Wonford Green 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 a comprehensive inspection of Wonford Green Surgery 16 June 2015.

Overall the practice is rated as good. We found the practice to be good for providing safe, caring, responsive, effective and well led services. It was also good for the care provided to older people, people with long term conditions, families, children and young people, people living in vulnerable circumstances and people experiencing poor mental health (including people with dementia). They were good for the care and treatment they offered working aged people (including those recently retired) and people whose circumstances make them vulnerable.

Our key findings were as follows:

- Arrangements were in place to ensure patients were kept safe. The practice learnt when things went wrong and shared learning with all staff to minimise the risk of reoccurrence
- Patients' needs were appropriately assessed and care and treatment was delivered in line with current legislation and best practice.
- We saw from our observations and heard from patients that they were treated with dignity and respect.
- 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
- The practice understood the needs of their patients and provided services that met their needs.
- The practice was well-led, had a defined leadership structure and staff felt supported in their roles.

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 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 providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams and shared information appropriately.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that 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 decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. 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 NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their

Summary of findings

needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. 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 a virtual group of eight people and was called upon when needed. The practice proactively tried to recruit new members. 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 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 enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

Older patients attending the practice received relevant immunisations from the practice nurses. The number of patients over 75 was relatively low, and many of those lived in care homes. The practice had established electronic care plans for those patients and shared details of appropriate interventions with the out of hour's service as needed. If patients living at home were identified as needing extra care or therapy this was arranged through a Rapid Intervention Centre, and if specialist medical input was needed the practice were able to access this through an acute service based at the Royal Devon & Exeter Hospital.

The practice followed up patients proactively following out of hours contact, A&E attendance or acute admission where appropriate.

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.

The practice used an annual call-up system for nurse-led review of patients with conditions such as cardiovascular disease, hypertension, asthma and diabetes. When patients did not attend the practice arranged reviews opportunistically and through automatic messages on prescriptions once the medication review date has passed. Practice nurses did not have separate clinics for long-term conditions but run mixed clinics with varying appointment times, allowing greater flexibility. They held regular virtual clinics with diabetes specialist nurses and initiated and monitored insulin prescribing.

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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 relatively 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 saw good examples of joint working with midwives, health visitors and school nurses.

GPs carried out routine eight week checks on babies and also coordinated this with a nurse appointment to enable the baby to have its first immunisation in one appointment. The GPs and nurses communicated and worked well with Health Visitors, Public Health Nurses, teachers, social workers and paediatricians over any concerns.

The practice referred to the local youth counselling service or initiated and engaged with multi-agency involvement through the local referral hub and Children and Adolescent Mental Health Service (CAMHS). They attended multi-agency meetings as appropriate. The practice provided fostering and adoption medical examinations and paternity DNA testing.

The practice offered a full range of contraception and was able to fit, monitor and remove intrauterine and subcutaneous contraceptives in-house. They offered routine cervical screening and screening for sexually transmitted infections. Where appropriate they referred patients on to the local sexual health service at the Walk in Centre in central Exeter.

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 reflects the needs for this age group.

The practice recognised that patients on a low income often requested prescriptions for items available over the counter. The practice informed patients about a local Pharmacy First scheme to

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allow patients to obtain these free of charge directly from a pharmacy. They offered e-mail and online prescription ordering and worked with local pharmacies so that patients could request their medicines electronically and collect them from their preferred outlet.

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 homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability and 73% 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. Information was given to vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). 71% of people 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 advance care planning for patients with dementia.

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

The practice routinely referred patients to the local Depression & Anxiety Service (DAS), low-cost counselling centre, substance abuse agency and domestic abuse support service, as well as relevant national organizations offering telephone support or local groups. They referred patients with cognitive impairment to the local Memory Clinic where appropriate, and those with functional mental

Summary of findings

illness to the Adult Mental Health Assessment Service. The practice regularly hosted a DAS worker in the practice and share care of patients addicted to opiates with the Recovery and Integration Service (RISE).

Summary of findings

What people who use the service say

We spoke with 11 patients during our inspection and received 26 completed Care Quality

Commission (CQC) patient feedback cards. We looked at the completed CQC comment feedback cards and all were very positive about the practice. All the patients we spoke with during the inspection told us they were satisfied with the overall quality of care and support offered by the practice from both clinical and non-clinical staff. Most of the patients we spoke with had been registered with the practice for many years and told us staff were friendly, efficient and understanding and the GPs gave consistently good care. This was similar to the findings of the latest national GP patient survey which found that 93% of 113 respondents had confidence and trust in the last GP they saw or spoke to and 73% said that they would recommend the practice to someone new.

92% of patients stated in the patient survey that the last appointment they made had been convenient. Patients said they usually had to wait but were appreciative that the GP gave them the time they needed to discuss their concerns. Only 56% of patients who responded via the GP survey said they didn't normally have to wait to be seen but 87% said the last GP they saw or spoke to was good at giving them enough time. This was comparable with the national average of 87%.

Wonford Green Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) lead inspector. The team included a GP specialist, a nurse specialist 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 Wonford Green Surgery

Wonford Green Surgery provides GP primary care services to approximately 5200 people living in different areas of Exeter city, namely Wonford, St Loyes, Heavitree and parts of Whipton. The practice serves approximately 5200 patients. The national general practice profile

shows the practice has a higher than average to England population of patients aged under 18 years old. They are also below the national and local average for 75 years and older.

There are three GP partners and two salaried GPs; two male and three female. Each week collectively the GPs work the equivalent of approximately three and a half full time GPs.

The practice has been registered as a GP teaching and training practice for three years. There is one GP trainer. The practice provides training opportunities to doctors seeking to become qualified GPs.

The team were supported by a practice manager, two nurse practitioners, one phlebotomist (staff who take blood) and a nurse assistant. The clinical team were supported by additional reception, secretarial and administration staff.

Patients using the practice also had access to community staff including community matron, district nurses, community psychiatric nurses, health visitors, physiotherapists, speech therapists, counsellors, podiatrists and midwives.

The practice is offers appointments from Monday to Friday, between the hours of 8.30am and 5.30pm. The practice operates a 'phone on the day' appointment system for GP appointments. A small number of pre-bookable appointments are available up to 2 weeks in advance for those who may find these more convenient. The practice offers appointments until 8.45pm one evening a week.

The practice had opted out of providing out-of-hours services to their own patients and referred them to another out-of-hours service.

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.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 16 June 2015.

During our visit we spoke with a range of staff including five GPs, two practice nurses, the practice

manager and six members of reception and clerical staff. We spoke with 11 patients who used the service. We reviewed 26 comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

- 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 prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example recently the wrong patient was contacted to make an appointment for a blood tests and a GP appointment. The mistake was identified and actions taken to ensure this could not happen again.

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

Learning and improvement from safety incidents

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

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. S/he showed us the system used to manage and monitor incidents. We saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared. For example on one occasion a prescription was given to the wrong patient. This was swiftly investigated and was found to be an issue where the wrong patient was booked in for an appointment and seen by the GP. The issue was dealt with quickly and no harm came to the patient. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for.

Reliable safety systems and processes including safeguarding

The practice had a detailed child protection and vulnerable adults policy and procedure in place which incorporated information on the Mental Capacity Act 2005. The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. All staff had received safeguarding training which was updated annually.

All the staff we spoke with were able to confidently discuss what constituted a child and adult safeguarding concern. They were aware of how to report suspected abuse and who to contact if they needed advice. We were given examples of safeguarding concerns being raised with the relevant authorities and how the practice had been involved in managing these concerns. Monthly meetings were held at the practice with a Health Visitor and where required Social Workers to ensure good communication and all parties were up to date with relevant information linked to children and families welfare. If reception staff had any concerns about a patient's welfare while at the practice, they could communicate these to clinicians prior to the patient being seen by the GP or nurse. Where concerns already existed about a family, child or vulnerable adult, alerts were placed on patient records to ensure information was shared between staff and to encourage continuity of care. All those on the register were discussed at quarterly safeguarding meetings.

The practice referred to the local youth counselling service or initiated and engaged with multi-agency involvement through the local referral hub and CAMHS. They attended multi-agency meetings as appropriate. The practice provided fostering and adoption medical examinations and paternity DNA testing.

The lead GP for safeguarding was not present on the day but provided us with a written report. They had completed

training to level three and were knowledgeable about the contribution the practice could make to safeguarding patients and were proactive in raising concerns to the Local Authority and police where required, with evidence recorded as part of safeguarding records.

A chaperone policy was in place, and notices for patients in the waiting area and consultation rooms. Speaking with staff who acted as chaperones, they were clear of the role and responsibility. Only clinical staff acted as chaperones. Where a chaperone was declined or accepted the details were recorded within patient's records.

Medicines management

There were clear systems in place for medicine management. If patients required medicines on a repeat prescription these were re-authorised by a GP at least once a year following a medicine review. For patients with long term conditions this was usually at the same time as their annual check-up. All prescriptions were printed and there were checks in place to ensure prescriptions were secure. Reception staff were aware of questions to ask to ensure the security of prescriptions being collected by patients.

We saw there were medicines management policies in place, and the staff we spoke with were familiar with these. We checked the medicines held at the practice. These were all appropriately stored. Medicines to be used in the case of an emergency were available. We saw that these were checked by the practice nurse, were readily available and within their expiry date. There was a system in place to re-order medicines when their expiry date was approaching. Clear records were kept whenever emergency medicines were used.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. Training records showed that nurses had received appropriate training to administer vaccines. Controlled drugs were not held at the practice. Some medicines and vaccines were required to be kept in a fridge. The fridge temperature was monitored twice daily and records showed they were stored within the correct temperature limits.

Evidence was seen of medicine audits being carried out. The practice was responsive when new advice was received and carried out medicine audits appropriately. We saw evidence that changes to medicine prescribing were made when required. When new patients registered with the practice their electronic records flagged that their medicine must be reviewed when their paper records from their previous practice were received. We saw that where a new patient had regular medicines the GP checked this and made an appointment to see the patient to discuss any changes that may be required.

Cleanliness and infection control

We observed all areas of the practice to be visibly clean, tidy and well maintained. 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.

All of the staff we spoke with about infection control said they knew how to access the practice's infection control policies. Infection control training was provided for staff. The practice had a lead for infection control who had undertaken further training to enable them to provide advice about the practice infection control policy and carry out staff training. We saw evidence that the lead had carried out an infection control audit in March 2014 and that any improvements identified for action were completed on time. For example the replacement of pedal bins and the deep cleaning of some areas.

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.

Nurses and the senior health care assistant told us that personal protective equipment was available for use and were able to demonstrate a sound understanding of their responsibility in its use. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The risk of the spread of infection was reduced as all instruments used to examine or treat patients were single use. Hand washing instructions were also displayed in the treatment rooms by hand basins and there was a supply of liquid soap and paper hand towels. The privacy curtains in the consultation rooms were cleaned (or changed if they were the disposable type) every six months or more

frequent if necessary. A needle stick injury policy was in place. This outlined what staff should do and who to contact if they suffered a needle stick injury. We saw there were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We looked at some of the practice's clinical waste and sharps bins located in the consultation rooms. All of the clinical waste bins we saw had the appropriately coloured bin liners in place and all of the sharps bins we saw had been signed and dated as required.

Equipment

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

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Newly appointed staff had this expectation written in their contracts.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix met planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, staffing and equipment. Health and safety information was displayed for staff to see and there were identified health and safety representatives. The practice had carried out a fire risk assessment including actions required to maintain fire safety.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Staff told us they felt confident to deal with a medical emergency and had received basic life support training in the last year. We saw the practice had emergency equipment available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment. We saw checks were in place to ensure oxygen and the defibrillator was checked regularly to ensure it was in working order.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The business continuity plan also contained relevant contact details for staff to refer to.

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 that guidance from local commissioners was readily accessible in all the clinical and consulting rooms.

We saw minutes of clinical meetings which showed this was then discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

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

Read coding was extensively used for patients. Read coding records the everyday care of a patient, including family history, relevant tests and investigations, past symptoms and diagnoses. They improve patient care by ensuring clinician's base their judgements on the best possible information available at a given time. The GPs and nurses we spoke with were all familiar with read coding and its benefits when assessing patients' conditions.

The GPs told us they lead in specialist clinical areas such as weight management, mental health and chronic pain management. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to review and discuss new best practice guidelines, for example, for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

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

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. 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 showed us nine clinical audits that had been undertaken in the last year. All of these audits had dates factored in to repeat the process and complete a full cycle. The practice showed us an example where a change had occurred resulting from an audit. We saw that an audit regarding the management of cervical smears appointments and the number of patients that did not attend appointments. All patients that did not attend the first invitation were written to and telephoned to invite them again and to discuss any barriers there may hay been. We saw evidence to show that this had resulted in four women having then had their cervical smear and another four considering it. This process was being continued audited.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor and improve outcomes for patients. For example, data showed that 84% of patients on the diabetic register had received a foot examination this compared similarly to the national average of 87%.

Good

Are services effective?

(for example, treatment is effective)

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of anti-coagulation drugs and the monitoring of the international normalized ratio (INR) these are the measures of the extrinsic pathway of coagulation. Following the audit, the GPs identified that some competencies for staff that were monitoring INR levels needed formalising. This had been addressed.

The practice was aware of all the areas where performance was not in line with national or CCG figures and we saw action plans setting out how these were being addressed.

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

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

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

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. Staff received training in mandatory courses, such as fire safety, manual handling, health and safety, infection control and equality and diversity through an online virtual college. The continuing development of staff skills and competence was recognised as integral to ensuring high quality care. Role specific training was provided. The practice nurses had been trained to administer vaccines and had attended updates on cervical screening. Nursing staff had attended training courses about respiratory diseases and diabetes in order to maintain and increase their skills and knowledge in those areas. Staff were proactively supported to acquire new skills and share best practice. Staff told us they had sufficient access to training and were able to request further training where relevant to their roles. Staff spoke with a sense of pride and told us Wonford Green Surgery was a good place to work.

We noted a good skill mix amongst the GPs. They had specialism areas in obstetrics, gynaecology, child health, mental health, minor surgery and dermatology. All GPs we spoke with told us they were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals which 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, one health care assistant had requested training in a weight management scheme. The practice had encouraged and arranged this and the health care assistant had developed her role to become competent in this field

.**Working with colleagues and other services**

The practice worked with other service providers to meet patient needs and in particular those 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

Good

Are services effective?

(for example, treatment is effective)

were received. When GPs were on leave there was a buddy system in place for correspondence and results to be reviewed and actions taken. All staff we spoke with understood their roles and felt the system in place worked well.

Discussions with staff showed the practice worked in partnership with other health and social care providers such as social services, local mental health teams and district nursing services to meet patients' needs in an effective way. The practice held monthly multi-disciplinary meetings and would invite district nurses, emergency care practitioners, the intermediate rehabilitation care and support team, adult social services and palliative care nurses. Monthly child protection meetings were held with health visitors, school nurses and midwives.

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.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, 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.

Regular meetings were held throughout the practice. Information about risks and significant events were shared openly at meetings and all staff were able to contribute to discussions about how improvements could be made.

There was a practice website with information for patients including signposting, services available and latest news. Information leaflets and posters about local services were available in the waiting area. The practice used a text messaging service to remind patients of any significant things and appointment times.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. For example the practice kept records that showed us that 70% of the care plans of people with dementia had been reviewed in last year with a face to face meeting with them. Staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for 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 discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice obtained written consent for significant minor procedures and all staff were clear about when to obtain written consent.

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

Health promotion and prevention

New patients were offered a health check with the health care assistant / practice nurse 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. 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 every opportunity for chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

Good

Are services effective?

(for example, treatment is effective)

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. The practice's performance for cervical smear uptake in 2013/2014 was 69.8%, which was worse than the national average of 81.9%. This year's data showed that improvement had been made and currently 71% of women have had a cervical smear undertaken. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend.

Health promotion literature was readily available to patients and was up to date. This included information about services to support them in, for instance, smoking cessation and weight management schemes. Patients were encouraged to take an interest in their health and to take action to improve and maintain it.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice nurse had a comprehensive system in place to ensure that the child's immunization status was checked from the records of the country of origin so that the child was fully immunised in line with current guidance. There was a clear policy for following up non-attenders by the practice nurse.

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 GP patient survey 2014 which surveyed 397 patients of which 113 responded and a survey of 192 patients undertaken by the practice over 2013 to 2014. The evidence from these sources showed patients were satisfied with how they were treated and that they had been treated with compassion, dignity and respect. Data from the national GP patient survey showed the practice was rated above the national average (84%) as 88% of patients would describe their overall experience of the practice as good.

The practice was above the CCG average (98%) for its satisfaction scores for nurses. 100% of patients said they had confidence and trust in the last nurse they saw or spoke to and 93% of patients were highly satisfied with their confidence in the last GP they had seen. On the day of our inspection we spoke with 11 patients visiting the practice. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Patients spoke highly of the practice, the reception staff and the GPs. Patients described staff as caring, kind and respectful.

We observed staff interaction with patients was respectful and friendly. The consulting and treatment rooms were suitably equipped and laid out to protect patient privacy and dignity. We noted that consultation and treatment room doors were closed during consultations and conversations could not be heard through closed doors. Curtains were provided in consulting rooms and treatment rooms so patients' privacy and dignity was maintained during examinations, investigations and treatments. The practice reception area was separate from the waiting area to increase patient confidentiality. 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, observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 82.7% of practice respondents said the GP involved them in care decisions, this compared higher than the local (CCG) average of 79.4%.

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

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.

Patient/carer support to cope emotionally with care and treatment

The patient 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:

- 82.1% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and national average of 82.7%.
- 76.2% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 81% and national average of 78%.
- 90.9% of patients said they found the receptionists helpful compared to the CCG (local) average of 89.9% and the national average of 86.9%.

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 that staff responded compassionately when they needed help and provided support when required.

Good

Are services caring?

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

The practice routinely referred patients to the local Depression & Anxiety Service (DAS), low-cost counselling centre, substance abuse agency and domestic abuse support service, as well as relevant national organizations offering telephone support or local groups. They referred patients with cognitive impairment to the local Memory Clinic where appropriate, and those with functional mental illness to the Adult Mental Health Assessment Service. The practice regularly hosted a DAS worker in the practice and share care of patients addicted to opiates with the Recovery and Integration Service (RISE).

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example the practice has changed the GPs' surgery and appointment times. This was not as a direct result of formal patient feedback but that staff had become aware that patients were asking for an earlier or later appointment in the day. Therefore from July this year the majority of the GPs are starting morning surgeries at 8.30am and having their last appointment at 5.30pm. One evening a week the practice offered a late evening appointment with the last appointment available being 8:45pm.

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 had met with the Public Health team from the local authority and 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 population in the local area. This information was used to help focus services offered by the practice.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example following patient feedback higher chairs and high backed chairs were purchased for the in the waiting room. The patients also asked for a dedicated children's area. This was added to the waiting room, with coloured fencing and an activity table as well as a children's table with colouring crayons and paper.

Tackling inequity and promoting equality

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months.

The practice had level access from the car park to the front door. Inside the GP consultation rooms and the treatment rooms were located on the ground floor. The premises were modern and purpose built. The seats in the waiting area were differing heights and size. There was variation for diversity in physical health and all chairs had arms on them to aid sitting or rising. Audio loop was available for patients who were hard of hearing and staff were knowledgeable about the different needs of the patients who attended. There was disabled toilet access and baby changing facilities were available. The reception desk was had a lower section and was suitable for those people that used a wheelchair.

The practice had access to telephone translation services for patients whose first language was not English.

Access to the service

The practice was open and offered appointments from 8:30am 5:30pm Monday to Friday. The practice operated a 'phone on the day' appointment system for GP appointments. A small number of pre-bookable appointments were available up to 2 weeks in advance for those who may find these more convenient. One evening a week the practice offered a late evening appointment with the last appointment available being 8:45pm.

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 patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

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

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 80.3% were satisfied with the practice's opening hours compared to the CCG average of 78.6% and national average of 75.7%.
- 80.5% described their experience of making an appointment as good compared to the CCG average of 82.4% and national average of 73.8%.
- 71.8% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 71.4% and national average of 65.2%.
- 76.6% said they could get through easily to the practice by phone compared to the CCG average of 81% and national average of 71.8%.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a GP on the same day if they felt their need was urgent although this might not be their GP of choice.. They also said they could see another GP if there was a wait to see the GP of their choice.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. We saw that information was available to help patients understand the complaints system, which was set out in a complaints leaflet, and was available in the practice and on their website. None of the patients we spoke with had ever needed to make a complaint about the practice. We looked at the six complaints received in the last six months and found these were satisfactorily handled, dealt with and responded to in a timely way. There was openness and transparency with dealing with the complaints, and learning from complaints were shared with the staff team.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and explained in the practice statement of purpose document. The practice vision and values included to be kind, caring and professional and to be a welcoming, patient focused practice with a strong emphasis on team working. We spoke staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice.

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 a partner was the lead for safeguarding. We spoke with a range of staff including five GPs, two practice nurses, the practice manager and six members of reception and clerical staff, they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

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

The practice had completed a number of audit cycles, for example, we saw an audit of patients who did not attend appointments. The first audit showed the percentage of patients who did not attend their appointment was 15%. After intervention, on re-audit the percentage had decreased to 1.8%.

The practice had robust arrangements in place for identifying, recording and managing risks. Identified risks were included on a risk matrix maintained by the practice manager which graded risks as low, moderate, high. Each risk was assessed, graded and mitigating actions recorded to reduce and manage the risk.

Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG.

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

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example there was a lead nurse for infection control. The senior partner was the team lead for critical event and significant event reviews. The members of staff we spoke with were all clear about their own roles and responsibilities. We saw from the minutes we looked at 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. Where staff were absent for any reason they were provided with minutes of the meetings to enable them to remain up to date. There was a willingness to improve and learn across all the staff we spoke with. The leadership in place at the practice was consistent and fair and as a result of the atmosphere generated, there was a low turnover of staff. The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies in place that included the induction policy and job descriptions which were in place to support staff. The staff handbook 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.

Are services well-led?

Good

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

All staff had an annual review of their performance during an appraisal meeting. This gave staff an opportunity to discuss their objectives, any improvements that could be made and training that they needed or wanted to undertake. Clinicians also received appraisal through the revalidation process. Revalidation is where licensed GPs are required to demonstrate on a regular basis that they are up to date and fit to practise.

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

The practice had gathered feedback from patients through patient surveys, complaints and compliments received. We looked at the results of the annual national GP survey for 2014, which 113 patients provided responses for. High levels of satisfaction were seen in the responses to the national GP survey. Access to the practice was very good and patients could see a GP quickly. 92% of patients reported that the last time they got an appointment that it was convenient to them, this compares slightly higher than the national average of 91%.

The practice had a small active virtual patient participation group (PPG) which had a membership of approximately 8 patients. The practice continually advertised for PPG members on the practice website and at the practice. New patients registering were given information about the PPG and directed to the website. The group communicated with each other via email or by meeting up when needed. The practice planned to review any patient feedback supplied via the PPG throughout the year. Unfortunately by the end of Sept 2014 they hadn't received any feedback from the PPG around any issues they would like addressed. As a result of this and because of the small number of members of the PPG the practice undertook an "Improving Practice Questionnaire" at the practice during Nov 2014. The summary of the results of this was shared with the PPG during February 2015. No comments were received back. An example of the questionnaire and summary of results was also published on the website.

The practice manager showed us how analysis of the GP patient survey took place. For example the administration and nursing team were given the results of the national survey to view prior to a staff meeting. They looked at the key findings and of those below the national mean score. 76% of patients said they had difficulty in getting through on the telephone to make an appointment compared to 81% local (CCG average) and 56% of patients said they didn't have to wait too long to be seen, this compared lower of the local (CCG) average of 64%. The comfort of the waiting room was scored as 7% below the national average.

The survey was discussed and actions taken to make improvements for example, the introduction of on line access for patients so that they will be able to book in advance as well as have access to the same day appointments at 8.30am each morning. A poster was put up in the waiting room to inform patients that there was four administration staff answering the telephone each morning and that they may be held on hold but they will be answered. The waiting room was redecorated and had new lighting since the survey was undertaken.

The waiting time for patients was discussed by the GPs and is was linked to time keeping of GPs and the nursing team in their surgeries. The nursing team had variable times for different appointments and this helped them keep to time. In September 2014 the practice increased the phlebotomy and health care assistant hours thereby increasing the availability of appointments for patients and hoped this would be reflected when the survey is repeated.

There was a low turnover of staff at the practice. Staff said they felt their views were valued and they felt listened to. The practice had gathered feedback from staff through staff meetings, appraisals and informal discussions. There was an open culture and staff told us they did not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Minutes of all the meetings we reviewed showed there was a clear process of reporting progress back to staff and linking issues across the whole team.

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 and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.

Are services well-led?

Good

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

The practice has been registered as a GP teaching and training practice for three years. There is one GP trainer. The practice provides training opportunities to doctors seeking to become qualified GPs.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients. The practice had completed reviews of significant events and other incidents and shared with staff at meetings and clinical governance meetings to ensure the practice improved outcomes for patients. For example one significant event affected the GPs, nursing team and administration team. All staff were reminded of correct procedures and measures put in place to prevent the situation arising again.