

Tanworth-in-Arden Medical Practice

Quality Report

The Birches
Broad Lane
Tanworth-in-Arden
Solihull
B94 5DY
Tel: 01564 742274
Website: www.tiamp.co.uk

Date of inspection visit: 18 September 2015
Date of publication: 18/02/2016

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

Ratings

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

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	3
The six population groups and what we found	5
What people who use the service say	8
Areas for improvement	8

Detailed findings from this inspection

Our inspection team	9
Background to Tanworth-in-Arden Medical Practice	9
Why we carried out this inspection	9
How we carried out this inspection	9
Detailed findings	11
Action we have told the provider to take	21

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Tanworth-in-Arden Medical Practice on 18 September 2015. Overall the practice is rated as good.

Our key findings 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. We saw evidence where significant events and complaints were discussed and saw examples of changing practice in response to these.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management.

- Risks to patients were assessed and well managed.
- Patients said they were treated with kindness, professionalism and respect.

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

Importantly, the provider must:

- Ensure that supplies of equipment and medicines for use in an emergency are appropriately maintained.

The provider should:

- Review the checking process for monitored dosage packs to mitigate the risk of medicine dispensing errors.
- Review the documentation of near misses in the dispensary so that lessons could be learned.

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?

The practice is rated requires improvement for providing safe services as the oxygen cylinder was found to have expired in September 2014. The practice was going to address this after the inspection.

Staff knew how to raise concerns and were able to report incidents and near misses. Lessons were learned when things went wrong and improvements were made. Risks to patients were assessed and well managed. The documentation of risk assessments should be improved. Although risk assessments had been completed we highlighted during the inspection that risk assessments could be logged in the risk log and therefore documented in one place. The practice manager was going to review this.

Requires improvement



Are services effective?

The practice is rated good for providing effective services. National patient data showed that the practice was at or above the average for the locality on the whole. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Staff had received training appropriate to their roles and the practice was looking to move forward to electronic learning for some training. Staff routinely worked with multidisciplinary teams.

Good



Are services caring?

The practice is rated good for providing caring services. Patients felt involved in their care and treatment and described staff as helpful, considerate and kind. Patient information was easy to understand and accessible to patients. We saw staff treated patients with dignity and respect and were professional at all times.

Good



Are services responsive to people's needs?

The practice is rated good for providing responsive services. The practice responded to the needs of its local population and engaged well with South Warwickshire Clinical Commissioning Group (CCG). The practice had good facilities and was well equipped to meet the needs of their patients. Information about how to complain was available and easy to understand. Learning from complaints was shared and discussed at practice meetings.

Good



Are services well-led?

The practice is rated good for being well-led. It had a clear vision and strategy. The practice was looking at ways to continuously improve

Good



Summary of findings

and they had a programme of continuous clinical and internal audit. There was a clear leadership structure and staff felt supported and valued. The practice had a number of policies and procedures to govern activity.

The practice proactively sought feedback from staff and patients, which it acted on and had an active Patient Participation Group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

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

The practice is rated as good for the care of older people. In 2015 the practice employed a care co-ordinator with responsibility for proactive review of the elderly. This involved co-ordinating with Age Concern colleagues and the wider team to discover and anticipate problems in the hope of addressing issues early and preventing morbidity and mortality. At the time of the inspection 84 face-to-face interviews had taken place. The practice had received positive comments about this from patients.

As part of the practices' weekly medicines delivery service they employed two regular drivers who knew the patients well. They reported back if a patient seemed unwell or had any issues enabling early intervention from an appropriate team member particularly amongst older patients. This allowed the practice to set up services to support the patient in continuing independent living. The practice delivered monthly to 180 patients. An additional 47 patients had weekly deliveries of daily dose systems.

Good



People with long term conditions

The practice is rated as good for the care of people with long term conditions. Chronic disease management was central to the practice's role. The practice had robust recall systems for patients, arranging individual reviews at the patient's convenience. During reviews the practice tried to empower and educate patients through the services they provided such as heart clinics, and made additional advice available online. All the practice's respiratory disease patients had written management plans and as appropriate carried stand-by medicine for early intervention with exacerbations.

The practice reviewed all diabetic patients at least six monthly. Patients in other chronic disease categories were reviewed at least annually. Patients with complicated or difficult issues were seen more frequently than this.

The practice had a system for reviewing test results and an auditable process of patient recall.

Many of these patients were on multiple medicines and a medicines review was standard practice during each patient contact and at least annually. The practice achieved near maximum points on the Quality and Outcomes Framework (QOF) in this category. QOF is a system intended to improve the quality of general practice and reward good practice.

Good



Summary of findings

Families, children and young people

The practice is rated as good for the care of families, children and young people. The practice had family friendly facilities and worked closely with health visitor and midwifery colleagues who had rooms at the practice. The practice had a policy that all sick children under five were seen on the same day if parents were worried.

The practice was committed to providing a confidential and comprehensive contraceptive and sexual health service with special regard for young people and this was advertised on their website and in the practice leaflet. Two of the GPs had additional training in contraceptive implants.

Good



Working age people (including those recently retired and students)

The practice is rated as good for the care of working age people, recently retired people and students. The practice kept specific early and late appointments for working people and would often arrange to see patients with urgent problems and take blood samples before surgery started for this population group. All the clinicians at the practice took blood samples during their consultations saving time and a repeat attendance for the patient. We did, however, note that the practice did not offer extended hours.

Good



People whose circumstances may make them vulnerable

The practice is rated as good for the care of people living in vulnerable circumstances. As a small, rural practice the practice knew their patients well. They would see vulnerable patients at short notice and they maintained a special considerations board to ensure prompt and appropriate response to any request from these patients.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people who experienced poor mental health. Clinicians would pre-book patients who experienced poor mental health to avoid having to negotiate the appointments system. Patients could ring and leave a message for their clinician which would be answered that day.

The practice had an in-house clinic from an Improving Access to Psychological Therapies (IAPT) counsellor and had shared clinical meetings allowing a joint approach.

In 2015 the practice tried to identify potential patients with memory issues using in-house searches and national audits. The practice diagnosis rate based on prevalence of dementia rose from 24.2% in

Good



Summary of findings

Sept 2014 to 49.3% in March 2015. The practice reviewed, referred and treated all patients identified in this way. The lead clinicians had attended dementia awareness training and the practice was in the process of being registered as 'dementia friendly'.

Summary of findings

What people who use the service say

The national GP patient survey results published in January 2015 showed the practice was performing above local and national averages. There were 117 responses and a response rate of 49%.

- 80.4% found it easy to get through to this surgery by phone which was above the CCG average of 76.2% and a national average of 74.4%.
- 92.5% found the receptionists at this surgery helpful which was above the CCG average of 88.3% and a national average of 86.9%.
- 94.1% said they were able to get an appointment to see or speak to someone the last time they tried which was above the CCG average of 89.3% and a national average of 85.4%.
- 93.2% said the last appointment they got was convenient which compared with a CCG average of 92.6% and a national average of 91.8%.
- 81.6% described their experience of making an appointment as good which was above the CCG average of 76.9% and a national average of 73.8%.

- 80.4% said they usually waited 15 minutes or less after their appointment time to be seen which was above the CCG average of 68.5% and a national average of 65.2%.
- 73.1% felt they did not normally have to wait too long to be seen which was above the CCG average of 58.9% and a national average of 57.8%.

The practice was below local and national averages in the following area:

- 37.8% said they usually got to see or speak with their preferred GP compared with a CCG average of 67.4% and a national average of 60.5%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received six comment cards which were all positive about the standard of care received. Patients described staff as considerate, respectful, professional and efficient.

Areas for improvement

Action the service **MUST** take to improve

- Ensure that supplies of equipment and medicines for use in an emergency are appropriately maintained.

Action the service **SHOULD** take to improve

- Review the checking process for monitored dosage packs to mitigate the risk of medicine dispensing errors.
- Review the documentation of near misses in the dispensary so that lessons could be learned.

Tanworth-in-Arden Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

a Care Quality Commission (CQC) inspector. The team included a GP specialist advisor, two Pharmacist advisors, a practice manager specialist advisor and an expert by experience. Experts by experience are members of the inspection team who have received care and experienced treatment from a similar service.

Background to Tanworth-in-Arden Medical Practice

Tanworth-in-Arden Medical Practice is a semi-rural practice located just outside of Tanworth-in-Arden. They moved in to the purpose built premises in 2001 and became known locally as The Birches. The practice offers a wide range of services to their patients and also offers additional NHS services the opportunity to use their building, such as Abdominal Aortic Aneurysm (AAA screening), digital retinopathy clinics and Psychological Therapy - Improving Access to Psychological Therapies (IAPT). IAPT is an NHS programme rolling out services across England offering interventions approved by the National Institute of Health and Clinical Excellence (NICE) for treating people with depression and anxiety disorders. Tanworth-In-Arden Medical Practice is a dispensing practice.

The practice is a training practice offering places to trainee GPs. Trainee GPs are fully qualified doctors who are undergoing their final training to become a GP. The practice is also a teaching practice and provides medical students from Warwick University with placements.

The practice has two GP partners and two salaried GPs. There are two female and two male GPs which provided a choice for patients. The practice has two nurses, a healthcare assistant, a phlebotomist (a person trained to take blood), a dispensing manager and four dispensers.

The clinical team are supported by a practice manager, an assistant practice manager, a head receptionist and a team of reception staff and a medical secretary. The practice has a General Medical Services (GMS) contract with NHS England.

The practice is open between 8.30am and 6.30pm Monday to Friday. Appointments are from 8.30am to 12.30pm every morning and 2.30pm to 5.30pm every afternoon.

The practice does not provide out of hours services to their own patients but provided information about the telephone numbers to use for out of hours GP arrangements (NHS 111). Alternatively patients are provided with the details of Solihull walk-in centre located at Solihull Hospital which is open from 8am to 8pm seven days a week.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme under section 60 of the Health and Social Care Act 2008 as part of our

Detailed findings

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 references to the Quality and Outcomes Framework data in this report relate to the most recent information available to CQC at the time of the inspection.

How we carried out this inspection

Before the inspection, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. These organisations included NHS England and South Warwickshire Clinical Commissioning Group (CCG). We carried out an announced inspection on 18 September 2015. We sent CQC comment cards to the practice before the inspection and received six comment cards giving us information about these patients' views of the practice. During our inspection we spoke with a range of staff and with patients who used the service. We observed how people were being cared for during the inspection.

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)

Are services safe?

Our findings

Safe track record and learning

The practice prioritised safety and reported and recorded significant events. Staff used incident forms on the practice intranet and sent completed forms to the practice manager. In the absence of the practice manager the assistant practice manager dealt with significant events. The incidents were discussed at weekly meetings. The staff we spoke with were aware of their responsibilities to raise concerns and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed and saw evidence of changing practice in response to these. For example, in response to a number of patients displaying aggressive behaviour due to waiting when appointments were overrunning the practice started to inform patients if appointments were running late.

National patient safety alerts were disseminated by email 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. For example, a batch of drugs had to be re-called and this was discussed at the practice meeting.

Overview of safety systems and processes

The practice had processes and practices in place to keep people safe, which included:

- The practice had systems to manage and review risks to vulnerable children, young people and adults. One of the partners was the safeguarding lead for the practice. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. They had received their last updates in May 2015. 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 safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily

accessible via a flow chart in the practice manager's room, all GP rooms and in the main reception area. There was a system to highlight vulnerable patients on the practice's electronic records.

- There was a chaperone policy and information to tell patients the service was available was visible on the waiting room noticeboard and in consulting rooms and on the practice web site. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. All nursing staff, including the health care assistant, had been trained to be a chaperone. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.
- There were procedures in place for monitoring and managing risk to patients and staff safety. We saw the accident book and accident report forms which were kept by the practice manager. All staff we spoke with were aware of how to log accidents. There was a health and safety policy available and fire training had been given to all staff in July 2014. The practice had fire risk assessments in place and held fire drills regularly. Although risk assessments had been completed we highlighted during the inspection that risk assessments could be logged in the risk log and therefore documented in one place. The practice manager was going to review this.
- We observed the premises to be visibly clean and tidy. One of the practice nurses was the infection control lead. There was an infection control protocol in place and staff had received up to date training.
- 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 identity, references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Arrangements were in place for the safe and secure storage of medicines in the dispensary. Systems were in place for

Are services safe?

dispensing and checking medicines. We observed that the dispensary staff worked professionally to ensure patients' medicines were dispensed safely. There were basic standard operating procedures (SOP) in place for the dispensary staff; these were regularly reviewed at monthly meetings over a rolling period. Dispensary staff informed us that they did not use a double check system during dispensing of the prescriptions. The SOP for dispensing a prescription did not indicate that this check was required. The checking process for the monitored dosage packs did include a second accuracy check before the medicine was allowed to leave the premises. However, it did not include checking the original packs against the monitored dosage pack and prescriptions. These could reduce the risk of medicine dispensing errors.

We saw records showing all members of staff involved in the dispensing process had received appropriate training and included checks of their competence.

Systems were in place to alert dispensary staff if there was a medicine interaction with another medicine. We were told by the dispensary staff that they informed the prescribing GP of the medicine related interaction alerts. One of the prescribing GPs also informed us that dispensing staff informed them about alerts regarding prescribing interactions.

Dispensing errors were recorded and systems were in place to action any medicine recalls. We saw evidence that information about errors was used to make changes to reduce the risk of future errors. We were told that all significant errors were reported directly to the lead GP. Medicine incidents were discussed at staff meetings in order to learn lessons and protect patients from harm. We were given an example of a medicine error regarding missed warfarin (a medicine taken to prevent the blood from clotting and to treat blood clots and overly thick blood) doses; this had been discussed at a dispensary meeting and the actions implemented to prevent a repeat occurrence. We saw evidence of the use of stickers, as actioned in the dispensary meeting following this error. Not all medicine incidents were recorded. In particular near misses in the dispensary were not always documented. It was therefore not possible to know what action was taken or what lessons were learnt to prevent these incidents happening again.

Blank prescription pads were being stored in a locked cupboard, the key for which was located in a key safe

within the dispensary area. The digital code for the safe was known only to the dispensary staff. The serial numbers of the prescription pads were recorded as were details of their use.

Repeat prescribing was undertaken in line with national guidance. We found that repeat prescriptions were signed by a GP before medicines were given to the patient. We were told that the designated duty GP would sign the repeat prescriptions before they were dispensed. The duty GP reviewed patient test results, out of hour's reports and discharge summaries and actioned appropriate changes to medicine records. Any repeat requests that were past authorisation were passed to the duty GP.

High risk medicines had a special docket attached for the duty GP to look up the test result prior to the prescription being handed out to patients; this requirement was computer generated. There was an SOP detailing the medicines and frequency and range of tests required.

The practice held stocks of controlled drugs (CDs). We noted there were SOPs available which set out how they were managed. CDs were stored in a CD cupboard and access to them was restricted with the key held securely in a digitally controlled key safe. The total quantities of CDs were documented in a CD register. The dispensary staff also undertook weekly audits of controlled drugs, with double signatures on all entries. In addition to CDs, the cupboard also held their backup stock of emergency medicine. The stock levels and expiry dates of the emergency medicine were monitored by the dispensary staff weekly, along with the CDs.

We checked how medicines were stored and handled in the dispensary, including all medicine refrigerators located within the practice. Refrigerators that were used to store medicines and vaccines were locked and secure. Two of the refrigerators in the treatment room did not have any keys, but were located in a secure locked area. We saw daily refrigerator temperature records which were being documented and were all recorded temperatures had been within safe temperature ranges for medicine and vaccine storage.

Arrangements to deal with emergencies and major incidents

All staff received annual basic life support training. There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff

Are services safe?

to any emergency. There was an oxygen cylinder and emergency medicine bag located in the treatment room. The expiry dates and stock levels of the medicines were being checked and recorded monthly. Although the oxygen cylinder was being regularly checked for working order, it was found to have expired on 21 September 2014.

Following the inspection the practice provided evidence that the oxygen had been replaced. There was no warning sign displayed on the door where it was located. The practice told us they were going to address this straight after the inspection. No drugs were stored in the GPs' bags.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and practice nurse were able to give a clear rationale for their approaches to treatment. Weekly team meetings took place at the practice and the latest clinical guidelines such as those from National Institute of Health and Care Excellence (NICE) were discussed. Our discussions with the GPs and nurse demonstrated that they completed thorough assessments of patients' needs in line with NICE guidelines and these were reviewed when considered appropriate.

One of the GPs carried out minor surgery most Wednesday mornings. Cryotherapy was also available. Cryotherapy is a technique that uses an extremely cold liquid or instrument to freeze and destroy abnormal skin cells that require removal. One of the GPs also ran an in-house referral service for dermatology. This meant that patients were not referred unnecessarily and a greater range of treatments was available which was more convenient for patients.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). This is a system intended to improve the quality of general practice and reward good practice. The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Current results were 98.6% of the total number of points available, with 7.7% exception reporting. Exception reporting relates to patients on a specific clinical register who can be excluded from individual QOF indicators. For example, if a patient is unsuitable for treatment, is newly registered with the practice or is newly diagnosed with a condition. Data from 2013/14 showed;

- Performance for diabetes related indicators was 96.7% which was above the CCG average by 1.4% and above the national average by 6.6%
- The percentage of patients with hypertension having regular blood pressure tests was 93.6%. This was the same as the CCG average and above the national average by 5.2%.

- Performance for mental health related and hypertension indicators was 100% which was above the CCG average by 6.3% and above the national average by 9.1%.

The practice reviewed all diabetic patients at least six monthly and initiated insulin in appropriate patients. Patients in other chronic disease categories were reviewed at least annually. Patients with complicated or difficult issues were seen more frequently than this.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and patients' outcomes. There had been two clinical audits completed in the last two years; both of these were completed audits where the improvements were implemented and monitored.

One audit had been carried out on the appropriate prescription of glipton (medicines used for diabetes) therapy for diabetes and one on referrals to orthopaedics for bone disease. Both audits were completed and changes to practice monitored. For example, the practice was monitoring patients with diabetes more frequently as their audit showed 50% of patients had not been monitored according to NICE guidance. The second audit concluded that the majority of orthopaedic referrals were appropriate and no change in practice was necessary.

Effective staffing

We found that the partners valued the importance of education and effective skill mix. Tanworth in Arden Medical Practice was a training practice providing GP training places for two GP trainees. A GP trainee is a qualified doctor who is training to become a GP through a period of working and training in a practice. Only approved training practices can employ GP trainees and the practice must have at least one approved GP trainer. Tutorials took place weekly on a rota between GPs. The trainees were supervised by the duty GP of the day who was on hand for any queries or for reviewing patients. The practice also provided placements for medical students who had not yet qualified as doctors. Second year students from Warwick University attended the practice one day a week for a period of eight weeks. The practice ran medical student surgeries each week for 30 minutes with the student and GP. The practice also took final year students from Imperial College London for three week attachments.

Are services effective?

(for example, treatment is effective)

The learning needs of staff were identified through a system of appraisals and meetings. All staff had the essential training for their role and the practice was looking to introduce e-learning for all staff.

The practice nurses had both completed sexual health training as requested at their appraisals. Staff at the practice had the skills, knowledge and experience to deliver effective care and treatment.

Coordinating patient care and information sharing

The practice used electronic systems to communicate with other providers and to make referrals. Staff felt that the system was easy to use and patients welcomed the ability to choose their own appointment dates and times through the Choose and Book system. Choose and Book enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to co-ordinate, document and manage patients' care. Scanned paper letters were saved on the system for future reference. All investigations, blood tests and x-rays were requested and the results were received online.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they were discharged from hospital. The practice had a system in place to ensure a GP or nurse reviewed patients within 72 hours of discharge for patients on the unplanned admissions register. We saw evidence that multi-disciplinary team meetings took place on a quarterly basis and that care plans were routinely reviewed and updated. The meetings involved Macmillan nurses from the local hospice, district nurses, occupational therapists and health visitors.

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment.

Health promotion and prevention

Information about health conditions and self-care was available in the waiting area of the practice. The practice offered a full range of contraceptive services. Details about confidentiality were clearly advertised to reassure patients. Patients who may be in need of extra support were identified by the practice.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 86%, which was above the national average of 82%.

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

- Childhood immunisation rates for the vaccinations given to under two year olds ranged from 92% to 100% which was comparable to the CCG average of 95% to 100%.
- Flu vaccination rates for the over 65s were 72% comparable to the CCG average of 73%.
- Flu vaccination rates for those patients in the at risk groups were 46%, just under the CCG average of 52%.

The practice had access to appropriate health assessments and checks. For example, patients over the age of 75 years had annual health checks. Patients were selected in order of priority, such as any older patients who had new medical problems or had deterioration in their health. The practice also carried out NHS health checks for people aged 40-74 years.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Results from the national GP patient survey showed patients were happy with how they were treated. The practice was in line with and in some cases above average for its satisfaction scores on consultations with doctors and nurses for example:

- 89.8% said the GP was good at listening to them compared to the CCG average of 92.1% and the national average of 88.6%.
- 93.3% said the GP gave them enough time compared to the CCG average of 90.4% and national average of 86.8%.
- 96.9% said they had confidence and trust in the last GP they saw compared to the CCG average of 97.1% and the national average of 95.3%.
- 89.8% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 92.1% and national average of 88.6%.
- 95% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 90.1% and the national average of 90.4%.
- 92.5% patients said they found the receptionists at the practice helpful compared to the CCG average of 88.3% and the national average of 86.9%.

We reviewed six CQC comment cards completed by patients prior to the inspection. Patients commented positively on the respectful and considerate way that staff treated them and complimented their professionalism. We spoke with 10 patients on the day of our inspection; this included a member of the patient participation group (PPG). A patient participation group is a group of patients registered with a practice who work with the practice to improve services and the quality of care. Almost all of the patients were satisfied with the care they received from the practice and commented that staff were kind, considerate and helpful.

We observed staff who worked in the reception area and other staff. Their approach was respectful and professional at all times.

Patients' privacy and dignity was maintained. For example, a private room was made available for when patients wanted to talk in confidence with the reception staff to reduce the risk of conversations being overheard. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained.

Care planning and involvement in decisions about care and treatment

Patients we spoke with told us that health issues were discussed with them and they felt involved in decision making about the care they received. Patients told us that they felt staff listened to them and they were able to make informed decisions about their treatment.

Results from the national GP patient survey we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 87.6% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 90.4% and the national average of 86.3%.
- 88% said the last GP they saw or spoke to was good at involving them in decisions about their care compared to the CCG average of 86.6% and the national average of 81.5%.

Staff we spoke with told us that translation and interpreting services were available for patients who did not have English as a first language. This was clearly advertised in waiting areas. Staff also had access to British Sign Language interpreters for hard of hearing patients.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with were positive about the emotional support provided by the practice and rated it well in this area. Notices in the patient waiting room sign posted people to a number of support groups and organisations.

The practice had a register of carers. Carers known to the practice were coded on the computer system so that they could be identified and offered support. All carers were seen annually. Of the practice list 1% of patients were identified as carers.

Are services caring?

Support was provided to patients during times of bereavement. Staff we spoke with recognised the importance of being sensitive to patients' wishes.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with South Warwickshire CCG to plan services and to improve outcomes for patients in the area. The CCG commented that the practice engaged well with them.

Services were planned and delivered to take into account the needs of different patient groups and to help provide flexibility, choice and continuity of care. For example;

- In 2015 the practice employed a care co-ordinator with responsibility for proactive review of the elderly. This involved co-ordinating with Age Concern colleagues and the wider team to discover and anticipate problems in the hope of addressing issues early and preventing morbidity and mortality. At the time of the inspection 84 face-to-face interviews had taken place. The practice had received positive comments about this from patients.
- As part of the practices' weekly medicines delivery service they employed two regular drivers who knew the patients well. The drivers reported back if a patient seemed unwell or had any issues which enabled early intervention from an appropriate team member and allowed the practice to set up services to support the patient in continuing independent living. The practice delivered monthly to 180 patients. An additional 47 patients had weekly deliveries of daily dose systems.
- The practice had robust recall systems for patients, arranging individual reviews at the patient's convenience. During reviews the practice tried to empower and educate patients through the services they provided such as heart clinics, and made additional advice available online. All the practice's respiratory disease patients had written management plans and where appropriate carried 'stand-by' medicine for early intervention for circumstances when their condition worsened.
- The practice reviewed all diabetic patients at least six monthly. Patients in other chronic disease categories were reviewed annually. Patients with complicated or difficult issues were seen more frequently than this.
- The practice had a policy that all sick children under five years of age were seen on the same day if parents were worried.
- The practice was committed to providing a confidential and comprehensive contraceptive and sexual health service with special regard for young people and this was advertised on the practice website and in their leaflet. Two of the GPs had additional training in contraceptive implants.
- The practice kept specific early and late appointments for working people and would often arrange to see urgent problems and take blood samples before surgery started for this population group.
- The practice would see vulnerable patients at short notice and they maintained a special considerations board to ensure prompt and appropriate response to any application from these patients.
- In 2015 the practice tried to identify patients with memory issues using in-house searches and national audits. The practice diagnosis rate based on prevalence of dementia rose from 24.2% in Sept 2014 to 49.3% in March 2015. The practice reviewed, referred and treated all patients identified this way.
- The practice had a named GP on duty each day. The duty GP was available all day from 8:30am to 6:30pm for emergencies. They reviewed all blood results and letters from the last 24hours and actioned appropriately. They were able to answer reception, nursing and dispensing queries. They saw any emergencies and home visits that day and were responsible for signing prescriptions in the dispensary. The named GP also supervised the trainee GP.

The practice also provided the following:

- There were longer appointments for people with a learning disability.
- Home visits were available on request for older patients and patients who would benefit from these.
- Parking facilities and easy access for wheelchairs and buggies
- The practice had a family friendly waiting room with baby changing facilities. Parents could also ask to use a private room for breast feeding.

Are services responsive to people's needs?

(for example, to feedback?)

- The practice had a hearing loop and translation services. Patients with visual or hearing impairments were flagged up on the practice's computer system so that reception staff and clinicians could offer additional assistance.
- The practice had a good minor surgery service and had robust process for samples and on-going follow up.

Staff were able to share an example where they responded to a patient's individual needs. A child was finding hospital attendance distressing so the practice took over phlebotomy (blood taking) for this patient which resulted in a happier and more settled child.

Access to the service

The practice was open between 8.30am and 6.30pm Monday to Friday. The practice closed between 1pm to 2pm. During this time the GPs went on their home visits. Appointments were from 8.30am to 12.30pm every morning and 2.30pm to 5.30pm daily. Appointments were available up to four weeks in advance; urgent appointments could be booked on the day if the patient called the practice between 8.30am and 9am.

Results from the national GP patient survey published in January 2015 showed that patients' satisfaction with how they could access care and treatment was comparable to local and national averages. Most of the patients we spoke with said they were able to get appointments when they needed them. For example:

- 74.6% of patients were satisfied with the practice's opening hours compared to the CCG average of 75.5% and national average of 75.7%.
- 80.4% of patients said they could get through easily to the surgery by phone compared to the CCG average of 76.2% and national average of 74.4%.

- 81.6% of patients described their experience of making an appointment as good compared to the CCG average of 76.9% and the national average of 73.8%.
- 80.4% of patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 68.5% and national average of 65.2%.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager handled all complaints at the practice.

We saw that information was available to help patients understand the complaints system on the website and leaflets were available which set out how to complain and what would happen to the complaint and the options available to the patient.

We looked at the complaints received in the last year and found these had been dealt with according to their policy and procedure. Complaints were discussed at practice meetings and lessons were learned from these. For example, one of the complaints we reviewed was about a delay in a referral letter being sent. This was due to an in-house error. A clear explanation and apology was provided to the patient and this was discussed at the practice meeting. We did note that advocacy information was not available on the response letters the practice sent out. This was discussed during the inspection and the practice manager was going to review this.

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 development plan for 2015. The practice manager hoped to make improvements by introducing e-learning for all staff, updating staff folders and completing all appraisals by the end of 2015. At the time of the inspection the deputy practice manager was on maternity leave and there had been pressure on the practice manager. The practice was also looking at improvements such as a new telephone system, new chairs for the upstairs waiting area, hand dryers in toilets and electronic prescribing at the dispensary. Despite having a clear vision to deliver high quality care the practice was continuously looking to improve and the vision and values were regularly monitored.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity. Although all policies were available they were not equally accessible and not all kept together. We discussed this during the inspection and the practice manager told us they were reviewing this imminently.

- There was a clear leadership structure with named GPs in lead roles. Staff we spoke with told us there was an open door policy and they felt valued and supported.
- There were robust arrangements for identifying, recording and managing risk. However, they were not all logged in one place. This was going to be reviewed by the practice manager.
- The practice had a programme of continuous clinical and internal audit which was used to monitor quality and make improvements.

- The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing better than national standards. QOF was regularly discussed at practice meetings.

Leadership, openness and transparency

Meetings were held regularly and minutes kept and circulated to the team via a newsletter. Staff told us there was an open culture and they were happy to raise issues at practice meetings. The partners were visible in the practice and staff told us they would take the time to listen to them.

All staff were encouraged to identify opportunities to improve the service delivered by the practice. Staff interacted with each other socially and gave examples of support they had received when they had been in difficult situations.

Seeking and acting on feedback from patients, the public and staff

The importance of patient feedback was recognised and there was an active patient participation group (PPG). We met with a member of the PPG during the inspection. The PPG had seven members and met quarterly. The PPG were trying to recruit new members.

The practice was working closely with the PPG to look at a new phone system. The PPG felt that the practice listened to them and were co-operative. They were working on a charity event together to be held at the end of October 2015.

Staff we spoke with said they would not hesitate to give feedback. They felt engaged with the practice and were valued.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment This was a breach of Regulation 12 (2) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How we found the regulation was not being met: We found that the oxygen cylinder had expired In September 2014. The provider needs to ensure that supplies of equipment and medicines for use in an emergency are appropriately maintained.