The Village Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Village Surgery on 26 January 2015. 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 older people, people with long-term conditions, families, children and young people, working age people (including those recently retired and students), people whose circumstances may make them vulnerable and people experiencing poor mental health (including people with dementia).

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

- Staff 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.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- 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.
- Results from the latest GP national survey showed the practice was performing at higher than local and national average levels in all outcomes.
- The practice provided timely follow up and offered support and extended appointments for patients who had attended accident and emergency with a non-life threatening issue.

Summary of findings

However there was one area of practice where the provider needs to make improvements.

Importantly the provider should

- Ensure that patients, visitors and staff are protected from the risk of water borne infection by means of completing a legionella risk assessment.

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 safe. Staff understood and fulfilled their responsibilities to raise concerns, and 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 well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. National Institute for Care Excellence (NICE) guidance was referenced and used routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff had received training appropriate to their roles and further training needs had been identified and planned. The practice could identify all appraisals and staff had personal development plans in place. We saw evidence of multidisciplinary working.

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS England Area Team and clinical commissioning group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice, a named GP and 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. There was an accessible complaints system with evidence the practice responded quickly to issues raised. We saw examples of shared learning from complaints with staff and other stakeholders.

Summary of findings

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 governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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 the practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example in dementia and end of life care. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs. Annual health assessments were offered to all patients aged over 75, including those with no pre-existing medical conditions.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and 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 a structured annual review to check that their health and medication needs were 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 population group of families, children and young people. Systems were in place for identifying and following-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 relatively high for all standard childhood immunisations. Patients told us and we saw evidence that showed children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We were provided with examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of working-age people (including those recently retired and students).

Summary of findings

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 which reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector 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 and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). All 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 patients experiencing poor mental health including those with dementia. The practice had in place advance care planning for patients with dementia.

The practice sign-posted patients experiencing poor mental health to various support groups and third sector organisations. The practice had a system in place to follow up on patients who had attended accident and emergency where there may have been mental health needs. Staff had signed up to receive additional training on how to promote care for people with dementia.

Summary of findings

What people who use the service say

We spoke with seven patients during our inspection. They all described practice staff as caring, helpful and approachable. Patients also told us they were treated with dignity, compassion and involved in decisions about their care and treatment.

We collected 41 cards from a comments box left in the practice waiting room for two weeks before our visit. All of the comments received were positive about the experience of being a patient or carer of a patient registered at the practice. High satisfaction with all aspects of the practice was mentioned in 28 individual cards. Also 14 cards contained comments surrounding high quality and empathetic care by practice staff.

Data from the latest GP national survey published in January 2015 showed 98% of practice patients surveyed rated their overall experience of the practice as good or above. Also 95% of respondents had trust in the last GP they saw or spoke to. The survey results were highly positive about respondents' satisfaction levels with practice nurses. All of the outcome results concerning practice nurses were significantly above local and national averages. An example was 100% felt they had confidence and trust in practice nurses, also 96% felt the nurse involved them in decisions about their care.

Areas for improvement

Action the service SHOULD take to improve

Ensure that patients, visitors and staff are protected from the risk of water borne infection by means of completing a legionella risk assessment.

The Village Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

a Care Quality Commission (CQC) lead inspector. The team also included a GP and an expert by experience. . An expert by experience is a person who has personal experiences of using or caring for someone who uses this type of service

Background to The Village Surgery

The Village Surgery is situated in Wolstanton in the borough of Newcastle-Under-Lyme, Staffordshire. The historical roots of the practice date back over 100 years. The practice now operates from a purpose built building that was constructed in 1988 on the original site.

Patients of all ages are registered at the practice, there are currently just over 6500 patients being cared for.

There are three GPs (one male and two female) working in a partnership at the practice. The all-female nursing team consists of two practice nurses and a health care assistant. A practice manager, assistant practice manager, a team of seven reception and administrative staff and a domestic assistant undertake the day to day management and running of practice duties.

The practice holds a General Medical Services contract with NHS England and has expanded its contracted obligations to provide enhanced services to patients.

The practice does not provide out-of-hours services to the patients registered there. These services are provided by Staffordshire Doctors Urgent Care Limited.

Why we carried out this inspection

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

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 visiting, we reviewed a range of information that we held about the practice and asked other organisations to share what they knew. We carried out an announced visit on 26 January 2015. During our visit we spoke with a range of staff including two GPs, a practice nurse, a healthcare assistant the practice manager, assistant practice manager and three members of reception and clerical staff. We also spoke with seven patients who used the service. We observed how people were cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We 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:

Detailed findings

- 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

Good

Are services safe?

Our findings

Safe track record

The practice 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. For example some patients who were housebound had not received injections of medication they needed to treat their long term medical condition. This occurrence was recorded as a significant event .The event was investigated, an audit of patients affected was completed and communication on actioning requests within the practice and information sharing with other professionals was improved.

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. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held every two weeks 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 said they felt encouraged to do so.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last 10 years and we were able to review these.

Serious events were raised by completion of a standard form which was submitted to the practice manager. Seven serious events had been recorded in the last 12 months. We tracked two incidents and saw that investigation, discussion and action had taken place in a comprehensive and timely manner. We saw action had been taken as a result of serious event reporting. For example the practice had changed the method of issuing prescriptions following a dosage error. This occurrence had also been discussed with the pharmacy which issued the medication. No harm had occurred to the patient and to minimise the risk of reoccurrence the event had been discussed and revaluated every three months to minimise the risk of reoccurrence.

National patient safety alerts were passed on to staff at the practice clinical meeting by the GP who received them. Staff we spoke with were able to give examples of recent alerts. They also confirmed alerts were discussed at clinical 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 children, young people and vulnerable adults. We looked at training records which showed 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. We saw that contact details for local safeguarding teams were easily accessible.

The practice had a dedicated GP the lead contact in safeguarding vulnerable adults and children. All GPs and practice nurses had received safeguarding training to an appropriate level. All other staff were trained to level one in safeguarding. We reviewed the training of all staff and saw they had training appropriate to their role. All staff we spoke with were aware of who the nominated safeguarding leads were and how to raise a safeguarding concern.

There was a system in place that highlighted 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 classified by social services as being at risk.

The practice had a process of contacting any patient who had been to A&E more than once by telephone. Following discussion they were offered an extended appointment with a GP. We saw minutes of weekly complex needs meetings that showed patients were being followed up, supported and referred for further assessment if necessary.

Good

Are services safe?

An example was an older patient who had attended A&E because they were unable to cope with their personal and physical needs at home. A GP had seen the patient and assessed their personal needs to ensure that they were met. This had led to the patient being referred to social services for a care needs assessment.

The staff we spoke with could clearly demonstrate the action they would take if they had concerns in relation to a patient who did not attend an appointment. For example if a child did not attend for immunisations. We saw records that showed the practice had followed up patients who may be vulnerable.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found that they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept within the required temperatures which described the action to take in the event of a potential failure. We saw records to confirm staff members undertook daily checks of the medicines.

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 waste regulations.

The nurses administered vaccines using patient group directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of these directions and evidence that nurses had received appropriate training to administer vaccines.

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

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy. All staff received induction training about infection control and had received updates specific to their role. We reviewed records of the most recent practice audit which had been performed in March 2014. As a result of this audit, the practice had installed new flooring in a treatment room to reduce the risk of infection.

The practice had a number of policies to promote cleanliness and control infection. These included infection control and specimen handling. There were procedure documents and flowcharts to support these policies to enable staff to plan and implement measures to control infection. For example we saw that clinical waste was separated from domestic waste. Staff were able to describe items that would be classified as clinical waste and how to dispose of them in a correct manner. There was a policy and procedure in case a member of staff suffered a needle stick injury.

The practice had hand gel dispensers and hand decontamination notices at regular points throughout the premises. All treatment rooms had hand washing sinks with soap dispensers, paper towels and hand gel dispensers available.

There was a good supply of personal protective equipment in the form of disposable gloves, aprons, eye protection and covers in clinical areas for staff to use to minimise the risk of the spread of infection.

The practice did not have a formal written policy for the management, testing and investigation of legionella (a germ in the environment which can contaminate water systems in buildings). The practice manager documented the flushing of the water system on a weekly basis. There was no formal assessment of the risk of water borne germs or ongoing assessment of the water quality or temperature that may facilitate the growth of germs. We asked the practice to check that their actions are sufficient for reducing the risk of water borne infection.

Equipment

Staff we spoke with told us they had suitable 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 date of the last test. We saw evidence of calibration of clinical equipment. One example was a set of weighing scales.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to a staff member commencing employment. For example proof of identification, references, qualifications, professional registrations with the appropriate body and criminal records checks through the Disclosure and Barring Service (DBS).

The practice manager told us about arrangements for planning and monitoring the number and skill mix of staff needed to meet patients' needs. This was based on providing a minimum of two staff to perform reception and call answering duties. In periods of high activity or staff illness other members of staff were trained and experienced in how to provide reception and telephone duties. The practice manager told us that this helped to maintain the day to day staffing requirements and provided additional support in times of high demand on services.

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. We looked at records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

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. The practice had recently employed a contractor to undertake an assessment of risks concerned with the building and the day to day running of the practice. This assessment led to an action plan of works necessary to mitigate identified risks. An example was the practice had recently arranged electrical rewiring to reduce the risk of fire and loss of power.

A GP told us about the arrangements for patients with long term conditions if their health deteriorated quickly. These patients at high risk of admission to hospital had a care summary record at their home. This document contained information about symptoms that were normal for the patient. This included vital signs (blood pressure, heart rate) and a list of normal daily activities. A GP told us that this document gave ambulance paramedics and other health professionals who had been called to see the patient urgently a method of comparing their findings with measurements and information that would be deemed to be normal for the patient. The document identified a method to contact the practice on a bypass number to speak directly to a GP.

Data from the Quality and Outcomes Framework (QOF) showed that patients from the practice with chronic obstructive pulmonary disease (COPD) were less likely to be admitted to hospital in an emergency than the local clinical commissioning group (CCG) average. A GP told us he thought this was due to patients being given clear instructions on their condition and good access to the GPs when required.

The practice had a health and safety policy which was available for staff to read. The practice manager was the designated lead person with responsibility for health and safety and was aware of the progress of works detailed in the action plan.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed all staff had received training in basic life support. Emergency equipment was available at a secure central point. Equipment included oxygen and nebulisation (to assist someone with difficulty in breathing) and an automated external defibrillator (which provides an electric shock to stabilise a life threatening heart rhythm). There was also a pulse oximeter (to measure the level of oxygen in a patient's bloodstream). All the staff knew the location of this equipment and records confirmed it was checked regularly.

Emergency medicines were available in a lockable carry box within a secure central area of the practice. These were comprehensive and available to treat a wide range of medical emergencies. Examples were medicines for anaphylaxis (allergic reaction), convulsions (when a patient suffers a seizure/fit) and hypoglycaemia (a very low blood sugar level). 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.

The practice had a disaster recovery plan in plan to deal with unplanned events that may occur and hinder operation of the practice. Each risk had been rated and

Good

Are services safe?

mitigating actions recorded to reduce and manage the risk. The plan included details of alternative accommodation to operate the practice from in the event of a major issue with the existing premises. The document also contained details of who to contact in the event of specific issues, for example contact details for computer system failure.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff had received training in fire safety and fire drills were practised.

Risks associated with service and staffing changes had been included in the practice disaster recovery plan. An example was the inclusion of lower than expected staff members on duty due to illness. The practice administrative staff were all able to perform reception and telephone duties. The practice manager told us this gave them the option to redeploy staff to another area of practice work which helped to minimise the impact of short term staff shortages.

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 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.

All of the GPs and practice nurses at the practice we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines. An example was the discussion of the NICE guideline for the management of cardiovascular (heart and blood vessel) disease. Following discussion of this area at a clinical meeting, a GP produced a protocol on the management the risks associated with cardiovascular disease for practice staff to refer to. This document took account of current guidance and was reviewed at appropriate intervals to ensure it was still current.

We reviewed the most recent data available from the previous financial year 2013/2014 in 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. In the 40 clinical indicators we reviewed the practice was reported to have performed significantly above average in five, on or near average in 33 and significantly below average in two. The two outlying areas related to a higher than the local average number of patients at the practice accessing out-of-hours GP services. Also higher than expected numbers of patients with dementia being admitted to hospital in an emergency.

A GP told us about the action that the practice was taking in relation to the two outlying areas. The practice team had secured funding under a clinical commissioning group (CCG) local initiative to provide a complex needs clinic for patients who had attended A&E. If appropriate the practice manager contacted patients and offered them an appointment on the same day to attend the practice to see a GP. The appointment duration was 20 minutes to allow for discussion of health concerns and arrange follow up if required. The practice had provided this service since November 2014. We saw records that showed positive outcomes for patients who had used this service. An example was a patient whose circumstances made them vulnerable. The patient had attended A&E 11 times in three months prior to review at the complex needs clinic. Following review and signposting to support organisations, the patient had not attended A&E in the subsequent two months. The practice team had weekly meetings to discuss the needs of the patients seen.

The practice had identified two per cent of their patients who were at an increased risk of unplanned hospital admission. This had been done by the use of a computerised tool and application of the GPs' knowledge of their patients. The patients had an individual personal care plan which was reviewed on a three monthly basis. The care plan contained information about the patient's medical history, medication and allowed planning for future care needs. If applicable the patient identified a relative or carer to speak to the practice team on their behalf.

A GP at the practice had developed a dementia referral pathway tool to summarise the referral pathway for patients who were presenting with symptoms of dementia. The GP told us that previously the practice had a lower than expected prevalence of patients diagnosed with dementia. To increase the diagnosis of patients with dementia, clinical staff had opportunistically tested patients at the practice who were at a higher risk of developing dementia. The GPs had used a Six Item Cognition Impairment Test (6-CIT) to determine if patients needed referral to special clinics for further investigation and diagnosis. The practice had facilitated diagnosis of an extra 14% of the patients with dementia on their register using this method.

Good

Are services effective?

(for example, treatment is effective)

All of the patients at the practice on the register for people experiencing poor mental health had received an annual health assessment in the previous 12 months. The practice also screened all patients with a long term condition for symptoms of depression at their annual health check.

Local data showed that the practice was in the significantly better than average banding for lower than average referrals to outpatient attendances. All GPs we spoke with used national standards for the referral of suspected cancers 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.

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 a patient's age, gender and culture as appropriate.

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, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy 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 six clinical audits that had been completed in the last two years. All of these audits were completed and had been revisited to ensure that outcomes for patients had improved. An example was an audit into patients who had a recorded diagnosis of gout (pain and inflammation in joints). The aim of the audit was to ensure that this group had a recorded cardiovascular disease (CVD) score. Cardiovascular disease relates to the heart and blood vessels. The GP who undertook this audit, as evidence suggested that a high level of a blood marker in gout is linked to disease of the heart and blood vessels. The first audit showed that 83% of patients at the practice with gout had a recorded CVD risk score. The suggested target was 90%. The second audit seven months later showed that all patients at the practice with a diagnosis of gout had a recorded CVD score.

We saw other audits undertaken at the practice including the control of asthma symptoms, blood cholesterol levels and medication related audits. 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 on the interaction between calcium channel blockers (used to help reduce blood pressure) and lipid lowering medication (used to help reduce fatty blood cells linked to heart disease). This audit followed an alert from the Medicines and Healthcare Products Regulatory Agency (MHRA). Following the audit, the GPs reviewed all patients at the practice who took both of the medications. The GPs altered their prescribing practice and discussed the guidance at a clinical meeting to ensure continuity of future prescribing.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients who received repeat prescriptions were 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 used. The IT system flagged up relevant medicine's alerts when the GP was prescribing medicines. We saw evidence to confirm 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 evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had implemented principles of delivering appropriate care to patients who were approaching the end of their life. 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 participated in local benchmarking run by the Clinical Commissioning Group. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area.

Good

Are services effective?

(for example, treatment is effective)

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. We noted a good skill mix among the doctors with one having an additional diploma in family planning. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example the practice health care assistant had undertaken training to National Vocational Qualification (NVQ) level three.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example for the administration of vaccines.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage 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 communications with other care providers on the day they were received. 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. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice held multidisciplinary team meetings every three months 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 district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

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 all possible referrals last year through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. One GP showed us how straightforward this task was using the electronic patient record system, and highlighted the importance of this communication with A&E. The practice had also signed up to the electronic Summary Care Record and this was fully operational. 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 called Emis Web 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. 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 in their practice. We saw care records that showed staff had applied the principles of the Mental Capacity Act 2005 when involving patients in

Good

Are services effective?

(for example, treatment is effective)

decisions about the care they received. An example of this was a patient who decided on the treatment they chose to receive or not receive in the result of their health deteriorating.

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. We reviewed practice records which showed that all patients on the register with a learning disability had been reviewed in the last 12 months. 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 Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's consent was documented on a minor surgery template. The template recorded the relevant risks, benefits and complications of the surgery.

Health promotion and prevention

The practice had met with the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

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 all health concerns detected and these were followed up in a timely way. The GPs we spoke with told us that they used their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic NHS health checks and offering smoking cessation advice to smokers.

The practice health care assistant was trained in smoking cessation counselling. We reviewed practice data that showed in the 2013 – 2014 period the smoking cessation rate for patients at the practice who had undertaken the smoking cessation programme was 67%. This was well above both the national and local average for this programme. The health care assistant had received recognition from the CCG for the high achievement in this area. We spoke with the health care assistant about the service and they gave us positive examples of the support provided to patients at the practice to help them in cessation of smoking.

The practice's performance for cervical smear uptake was 81%, which was higher than the CCG and national average.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 244 patients in this age group took up the offer of the health check in the previous year. A GP showed us how patients were followed up as appropriate if they had risk factors for disease identified at the health check and how they scheduled further investigations.

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 for all immunisations was at or above average for the CCG.

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 in January 2015 and patient satisfaction questionnaires sent out to patients by each of the practice's partners. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was also comparable with the local and national average in its satisfaction scores on consultations with doctors with 88% of practice respondents saying the GP was good at listening to them and 92% saying the GP gave them enough time.

Patients at the practice rated the care given by the practice nurses highly. The national patient survey we reviewed showed that satisfaction scores were significantly above both the local and national average. For example 98% of practice respondents said the nurse treated them with care and concern and 100% of respondents said that they had confidence in the nurse who treated them.

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 41 completed cards and all 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. A total of 14 cards mentioned the high level of care provided by practice staff in a time of difficulty for the person completing the card.

We also spoke with seven 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. Washable curtains 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 observed that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice switchboard was located away from the reception desk and low level music was played in the background which helped keep patient information private. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients at the practice responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results showed that respondents rated the practice at higher satisfaction levels than the local and national average in these areas. For example, data from the national patient survey showed 82% of practice respondents said the GP involved them in care decisions and 89% felt the GP was good at explaining treatment and results. We also saw that the satisfaction levels with practice nurses in those areas were significantly above the local and national averages. For example 96% of practice respondents felt the nurse involved them in their care. This result was 30% higher than the national average and 27% higher than the clinical commissioning group (CCG) average.

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

Good

Are services caring?

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 very positive and aligned with these views.

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

We saw that patients had been supported to make decisions about the care they wish to receive or wish not to receive in the future. An example of this was a do not attempt cardio-pulmonary resuscitation directive (DNACPR). This directive allowed the patient, relatives, carers and GPs to discuss the personal wishes of a patient approaching the end of their life, which meant resuscitation attempts may be inappropriate. A GP told us of the process of involving and supporting a patient and others close to them in such a difficult and emotional time. We saw records that showed such discussions had taken place and that this was recorded and shared with other partners who were involved in the patients care, for example community nurses and GP out-of-hours services.

Patient/carer support to cope emotionally with care and treatment

All of the survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 84% of respondents to the national patient survey said they felt that the GP who treated them, did so with care and concern. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted staff responded compassionately when they needed help and provided support when required.

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

Staff told us families who had suffered bereavement were contacted where appropriate. A GP told us based on the individual circumstances a GP would call the families if appropriate. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or signposting to a support service.

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 patients' 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) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

The practice offered extended appointments when reviewing patients who experienced poor mental health, a GP told us this was to ensure they had time to discuss issues and so the patient would not feel rushed. Patients who had attended accident and emergency with a health problem or injury that was not life threatening were contacted to discuss their health needs. If necessary these patients were offered a same day extended appointment if they wanted it.

Patients had access to home visits when appropriate and patients we spoke with on the day of inspection confirmed they could request a GP home visit if needed.

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). PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services. An example was the purchase of a television screen to display practice and health promotion information to patients in the practice waiting room.

Tackling inequity and promoting equality

The practice had access to telephone translation services for patients who did have English as their first language.

Facilities at the practice for the consultation and treatment of patients were all situated on the ground floor. Doorways and corridors were wide enough to allow prams and wheelchairs to turn and access all rooms. We saw patients with walking aids mobilising through the practice without hindrance. There was a hearing loop available for patients and visitors with hearing aids.

The practice staff we spoke with were all able to demonstrate they recognise the importance of treating all patients, carers and visitors with equality and respecting diversity.

We spoke with a practice receptionist who told us about the support they had provided to a patient who had a communication difficulty. Due to her awareness of this type of communication difficulty, she had noticed the patient displayed non-verbal signs of distress when reading written instructions from a GP. She told us that she explained the instructions to the patient and spoke with the GP about communicating in joined up writing as some patients with this communication difficulty may have experienced difficulty with reading joined up words. The GP confirmed they had also learned from this event.

Access to the service

The practice offered appointments from 7:30am to 6pm on a Monday, Tuesday and Wednesday, 8am to 6pm on a Friday also 8am to 1pm on a Thursday. During these hours the reception desk and telephone lines remained staffed.

Patients were able to book appointments with a preferred GP up to four weeks in advance. We saw that all GPs had appointments available in the following days.

Patients with urgent care needs were offered same day appointments. A GP told us they would never refuse to offer an urgent appointment or redirect a patient requesting appropriate assistance. The patients we spoke with on the day of inspection all confirmed that they had been able to access a GP on an urgent basis when required.

Appointments could be booked in person, via telephone or via an internet appointment system for patients who had registered their details for this method.

Telephone consultations were available for each GP at allotted times throughout the day. A GP commented this was particularly useful for patients with work commitments.

Comprehensive information was available to patients about appointments 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 to ensure patients received urgent medical assistance when the practice was closed. If

Good

Are services responsive to people's needs?

(for example, to feedback?)

patients called the practice when it was closed, their telephone was transferred to the 111 service. Information on the out-of-hours service was provided to patients on the practice website and in the waiting room.

Longer appointments were available for those who needed them. For example review appointments for patients with poor mental health and those identified with complex needs.

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. The practice displayed clear information on how to raise a complaint in the waiting room, practice booklet and on their website. 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.

The practice had received six recorded complaints in the previous 12 months. The practice manager told us that none of these complaints had been formally made and included those made on the NHS choices website. We saw that all of these complaints had all been dealt with in a timely and open way. We saw that one complaint regarding the cancellation of a procedure due to a temporary staff shortage had led to changes in the way the practice handled the rebooking of appointments or procedures. Staff had discussed this complaint and cascaded information to all team members to ensure if an appointment was cancelled with no alternative date available within an acceptable timeframe, the issue should be escalated to a senior member of staff to explore alternatives.

The practice reviewed complaints 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.

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 used the basis of the NHS constitution to pave out a clear vision to deliver high quality care and promote good outcomes for patients. The NHS constitution brings together details of what staff, patients and the public can expect from the National Health Service. The practice displayed this information on their website and in the waiting room.

All of the practice staff we spoke with knew the essence of these values and expectations and also their role in relation to them.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff within practice files. We looked at five of these policies and procedures and saw that they had been reviewed annually and were up to date. All of the staff we spoke with knew of the existence of policies and procedures and where to access them.

The practice held clinical meetings every two weeks and governance was discussed at each. We looked at minutes from the last four meetings and found that performance, quality and risks had been discussed. Weekly meetings to discuss patients were also held to discuss patients identified with complex needs.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us their risk assessment document which had been undertaken in previous months and addressed a wide range of potential issues, such as the loss of electrical power. We saw that recent work had been carried out to minimise identified risks. An example was electrical rewiring work to minimise the risk of fire and loss of power.

Leadership, openness and transparency

There was a clear leadership structure at the practice. All of the staff we spoke with were able to identify the key person for each lead role. For example, all knew who the lead for safeguarding was. Staff were also 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.

Staffing at the practice had remained unchanged for a number of years. The practice manager had worked at the practice for over 30 years. They told us they operated an open door policy for staff to approach them with any concerns or problems. Staff confirmed an open culture and they felt able to approach the GPs or practice manager at any time.

A GP told us that the practice staff regularly met with neighbouring practices in the clinical commissioning group (CCG) to benchmark their performance also to share and learn from others.

Practice seeks and acts on feedback from its patients, the public and staff

Staff at the practice and members of the patient participation group (PPG) met on a bi-monthly basis to discuss issues concerning the operation of services at the practice. PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services. We saw minutes of a recent meeting where it was agreed to redecorate and update the practice waiting room following patient comments about the waiting room appearance looking worn and tired. The PPG had commissioned their own website which displayed meeting dates, minutes and newsletters on their website to promote the work of the PPG and practice.

Each GP undertook annual patient satisfaction surveys for use in their appraisals. One GP told us this provided invaluable feedback to enable them to reflect on their strengths and highlighted areas for improvement.

The practice had showed yearly improvements in the GP national patient survey and used this information to plan and maintain performance. The latest GP national survey published in January 2015 showed that the practice had performed strongly in all areas and was above both the local and national averages in all measured outcomes.

We saw examples of the practice team had identified areas in which they could improve performance. An example was the practice had lower than expected numbers of patients diagnosed with dementia. A GP had introduced a dementia pathway document to highlight and demonstrate the dementia diagnosis pathway. This had resulted in an increase of 14% patients on the practice register for dementia.

Are services well-led?

Good

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place which included a personal development plan.

The practice had completed reviews of all significant events and other incidents and shared these with staff via meetings and to ensure the practice improved outcomes for patients.