The Eden Surgeries

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

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

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

Overall we found the practice provided patients with a good service. The practice had a smaller branch surgery at Hatfield Broad Oak which we did not inspect but from which we did collect comment cards.

Our key findings were as follows:

- The practice had a proactive Patient Participation Group that met three times last year. We saw that actions had been taken by the practice to the Patient Participation Groups requests and action plans were outlined in meeting minutes.
- The practice had a care home protocol that formalised arrangements between the practice and the care home, from raising a concern to requesting a home visit. This had been recently agreed and was clear on all aspects of service provision and communication between the care home and the practice.
- Patients completed CQC comment cards to tell us what they thought about the practice. We received 59 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Three comments were less positive but there were no common themes to these. We also spoke with nine patients on the day of our inspection. All told us they were satisfied with the care provided by the practice.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated through meetings to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and the practice responded appropriately. The practice regularly reviewed staffing levels to ensure there were enough staff on duty to keep people safe.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 through meetings to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and the practice responded appropriately. The practice regularly reviewed staffing levels to ensure there were enough staff on duty to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) which had been made easily accessible on the computer system and was used routinely. People's 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 planned as part of the appraisal system. The practice could show us all appraisals and the personal development plans for all staff. Staff worked with multidisciplinary teams to ensure proactive care pathways.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand and available in a number of formats. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

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

Summary of findings

local hospice, care homes, their own patient group, the NHS Area Team and Clinical Commissioning Group (CCG) to ensure improvements to services where these were identified. Patients said they knew how to make an appointment with a named GP and that there was continuity of care. Urgent appointments were available the same day.

The practice had good 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 and appropriately to issues raised. Learning from complaints with staff and other stakeholders took place during meetings which was evident in the minutes we reviewed.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular meetings where governance was discussed. There were systems in place to monitor and improve quality and identify risks. The practice proactively sought feedback from patients, which it acted on. The Patient Participation Group (PPG) was active and produced annual reports and an action plan that we saw was being actioned. Staff had received inductions, regular performance reviews and attended staff meetings and events; to develop their roles and keep them up to date with the status of any issues or events on-going at the practice.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice 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 proactive, personalised care to meet the needs of the older people in its population and had a range of services.

The practice identified people aged over 75 with the patient record computer system; each person had a named accountable GP in line with the recent GP 2014 to 2015 contract changes.

The practice had a good uptake of flu and shingles vaccinations or those patients eligible to receive it.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Flexibility with appointments and home visits were available when needed. All these patients had a named clinical lead to oversee a structured annual review to check that their health and medicine needs were being met. For those people with the most complex needs, the named clinical lead worked with relevant health and care professionals to deliver a multidisciplinary package of care.

We found patients had been advised with regards to any specialist services they could access to meet their individual needs and had been signposted to additional support networks to assist them. These included services available within the practice, for example the dietician for diabetic patients.

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 very high 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 were told that if an appointment was needed for a child urgently they were always seen.

Summary of findings

We saw good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

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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 proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

The practice provided screening clinics and signposting for this population group. These included family planning, contraception and follow-up, cervical smears, health advice regarding lifestyle, diet, smoking and alcohol intake, new patient health checks and chlamydia screening. Well man and well women clinics were also offered at the practice to promote health and to detect early signs of disease.

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 including

Summary of findings

homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability and 95% of these patients had received a follow-up. 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. Staff had received training in safeguarding for vulnerable adults and children and this was documented in their files.

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). All of the patients experiencing poor mental health had received an annual physical health check. 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 advanced care planning for patients with dementia.

Summary of findings

What people who use the service say

We spoke with nine patients on the day of our inspection and reviewed 59 comment cards completed by people who attended the practice ahead of our visit. The nine patients we spoke with, and the comment cards we reviewed, all commented positively about the practice. People told us the reception and dispensary staff were polite and helpful. They said that the repeat medicines collection service had really improved over the last six months. We were also told that the clinicians listened and supported patients and the practice was safe, clean and tidy. People also told us that they could access appointments at times to suit them.

Staff that provided end of life care to patients that received care from the practice told us the practice care was safe, effective, caring, responsive, and well-led. The staff said they had good communication links with the practice and attended regular clinical meetings.

The Eden Surgeries

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to The Eden Surgeries

The Eden Surgeries practice provides primary medical services to approximately 9050 people over two sites, Hatfield Heath, and Hatfield Broad Oak, on the Essex/ Hertfordshire borders. They are a dispensing practice, dispensing to 95% of the people registered with them. A dispensing practice is where GPs are allowed to dispense the medicines they prescribe for people who live remotely from a community pharmacy. Not all patients at the practice are entitled to this service. The practice holds a GMS contract to provide primary medical services. There are four GP partners two female and two male, a nurse practitioner, two nurses that can prescribe, a general nurse, and a healthcare assistant.

The practice had opted out of providing out-of-hours services to the people registered at the practice.

Why we carried out this inspection

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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.

How we carried out this inspection

Before we inspected the practice, we reviewed a range of information we held about the practice and asked other organisations and healthcare professionals that work with the practice to share with us what they knew.

We carried out an announced inspection on 9th October 2014. During our inspection we spoke with a range of staff including GPs, the practice manager, the practice nurses, reception administrative staff, and staff from the dispensary. We also reviewed comment cards left by patients who shared their views and experiences of the service. These had been provided by the Care Quality Commission (CQC) before our inspection took place. We also spoke with patients who used the service during the day of the inspection. We observed how patients were cared for and talked with carers and/or family members and reviewed practice records. We observed how staff dealt with patients over the telephone and we discussed patient care planning.

Detailed findings

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

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

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

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

People experiencing poor mental health (including people with dementia)

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Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve patient safety.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 18 months. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

We saw weekly meetings took place and significant event outcomes were shared with staff. Staff were aware of the significant event reporting process and how they could escalate concerns within the practice. The staff members we spoke with felt comfortable to raise any concerns however small. Staff knew that following a significant event, the practice manager and GPs discussed these incidents to establish the details and the full circumstances.

Policies and procedures were available for reporting accidents and incidents and responding to complaints.

These were developed in line with national and statutory guidance, for example, from the Health and Safety Executive.

The practice had a system to deal with alerts received from the Medicines and Healthcare products

Regulatory Agency (MHRA) and National Patient Safety Alerts (NPSA). The alerts had safety and risk information regarding medicine equipment and procedures, which can result in the withdrawal of a medicine from use and return to the manufacturer. All the alerts received by the practice had been allocated to staff members to action; these had all been completed.

The staff members at a local care home looking after older people with long term, or chronic conditions, and mild confusion, told us that they felt people received safe care and treatment that was always explained to them when they attended the home. They told us the practice contacted them each week to check whether anyone needed a visit or their advice. We saw that there were no complaints raised regarding patient safety on the comment cards we had left for patients to complete regarding safety with patient care.

Learning and improvement from safety incidents

The practice has a system in place for reporting, recording and monitoring significant events. We were told that the next practice 'close down' meeting would be used as a learning event for safety incident reviews.

The incidents policy and the actions taken for each incident followed a root cause analysis process (RCA). RCA is a method of problem solving that tries to identify the root causes of faults or problems. The practice had an effective recording system, and we could see the learning points, and changes to procedure where needed or identified. Any change to practice procedure following an incident and investigation was shared with staff at the practice in meetings which were evidenced in the meeting notes that we saw.

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 the practice training records which showed staff had received relevant role specific training on safeguarding. 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 lead in safeguarding vulnerable adults and children. They had been trained to level three and documents were viewed confirming that they were suitably qualified. All staff we spoke to were aware who these leads were and who to speak to 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 a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. All nursing staff had been trained to undertake the role of chaperone.

The practice monitored the emergency admissions, readmissions, unplanned admissions and discharges from

hospital for patients over 75 years of age. This monitoring supported the work to identify 'at risk' patients and avoid unplanned admissions to hospital. The practice wrote to all those patients they identified as 'at risk' and put together a care plan that had been discussed, agreed and signed by them. The plans were kept at the patient's home to inform visiting healthcare professionals, and recorded on their medical records at the practice.

The practice conducted regular assessments of children's development and monitored the uptake of primary and pre-school immunisation to identify children at potential risk. Where concerns were identified with regard to physical and/or mental health of a child, appropriate and timely referrals to partner agencies were made and documented.

Staff told us about the care they provided for patients who had been identified as vulnerable due to their diagnosis of a learning disability. The practice worked closely with local services for example adult social care, community health services, and financial support services to access specialist equipment and to promote patients independence. The practice also worked with the Department of Work and Pensions to provide evidence to support claims, to enable patient's access to services. They conducted annual health checks to ensure that patients' needs were identified and that they could access the care they required. The practice told us they had a register of patients who may be considered vulnerable due to a number of factors including deprivation or rural isolation. They monitored certain patient's medicine doses to ensure they received them correctly and appropriately for their planned care.

The practice monitored the A&E admissions of patients experiencing poor mental health or that had attended due to self-harm incidents. This monitoring supported the work to identify at risk patients and avoid unplanned admissions to hospital. The practice put together a care plan with the agreement of the person at risk, and these were kept at their home to inform visiting healthcare professionals, and recorded on their records at the practice.

The practice identified those patients on certain medicines that required extra monitoring to maintain their health. This monitoring was supported by the dispensary protocols and computer system to ensure patient's medicine regimes were maintained.

Medicines Management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely. There was a standard operating procedure (SOP) for ensuring that medicines were kept at the required temperatures in order to maintain their effectiveness. This also described the action to take in the event of a power failure. The practice staff followed the procedure. SOPs are written work processes that explain a procedure from start to finish; these processes should be regularly updated and reviewed.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with current guidance/ regulations.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic prescribing, growth hormone and ring pessary prescribing within the practice. The practice had also committed to the medicines management audits requested by the local area team for the NHS.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines. Two members of the nursing staff were qualified as independent prescribers and received regular supervision and support in their role as well as updates in the specific clinical areas of expertise for which she prescribed.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The practice employed a pharmacist to manage the dispensary service at the practice. Stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for

misuse) were held at the practice. There were SOP's that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs.

Practice staff undertook regular audits of controlled drug prescribing to look for unusual products, quantities, dose, formulations and strength. Staff were aware of how to raise concerns around drugs with the accountable officer in their area.

Dispensing staff at the practice were aware prescriptions should be signed before being dispensed.

The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary.

Records showed that all members of staff involved in the dispensing process had received appropriate training and their competence was checked regularly.

The practice had established a service for people to pick up their dispensed prescriptions at the main surgery and branch surgery locations with systems in place to monitor how these medicines were collected. They also had arrangements in place to ensure that people collecting medicines were given all the relevant information about the medicines that they required.

Information for patients around repeat prescriptions was clearly stated in the patient information leaflet which was available in the reception and waiting room and re-enforced with notices in reception and at the dispensary. There was also guidance on the practice website that repeat prescription requests could be made online, by post, or by request in person at the practice. Repeat prescriptions were provided on a 28 day cycle in line with the practice policy and national guidelines around medicines prescribing and repeat prescriptions. Arrangements could be made for alternative cycles if circumstances arose that required a different time period. Patients were reminded to make an appointment when requested, by the practice, for a medicine review.

The local care homes that we spoke with told us they had experienced no problems with prescriptions medicine received from the practice due to good communications with the dispensary and practice manager.

Patients we spoke with told us they were given information such as side-effects and any contra-indications about the medicines they were prescribed and dispensed. They told us that the repeat prescription service had improved over the last few months and they received their medicines in good time. They also confirmed that their prescriptions were reviewed and any changes were explained fully.

Cleanliness & 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 and coverings 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. This included procedures for dealing with bodily fluids, used needles and dealing with needle stick injuries.

The practice had a lead for infection control who had undertaken relevant training. Other staff had received training in infection control procedures that were specific to their role. We saw evidence that an infection control audit had taken place and repeat audits had been planned to ensure that improvement areas had been actioned and maintained.

The practice was clean and tidy on the day of our visit. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they thought the practice was clean and when asked had no concerns about cleanliness or infection control.

Signs showing effective hand washing techniques were displayed next to the hand washing facilities 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 germ found in the environment which can contaminate water systems in buildings). The records confirmed the practice had carried out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Are services safe?

We received comments from patients and healthcare professionals visiting the practice who told us they thought the practice was always clean and tidy when they attended.

The clinical staff underwent screening for Hepatitis B vaccination and immunity. People who are likely to come into contact with blood products, or are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of blood borne infections.

There were appropriate arrangements in place for the storage and disposal of waste matter including clinical waste. The practice employed an external cleaning contractor to carry out general cleaning tasks. A checklist was available for the cleaner to follow which included the areas to clean and the frequency. The practice manager then monitored the quality of the cleaning to ensure that it had been completed to an acceptable standard.

Equipment

Staff we spoke with told us they had sufficient quantities of appropriate 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. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales and the fridge thermometer.

We checked the equipment used by the practice to monitor patients with chronic disease and saw that, where required, this had been checked in line with the manufacturer's guidelines. The emergency equipment was checked regularly, and was appropriate for emergency use. The oxygen at the practice was in date and appropriate for use.

Staffing & Recruitment

The practice had suitable and robust procedures for recruiting new staff to help ensure that they were suitable to work in a healthcare setting. Employment references and criminal records checks were obtained for all newly appointed staff before they started work at the practice. We viewed the staff induction procedures and appraisal processes and found them appropriate and up to date and regularly reviewed.

The practice manager 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, including nursing and administrative staff, to cover each other's annual leave. Newly appointed staff had this expectation written into their contracts.

The practice manager demonstrated that the staffing levels were regularly reviewed to ensure that there was appropriate cover to deal with day-to-day appointments and home visits. The dispensary manager monitored the number of prescriptions dispensed each month to calculate the whole time equivalent number of staffing hours needed to provide an effective service.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included 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.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, staff had all undertaken basic lifesaving skills.

The practice also monitored repeat prescribing for people receiving medicine for all long term health conditions. This included those experiencing poor mental health.

Staff recognised and responded appropriately to vulnerable patients. They said they felt comfortable supporting patients who may experience difficulty communicating, have mobility issues or present differently from others due to their lifestyle choices.

We found that clinical and administrative staff had received safeguarding training to recognise and respond to safeguarding concerns. We saw there was a system in place for the timely identification and management of children where safeguarding concerns within a family were identified.

There were records of regular multidisciplinary meetings and these were held monthly. We also saw weekly meeting

notes where any issues were brought to the attention of clinical staff members. These discussions included reviewing any unplanned admissions for patients with long-term conditions.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). The location of this equipment was clearly sign posted and records confirmed that it was checked regularly. The notes of the practice meetings showed that staff had discussed a medical emergency concerning a patient and they had learned from this appropriately.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. 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 a heating company to contact if the heating system failed. Staff were aware of the arrangements at the practice for identifying and responding to emergency situations.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

We saw evidence that the fire equipment had been checked and was in working order.

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 saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us they supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened. The GPs and nursing staff also sought the advice of visiting healthcare professionals; for example we saw several diabetic patients that had been referred to the dietician holding a clinic at the practice on the day of our visit.

The senior GP partner showed us data from the local Clinical Commissioning Group (CCG) of the practice's performance for antibiotic prescribing, which was comparable to similar practices. The practice had also completed a review of case notes for patients with high blood pressure which showed all were receiving appropriate treatment and regular review. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital.

The GPs we spoke with used national standards for referral timescales; for example patients with suspected cancer referred and seen within two weeks. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

The practice identified people aged over 75 from the patient record computer system; each person had a named accountable GP in line with the recent GP 2014 to 2015 contract changes. There were records of regular multidisciplinary meetings, these were held monthly and detailed clinical discussions regarding vulnerable and end of life patients. We also saw weekly meeting notes where any issues were brought to the attention of clinical staff members. These discussions included reviewing any unplanned hospital admissions for patients with long-term conditions.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race were not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, managing child protection alerts, medicines management and dispensary management. The information staff collected was then collated by the practice manager, dispensary manager, and deputy practice manager to support the practice to carry out checks, monitoring, and audits.

The practice showed us six clinical audits that had been undertaken in the last two years. Two of these were completed audits cycles. Other examples included audits to confirm that the GPs, who undertook minor surgical procedures, were doing so in line with their registration and NICE 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 national performance measurement tool. For example, we saw an audit regarding the prescribing of analgesics and non-steroidal anti-inflammatory drugs. Following the audit, the GPs carried out medicine reviews for patients who were

Are services effective?

(for example, treatment is effective)

prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The computerised patient record system alerted GPs to relevant medicine alerts when prescribing medicines. The pharmacist employed by the practice confirmed that medicine alerts were discussed with the GP before dispensing/prescribing. The evidence we saw confirmed that the GPs had oversight and a good understanding of the best treatment for each patient's needs.

The practice had a palliative care register of 20 patients; they had regular internal as well as multidisciplinary meetings to discuss the care and support needs of these patients and their families and carers.

Patient's comments on the cards left by the CQC to collect their views about the practice were very positive about the monitoring and improvements they had received during their care and treatment.

Effective staffing

The practice staff included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending training courses such as annual basic life support. We noted a good skill mix among the doctors with them taking lead roles within the practice; for example Caldicott Guardian lead, Clinical Governance lead, Child and Vulnerable Adults lead, HR lead, and Medicines Management lead.

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 NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

The practice was a training practice and trained doctors to be general practitioners. Known as GP registrars during training, they are fully qualified doctors with hospital experience who are training to move into general practice.

Prior to their annual appraisals staff confirmed with us they were provided with the opportunity to make comments and requests on their appraisal documents to identify their own learning needs or requests.

Practice nurses received clinical supervision from the GPs and had defined duties they were expected to perform. They were able to demonstrate they were trained to fulfil these duties, for example, prescribing, administration of vaccines, and monitoring diabetes.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and support patients with more 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 system to ensure passing on, reading and acting on any issues arising from communications with other care providers on the day they were received by the relevant staff members. The GP who saw these documents and results was responsible for the action required. The staff members we spoke with understood their roles and felt the system in place worked well.

The practice held multidisciplinary team meetings monthly to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by community matrons, social workers, palliative care nurses where decisions were made about care planning.

Information Sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made referrals last year through the Choose and Book system(C&B). (The C&B system

Are services effective?

(for example, treatment is effective)

enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Administrative staff at the practice reported that this system worked well for patients at the practice. They told us they checked the website weekly to check for appointments patients did not attend for, cancelled, or rejected appointments.

For emergency patients, there was a method of providing a printed copy of a summary record for the patient to take with them to A&E. 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 'SystmOne' to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. The clinical staff we spoke with understood the key parts of the legislation regarding specific scenarios where capacity to make decisions was an issue for a patient.

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) and had a section stating the patient's preferences for treatment and decisions.

The actions being undertaken to support the work to identify 2% of at risk patients and avoid unplanned admissions to hospital required the practice to agree a care plan with the patients identified as at risk. The plans were signed by the person and kept at their home to inform visiting healthcare professionals of their wishes, and recorded on their records at the practice.

Clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged 16 or under who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health Promotion & Prevention

It was practice policy to offer a health check with the health care assistant to all new patients registering with the practice. The GP was informed of any health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers. The dietician ran a clinic on the same day the GP ran a diabetic clinic and we saw them refer patients to the dietician to support their treatment on the day of our visit.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability. We found that all of these patients were offered an annual physical health check. The practice had also identified the smoking status of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to patients that smoked. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs. For example a visiting dietician to work in co-ordination with the GPs and nurses during their clinics at the practice.

The nurses at the practice ran a variety of clinics that included; asthma/respiratory disease management clinics, diabetes management, family planning/contraception hypertension management, male hormone injections, and menopause advice. They also offered well woman and well man health promotion clinics. Patients were followed up if they had risk factors for disease identified at the health check and scheduled for further investigations.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey of 2013-2014, a survey of 120 patients that had been undertaken. The evidence from this survey showed patients were satisfied that they were treated with compassion, dignity and respect.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 59 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Three comments were less positive but there were no common themes to these. We also spoke with nine 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. Privacy curtains were provided in consulting and treatment rooms so that patients' dignity was maintained during examinations, investigations and treatments. We noted that consultation / 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.

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 they would investigate these and any learning identified would be shared with staff. We were shown an example of a report on a recent incident that showed the actions taken had been robust. There was also evidence of learning taking place as staff meeting minutes showed this had been discussed.

We saw the staff were polite, patient and helpful with older people whilst trying to book appointments and assist them with their enquiries. Staff told us they recognised people's individual needs such as limited mobility or difficulties reading or writing and tried to support them. The practice had made telephone appointments available at the end of surgery each morning and if an older person wanted to talk to a GP they were given one of these appointments.

We asked staff what training and support they were given to enable them to recognise and respond appropriately to vulnerable patients. Although they had not been given specific training staff said they felt comfortable supporting patients who may experience difficulty communicating, have mobility issues or present differently from others due to their lifestyle choices.

Care planning and involvement in decisions about care and treatment

The patient survey information of 2013-2014 we reviewed showed patients responded positively and generally rated the practice well in most areas.

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 was very positive with regards to treatment choice, support and care received.

Staff told us that translation services were available for patients who did not have English as a first language. We saw a leaflet in the waiting area informing patents this service was available.

We found regular patient care reviews were conducted by the GP and the nursing team for those patients identified with a long term condition. These were in consultation with patients and carers where appropriate to ensure the information was accurate and they were involved in their care. We found patients had been referred appropriately to specialists and in a suitable and timely way.

The practice monitored the emergency admissions, readmissions, unplanned admissions and discharges from hospital for patients with long term conditions, older people, those living in care homes and vulnerable at risk patients. This monitoring supported the work to identify at risk patients and avoid unplanned admissions to hospital. The practice wrote to all those they identified as at risk and

Are services caring?

put together a care plan with the agreement of the person at risk. The plans were signed by the person and kept at their home to inform visiting healthcare professionals, and recorded on their records at the practice.

The practice had a care home protocol that formalised all arrangements between the practice and the care home from raising a concern to requesting a home visit. This had been recently agreed and was clear on all aspects of service provision and communication.

Patient/carer support to cope emotionally with care and treatment

The practice identified people with caring responsibilities or those that needed additional support; this was recorded in their records. By identifying those with caring responsibilities this enabled staff to consider these responsibilities when discussing care and arranging appointments to ensure they were suitable for people. Notices in the patient waiting room and the 'help for carer's' section on the practice website also told people how to access a number of support groups and organisations. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them.

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 people's needs and had systems in place to maintain the level of service provided.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the Patient Participation Group (PPG). A PPG is a patient and staff group who meet to discuss ways in which the practice could be improved for the benefit of patients. Improvements that had been made included updating the practice website, increasing appointment availability, the draft practice leaflet was shared with the PPG for comments before release, compliments and complaints were discussed at meetings and decisions made regarding improving the patient survey.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services.

For example, those with a learning disability, palliative care needs, long term conditions, carers, and older people.

The premises and services had been adapted to meet the needs of people with disabilities. Access to consulting rooms were all on the ground floor. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice.

Access to the service

Appointments were available from 8am to 6:30pm on three weekdays and 8am to 4:30pm on two weekdays. The practice and dispensary was also open on Saturday mornings for pre-booked appointments. There were telephone appointments available after each morning surgery to talk to a GP.

Comprehensive information was available to patients about appointments in the practice leaflet and on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements in place so that patients could access urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave them details of how to contact the out-of-hours emergency service.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. There was a template held at the reception desk that detailed the time required for specific appointment types and which clinician to book the appointment with. This ensured the reception staff booked patient appointments appropriately and the surgery times were not compromised. Home visits were made to two local care homes on a specific day each week, by the GP to those patients who needed one.

Patients were generally satisfied with the appointments system. They confirmed that they could see a GP of their choice on the same day if they needed to on most occasions, but if not available were able to see another GP. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

The practice offered telephone consultations and online appointment booking for those patients who had signed up for it. The practice opened at 8am – 6.30pm three days a week and 8am - 4.30pm two days a week. There was also a surgery on Saturday mornings and the dispensary was open to provide medicine for those people registered at the practice. The branch surgery opened 8am – 6.30pm three days a week and 8am – 1pm two days a week.

Listening and learning from concerns & 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. The Practice Manager was the designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system within the patients practice leaflet and on the practice website. None of the patients we spoke with had ever needed to make a complaint about the practice, but one told us they would speak to the practice manager if they felt they needed to.

Are services responsive to people's needs?

(for example, to feedback?)

We reviewed complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way, and in line with the practice policy. Evidence of shared learning from complaints was disseminated with staff and other stakeholders, for example the PPG members. We saw minutes of team meetings showing that complaints were discussed to ensure all staff were able to learn and contribute to determining any improvement action that might be required.

Are services well-led?

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

Our findings

Vision and Strategy

The practice held a practice charter and a patient charter that outlined a clear vision to deliver high quality care and promote good outcomes for patients. These values were clearly displayed within the practice patient leaflet and on the practice website and staff members directed us to these information sources.

Governance Arrangements

The practice had a number of policies and standard operating procedures in place to govern activity and these were readily available to staff. We looked at six of these policies and standard operating procedures and most staff had completed a cover sheet to confirm that they had read the policy and when. All six policies and standard operating procedures we looked at had been reviewed annually and were up to date.

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

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards.

We saw the practice had achieved an overall level two for information governance using the 'information governance (IG) toolkit'. The IG toolkit is an online system which allows NHS organisations and partners to assess themselves against Department of Health IG policies and standards. It also allows members of the public to view participating organisations' IG toolkit evaluations. Level two is a satisfactory achievement for primary care services using this toolkit.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We also noted that the practice had half day shutdown days every four months where internal training issues were addressed and important practice issues discussed.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example; disciplinary procedures, induction policy, management of sickness, which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

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

The practice had an active PPG that included representatives from various population groups; including older people, working age people, and those with long term conditions. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG at the meeting in February 2014. The results and actions agreed from these surveys were available on the practice website. For example one action was to raise the awareness of the online system to patients and we saw plenty of information displayed informing patients how they could benefit from the use of this service. When we spoke with patients they were aware of the service and knew how they could access it.

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

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was supportive of training and that they had half day shutdown days where they had received training.

The practice was a GP training practice and trained doctors to be General Practitioners. Known as GP registrars during training, they are fully qualified doctors with hospital experience who are training to move into general practice. They consult in their own surgeries on a regular basis with appropriate supervision.

Are services well-led?

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

Some consultations are recorded (with the patient's consent) for teaching purposes. The information regarding the GP registrars was available to patients within the practice patient leaflet and on the practice website.

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