and a national average of 91.8%.
- 73.9% described their experience of making an appointment as good compared to a CCG average of 69.9% and a national average of 73.3%.
- 81.7% usually waited 15 minutes or less after their appointment time to be seen compared to a CCG average of 63.6% and a national average of 64.8%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 18 comment cards which were all very positive about the standard of care received. Comments included praise for very friendly and efficient staff who took the time to listen.

We spoke with four patients during the inspection. All four patients said that they were happy with the care they received and thought that staff were approachable, committed and caring.

Areas for improvement

Action the service MUST take to improve

Ensure all DBS checks are completed for staff carrying out chaperone duties

Action the service SHOULD take to improve

Carry out an up to date infection control audit

Have suitable arrangements in place to deal with bereavement

Chelmer Village Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP and a Practice Manager.

Background to Chelmer Village Surgery

Chelmer Village Surgery is located in a purpose built building in a residential area in Chelmsford, Essex. The practice profile shows the practice has a relatively high number of patients aged 0 to 14 years old and 30 to 44 years old, whereas there is a relatively low number of patients aged 50 years old and over. At the time of inspection the practice list size was approximately 4200 patients, this list was open. The practice had a General Medical Services contract. The practice has a male GP Principal and two female salaried GPs. The practice has one practice nurse, a practice manager, an administrator and three receptionists.

The practice is open between 9am and 6.30pm Monday to Fridays. Appointments are from 9am to 12.30pm and 2pm to 6.30pm daily, with the exception of Thursdays when appointments are offered from 9am to 1pm.

Out of hours services are offered by Primecare and patients are directed to call 111.

Why we carried out this inspection

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

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

We carried out an announced visit on 07 January 2016. During our visit we:

- Spoke with a range of staff including GPs, the practice nurse, the practice manager and receptionists, and we spoke with patients who used the service.
- Observed how people were being cared for and talked with carers and/or family members
- Reviewed the personal care and treatment of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.'

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

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

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

Detailed findings

- 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)

Requires improvement

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last two years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of six significant events that had occurred during the last 12 months and saw this system was followed appropriately. Significant events were a standing item on the practice meeting agenda and a dedicated clinical and practice meeting was held monthly to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. S/he showed us the system used to manage and monitor incidents. We tracked four incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared, for example changes to policies had been made and audits had been carried out to improve patient care and to prevent the incident reoccurring. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were disseminated by email to all practice staff. A search was always carried out by the practice manager to determine how many patients were potentially affected by the alert. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at clinical and practice meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed a dedicated GP as the lead in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and social services.

There was a chaperone policy, which was visible on the waiting room noticeboard. (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). The practice nurse had been trained to be a chaperone. Some reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities

when acting as chaperones, including where to stand to be able to observe the examination. Not all staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. Only the practice nurse had received a DBS check, there was not a risk assessment in place to address this issue. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). The practice took immediate action on the day of inspection and applied for the appropriate DBS checks.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

The practice nurse checked medicines were adequately stocked, within their expiry date and suitable for use, this information was not recorded, when discussed the practice nurse was keen to implement a more formal recording system. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs in accordance with national guidance.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs that had been updated in 2015. We saw evidence that the practice nurse had received appropriate training and been assessed as competent to administer the medicines referred to under a PGD from the prescriber.

We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again.

Cleanliness and infection control

We observed the premises to be clean and tidy. We were told that the GP Principle cleaned the premises. There were cleaning schedules in place, however cleaning records were not kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons, coverings and spillage kits were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice had a lead for infection control who had undertaken training to enable them to carry out infection control audits. All staff received induction training about infection control specific to their role. There had not been an infection control audit carried out since 2013.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). The practice had undertaken a risk assessment for legionella and had decided that the risk was sufficiently low to make formal testing unnecessary.

Equipment

Requires improvement

Are services safe?

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was January 2015 and a retest had been booked. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, ear syringes, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that most appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications and registration with the appropriate professional body. The appropriate checks through the Disclosure and Barring Service had not been carried out for non-clinical staff who acted as chaperones. (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). We discussed this with the practice manager at the time of inspection and DBS checks were immediately applied for.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff to cover each other's annual leave. The practice was planning on recruiting an additional part-time nurse at the time of inspection.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix met planned staffing requirements. The practice was planning to recruit an additional part-time nurse at the time of our inspection.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of anaphylaxis, asthma and meningitis. The practice did not routinely hold stocks of medicines for the treatment of cardiac arrest or hypoglycaemia. The reason for this was staff were not trained in giving cardiac arrest drugs, the practice immediately ordered appropriate drugs for dealing with hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of the utility companies. The plan was last reviewed in 2016.

The practice had carried out a fire risk assessment in 2015. There was a fire safety policy and records showed that staff practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

We discussed with the practice manager, GPs and nurse how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff. We saw minutes of clinical meetings which showed this was then discussed and implications for the practice's performance and patients were identified and required actions agreed. Clinical staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients taking long term medication received regular medication reviews. Feedback from patients confirmed they were referred to other services or hospital when required.

Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to review and discuss new best practice guidelines. Our review of the clinical meeting minutes confirmed that this happened.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their

records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The practice had a system in place for completing clinical audit cycles. The practice showed us four clinical audits that had been undertaken in the last year. All of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. Examples included audits to confirm that patients received appropriate two week wait referrals for cancer in line with National Institute for Health and Care Excellence guidance.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (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). For example, we saw an audit regarding the repeat prescribing of medicines. Following the audit, the GPs increased regular medication reviews for patients and a monthly audit was carried out to demonstrate gradual improvement.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets, It achieved 94.8% of the total QOF target in 2014, which was in line with the national average of 94.2%. Specific examples to demonstrate this included:

- Performance for diabetes related indicators was comparable to the national averages.
- The percentage of patients with hypertension having regular blood pressure tests was 87.64% which was above the national average of 83.65%.

Good

Are services effective?

(for example, treatment is effective)

- Performance for mental health related QOF indicators was better than the national average.

The practice was keen to continue their improving performance in relation to QOF.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake one audit a year.

The practice's prescribing rates were also similar to national figures. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

The practice had made use of the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups such as those with learning disabilities. Annual reviews were also undertaken for people with long term conditions such as diabetes.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all either have 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).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was providing training when required.

The practice nurse had a job description outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines and cervical cytology.

Working with colleagues and other services

The practice worked with other service providers to meet patient's 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. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from these communications. Out of hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. Where there had been one instance of a delay identified within the last year, this had been identified, analysed, shared and learned from.

Emergency hospital admission rates for the practice were relatively low at 10.41% compared to the national average of 12.3%. The practice undertook a regular audit of follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed.

The practice held monthly multidisciplinary team meetings to discuss patients with complex needs. For example, those with multiple long term conditions, mental health problems and those with end of life care needs and decisions about care planning were documented in a

shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

Information sharing

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency. The practice had also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

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. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for obtaining and documenting consent. For example, when administrating vaccines, a patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. If a clinician deemed it appropriate to gain written consent, the relevant forms were available.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

It was not practice policy to offer a health check to all new patients registering with the practice, this was available if patients requested it. All new patients taking long term medication would always receive a medication review when registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way.

Patients registered with the practice, aged 40 to 75 years old were offered NHS Health Checks by an external agency.

The practice was not offering smoking cessation advice unless patients specifically requested it.

The practice's performance for the cervical screening programme was 83.53%, which was above the national average of 81.83%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. A practice nurse had responsibility for following up patients who did not attend. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was comparable to CCG data for the majority of immunisations where comparative data was available. For example:

Good

Are services effective?

(for example, treatment is effective)

- Flu vaccination rates for the over 65s was 74.59% which was slightly above the national average of 73.24%. The flu vaccination rate for at risk groups was 40.2% which was below the national average of 45.73%.

Childhood immunisation rates for the vaccinations given were comparable to CCG and national averages. For example:

- The percentage of childhood PCV vaccinations given to under one year olds was 96.4% compared to the CCG percentage of 96.8%.
- The percentage of childhood Men C Booster vaccinations given to under two year olds was 96.7% compared to the CCG percentage of 95.4%.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey published 2 July 2015 and a survey of patients undertaken by the practice's 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).

The evidence from all these sources showed patients were not completely satisfied with how they were treated. For example, data from the national patient survey showed the practice was rated below the national average for patients who rated the practice as good or very good. The practice was also below average for its satisfaction scores on consultations with doctors and nurses. For example:

- 79.6% said the GP was good at listening to them compared to the CCG average of 87.1% and national average of 88.6%.
- 81.3% said the GP gave them enough time compared to the CCG average of 85.2% and national average of 86.6%.
- 89.6% said they had confidence and trust in the last GP they saw compared to the CCG average of 95.3% and national average of 95.2%
- 84.9% said the nurses were good at listening to them compared to the CCG average of 90.8% and national average of 91.0%.
- 85.2% said the nurses gave them enough time compared to the CCG average of 91.5% and national average of 91.9%.
- 96.9% said they had confidence and trust in the last nurse they saw compared to the CCG average of 96.7% and national average of 97.1%

Patients completed CQC comment cards to tell us what they thought about the practice. We received 18 completed cards and they were all very positive about the service experienced. Patients said they felt the practice offered a good service and staff were efficient, helpful and caring.

They said staff treated them with dignity and respect. We also spoke with three patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was shielded by glass partitions which helped keep patient information private. Additionally, 82.1% said they found the receptionists at the practice helpful compared to the CCG average of 85.4% and national average of 86.8%.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice below average in these areas. For example:

- 81.8% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 83.2% and national average of 86.0%.
- 71.2% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 79.2% and national average of 81.4%.

Good

Are services caring?

- 86.3% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 88.8% and national average of 89.6%.
- 78.1% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 84.4% and national average of 84.8%.

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

There had not been any demand for translations services in the past; we did see a notice behind the reception desk for staff to access services if needed.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were unsure about the emotional support provided by the practice and rated it below average in this area. For example:

- 76.8% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 83.4% and national average of 85.1%.
- 82.9% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 90.2% and national average of 90.4%.

The patients we spoke with on the day of our inspection and the comment cards we received were very positive about the care they received from staff within the practice.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We saw written information available for carers to ensure they understood the various avenues of support available to them.

There was not a policy in place to routinely contact families who had suffered a bereavement.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS England Area Team and Clinical Commissioning Group (CCG) engaged with the practice and other practices to discuss local needs and service improvements that needed to be prioritised.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example following patient feedback, the practice changed their recorded phone message to encourage patients to use online services.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities. The vast majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients.

The premises and services met the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

There was a system for flagging vulnerability in individual patient records.

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

The practice provided equality and diversity training through e-learning. Some but not all staff had completed this training.

Access to the service

The surgery was open from 9am to 6.30pm Monday to Friday. On Thursdays the practice closed at 1pm. Appointments were available from 9 am to 12.30pm and 2pm to 6.30pm on weekdays, with the exception of Thursdays when appointments were available from 9am to 1pm.

Comprehensive information was available to patients about appointments on the practice website and in the practice appointments leaflet. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments, with the exception of opening hours, and generally rated the practice well in these areas. For example:

- 62.6% were satisfied with the practice's opening hours compared to the CCG average of 71.4% and national average of 74.9%.
- 73.9% described their experience of making an appointment as good compared to the CCG average of 69.6% and national average of 73.3%.
- 81.7% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 63.6% and national average of 64.8%.
- 69.4% said they could get through easily to the surgery by phone compared to the CCG average of 64.7% and national average of 73.3%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another doctor if there was a wait to see the GP of their choice. Routine appointments were available for booking six weeks in advance. Comments received from patients also showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

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.

We saw that information was available to help patients understand the complaints system in a practice leaflet, on the practice website and on a patient complaints form. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at five complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way, openness and transparency with dealing with the compliant.

The practice reviewed complaints monthly and annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result.

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 vision to deliver quality care and promote good outcomes for patients. The practice was in a transitional phase at the time of inspection as the GP Principal was planning to retire imminently, the salaried GPs were hoping to take over the practice. There was not a documented business plan in place.

We spoke with six members of staff. All staff shared the vision of delivering quality care to patients. There was some uncertainty amongst staff at the time of inspection due to the changes in the leadership structure that were due to take place.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at eighteen of these policies and procedures, there was not a requirement for staff to have completed a cover sheet to confirm that they had read the policy and when. All the policies and procedures we looked at had been reviewed and were up to date.

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

The practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. This included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice also had an on-going programme of clinical and non-clinical audits which it used to monitor quality and systems to identify where action should be taken. Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff.

The practice had identified, recorded and managed risks. It had carried out risk assessments for fire and legionella. Where risks had been identified and action plans had been produced and implemented, for example with regards to fire safety

The practice held monthly staff meetings where governance issues were discussed. We looked at minutes

from these meetings and found that performance, quality and risks had been discussed.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment, equal opportunities, and induction policies which were in place to support staff. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff electronically on any computer within the practice.

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always take the time to listen to all members of staff.

We saw from minutes that practice meetings were held every month. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the virtual patient participation group (PPG), surveys and complaints received. It had a virtual PPG which was open to patients who had access to email; there was not an alternative option for patients without access to email. The virtual PPG had been contacted once at the time of

Are services well-led?

Good

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

inspection with a survey. The practice manager showed us the analysis of this survey. The results and actions agreed from these surveys are available in the practice waiting room. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

We also saw evidence that the practice had reviewed its' results from the national GP survey to see if there were any areas that needed addressing. The practice was actively encouraging patients to be involved in

shaping the service delivered at the practice.

The practice had also gathered feedback from staff through staff meetings and annual appraisals. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training. We looked at four staff files and saw that regular appraisals took place. Staff told us that the practice was supportive of training.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed We found that the registered person had not protected against the against the risk of inappropriate or unsafe care due to appropriate recruitment checks not being carried out for staff. Staff acting as chaperones had not all been subjected to the appropriate DBS checks. This was in breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014