# Stoke 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

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## Overall summary

**Letter from the Chief Inspector of General Practice**

We inspected Stoke Surgery on 2nd June 2015 as part of our comprehensive inspection programme.

We have rated the practice overall as providing a good service. Specifically we found the practice to be good for providing responsive, safe, effective, caring and well led services. It was also found to be providing good services across all the patient population groups.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- There were arrangements in place to respond to the protection of children and vulnerable adults and to respond to any significant events affecting patients' well-being.
- The practice worked well with other health care services to enable a multi-disciplinary approach in meeting the health care needs of patients receiving a service from the practice.
- The practice managed complaints well and took them seriously. Information about how to complain was available and easy to understand.
- There was a clear management structure with approachable leadership. Staff were supported and had opportunities for developing their skills, were well supported and had good training opportunities.
- The practice had good facilities and was well equipped to treat patients and meet their needs. Patients commented how helpful the staff were in trying really hard to get them a convenient appointment. This was

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reflected in the data from the national GP survey, 99% of 125 patients who responded reported a good overall experience of getting an appointment at a convenient time (the national average is 94%).

- The practice had a vision and informal set of values which were understood by staff. There were clear clinical governance systems and a clear leadership structure in place.

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

The provider should:

- Develop a web site to keep patients up to date and informed.
- Continue to try and develop a Patient Participation Group to encourage patient involvement and ensure the patient's voice is heard.
- Ensure all administration staff have an up to date appraisal.

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. Patients and staff were protected by strong comprehensive safety systems, which the practice was continually improving. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice used every opportunity to learn from incidents to support improvement. Information about safety was highly valued and was used to promote learning and improvement.

Risk management was comprehensive, well embedded and recognised as the responsibility of all staff. There were enough staff to keep people safe.

**Are services effective?**

Good

The practice is rated as good for providing effective services. We saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients.

The practice was using innovative and proactive methods to improve patient outcomes.

Staff had received training appropriate to their roles and training specific to the needs of the practice population groups. The practice were able to show us examples of staff appraisals and their personal development plans. Staff worked well within multidisciplinary teams.

**Are services caring?**

Good

The practice is rated as good for providing caring services. Feedback from patients about their care and treatment was consistently and strongly positive, and said they were treated with dignity and respect. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care.

**Are services responsive to people's needs?**

Good

The practice is rated as good for providing responsive services. The needs of the local population were reviewed and the practice 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. This was confirmed by the last GP patient survey which showed that 87% of 121 patients said they were able to get an appointment to see or speak to someone the last time they tried. However patients said that they usually had to wait a considerable

# Summary of findings

time to be seen. This was confirmed in the last GP patient survey which showed only 49% of patients said they waited for 15 minutes or less. The practice provided a flexible appointment system which involved a duty GP, to ensure all patients who needed to be seen the same day were accommodated and an open surgery two mornings a week when no appointment was necessary.

The practice had tried to recruit members to be part of a patient participation group (PPG) so that the patient voice could be better heard. To date no patients have responded to this initiative.

**Are services well-led?**

Good

The practice is rated as good for being well-led. Staff were clear about the vision of the organisation and their responsibilities in relation to this. The strategy to deliver the vision was regularly reviewed and discussed with staff. There was a leadership structure in place. The practice manager played a central role in the coordination and running of the practice.

Staff felt supported by management. There was a stable staff group and high level of job satisfaction and support for nursing and clerical staff. The practice had a number of systems, policies and procedures to monitor risk, clinical effectiveness and governance and to share learning from any events. The practice valued and proactively sought feedback from patients and staff and this had been acted upon. Clinical staff had received regular performance reviews but not all administration team had. All staff had completed an induction and attended regular staff meetings

Staff said they felt well supported and enjoyed their work. They said communication was good amongst each other and with other professionals visiting the practice.

# Summary of findings

## The six population groups and what we found

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

**Older people**

Good

The practice is rated as good for the care of older people. Older patients all had a named GP. All those who spoke with us had been offered regular health checks. The practice had provided care plans for the 2% of their adult patients at most risk of admission to hospital, in accordance with the direct enhanced service (DES) commissioning scheme which mainly encompassed elderly patients. All patients discharged from hospital were reviewed within 72 hours. Special messages were attached to the computerised patient records that Out of Hours services could see, to ensure consistent care.

The GP visited their own patients that resided in Nursing/Residential homes in the locality, there were 14 in total. During the visit the patients were reviewed and their long term conditions monitored and medicines reviewed. The practice worked closely with the Community Matron in caring for older patients and their holistic needs. The practice had a Palliative care nurse who visited the practice regularly and has immediate access to GP's to ensure timely intervention with the dying patient.

The Practice Manager is on the Caring for Care Homes Steering Group led by the CCG Medicines Optimisation Team. Meetings were held quarterly. The aim of this group was to improve the use of medicines in care homes, ensuring medicines are used safely and effectively and to share learning, experience, training and issue good practice in relation to improving medicines management in care homes. This impacted on how people ordered repeat medicines and how the GPs managed their prescribing.

**People with long term conditions**

Good

The practice is rated as good for the care of people with long term conditions. The practice has manages the care of their patients with long term conditions well. It has recall systems in place to ensure regular reviews of these patients. Diabetic patients have a joint appointment with the Practice Nurse and the GP every six months for a review of their condition and medication. The Practice Nurse actively refers Diabetic patients for diabetic education when appropriate.

The Practice Nurse carries out Asthma and COPD reviews with these patients and all Practice Nurses have received training in these reviews. Practice Nurses attended regular updates to enhance their knowledge of all long term conditions.

# Summary of findings

The practice had a close working relationship with the Long Term Conditions Matron (LTCM) who visited patients in their own homes to support them with their condition. The LTCM visited the practice every week to update the GPs and had access to update the patient's medical record.

Special messages were attached to the computerised patient records that Out of Hours services could see, to ensure consistent care. If a patient was admitted to hospital, the practice sent a written summary to the hospital with details of both the current problem and of past medical history including current medication and allergies to enable consistency of care.

When necessary, home visits were made by GPs or community nurses to carry out reviews.

The practice extended hour's appointments to allow access to working age patients with chronic diseases.

**Families, children and young people**

Good

The practice is rated as good for the care of families, children and young people. Baby and child immunisation programmes were well organised and available to ensure babies and children could access the full range of vaccinations and health screening. These included the 8 week check for both mother and baby, along with the immunisation clinics. Last year's performance for child immunisations showed that 96% of one year olds had received all their primary vaccinations required.

Patients told us that children and young people were treated in an age-appropriate way and we saw evidence to confirm this.

The practice offered ante-natal care via their midwife with two clinics per week held at the surgery and further clinics available at the Green Ark children's centre close by. The midwife has access to the GP if necessary. New mothers were sent appointments for their eight week check together with their child's first immunisations. All practice nurses were trained to give childhood immunisations and attended regular training to keep their knowledge up to date.

The practice offered a full range of contraceptive services including emergency contraception. All nurses were trained in cervical screening and attended regular updates. Patients were proactively offered chlamydia screening with self-test kits available in the surgery. The practice was also a nominated treatment centre as part of the screening service and held medication on site offering a convenient location for patients to receive their treatment.

# Summary of findings

The practice had a nominated Health Visitor and the GP's involved her in the patients care. The Health Visitor was based at the children's centre which was close to the practice and parents were encouraged to attend clinics there.

There was an alert on the clinical system to identify patients on the Child Protection register this was visible to all staff. GP's had all undertaken appropriate child protection training.

The practice worked closely with Insight – a service offering counselling for young people and they regularly saw patients at the surgery which was more convenient and familiar for the patient in distress.

Children were always offered an appointment on the day if an urgent appointment was needed. If an ill child attended the open surgery which was offered twice weekly, they would be seen without waiting.

**Working age people (including those recently retired and students)**

Good

The practice is rated as good for working age people. Advance appointments (up to six weeks in advance) were available for patients to book. The practice offered an online appointment booking service. The practice used a text message reminder service for patients and had used this to communicate with patients at short notice – for example if a GP is off sick. Patients could order their repeat prescriptions online and these could be sent to a pharmacy of their choice to avoid them needing to attend the practice. Several local pharmacies collected from the practice on a daily basis. The practice actively promoted the repeat dispensing facility to ensure patients had a supply of medication readily available without having to request it.

Suitable travel advice was available from the GPs and nursing staff within the practice and supporting information leaflets were available within the waiting areas.

The staff were proactive in calling patients into the practice for health checks. This included offering referrals for smoking cessation, providing health information, routine health checks and reminders to have medicine reviews. This gave the practice the opportunity to assess the risk of serious conditions on patients which attend. The practice also offered age appropriate screening tests including cholesterol testing.

The practice offered an extended musculoskeletal service within the surgery including the use of ultrasound to enhance diagnosis and guide injections. An osteopath held five clinics a week at the practice.

# Summary of findings

**People whose circumstances may make them vulnerable**

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of 36 patients with a learning disability and had carried out annual health checks for just fewer than 70% of these patients. This comprised of two separate appointments – one with the practice nurse and the second with the GP. One GP was responsible for carrying out these checks. If necessary the nurse/GP visited the patient at home for this.

The practice had a high number of non-English speaking patients. In some cases, family members would attend to translate with the patient's permission but usually the practice used the telephone language line and a longer appointment was offered to these patients to accommodate this. Patients needing the language line were flagged with an alert on the clinical system.

There was an alert on patient's records if they were blind or deaf to remind staff not to use the patient calling system but to collect them from the waiting room for their appointment.

The practice provided care for the local bail hostel and had a good relationship with the hostel manager to ensure these patients got the appropriate care they needed.

The practice looked after patients in a local brain injury unit and also a disability centre. If patients could attend surgery they were offered a home visit. The practice had a ramp and automatic doors to facilitate the use of wheelchairs into the building.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. Vulnerable patients had been advised 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 both normal working hours and out-of-hours.

The practice promoted their chaperone service and reminded patients that if they do require assistance, they could ask. All clinical staff and senior reception staff had received chaperone training.

**People experiencing poor mental health (including people with dementia)**

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). The practice maintained a register of patients who experienced mental health problems. The register supported clinical staff to offer patients an annual appointment for a health check and a medicine

# Summary of findings

review. The practice had a high prevalence of mental illness and managed a large number of patients with personality disorder. The practice promoted self-referral and provided patients with a list of services available together with telephone numbers and website addresses.

Patients on the Dementia register had an alert on the clinical system to advise staff of their diagnosis. The practice looked after a care home for older people suffering from mental health disorders. A lead GP undertook a ward round every week to review their care.

GP's were proactive in identifying patients with dementia and use recognised national assessments and referral processes. Families and friends are actively involved in their care.

Deprivation of liberty Safeguards (DOLS) were understood and all GP's had a laminated flow chart to refer to for DOLS assessment procedures.

The practice ran an open surgery twice a week for patients who find it difficult to attend pre-booked appointments due to their mental health. There was close liaison with the Psychiatry team and the practice facilitated the use of consulting rooms if this was more convenient for the patient.

# Summary of findings

## What people who use the service say

All of the 11 patients we spoke with were complimentary about the services they received at the practice. They told us the staff who worked there were very helpful and friendly. They also told us they were treated with respect and dignity at all times and they found the premises to be clean and tidy. Patients were largely happy with the appointments system.

We reviewed 15 CQC comment cards completed by patients prior to the inspection. All were

complimentary about the practice, staff who worked there and the quality of service and care provided.

None of those interviewed had any serious complaints regarding the practice. Patients praised the continuity of care and having had the same named GP in some cases throughout their life.

Patients said they did not feel rushed during their consultations although waiting times often were longer than 15 minutes. Patients told us they had a good rapport with their GP and felt no improvements were needed. They said GPs always phoned back when they said they would.

The latest National GP Patient Survey completed in 2014/15 showed patients were satisfied with the services offered at the practice, but that some improvement was needed in respect of waiting times at the surgery.

The results were:

GP Patient Survey score showed

- 95% of respondents said the last GP they saw or spoke to was good at giving them enough time this compared slightly higher than the local (CCG) result of 91%.
- The proportion of respondents who gave a positive answer to how easy is was to get through to someone at the GP practice on the phone – 75% compared to the local (CCG) average of 84%.
- 51% of respondents said they usually waited 15 minutes or less after their appointment time to be seen compared to the local (CCG) average of **71%**
- The percentage of patients rating their experience of making an appointment as good or very good was 74% compared to the local (CCG) average of 82%.

These results were based on 121 surveys returned. We discussed this result and the practice manager said the practice were fully aware of where improvement was needed. The practice were in the process of discussing how this could be improved and were constantly striving to improve patient satisfaction.

## Areas for improvement

**Action the service SHOULD take to improve**

- Develop a web site to keep patients up to date and informed.
- Continue to try and develop a Patient participation Group to encourage patient involvement and ensure the patients voice is heard.
- Ensure all administration staff have an up to date appraisal.

# Stoke Surgery

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC lead inspector. The team also included a GP specialist advisor, a nurse specialist advisor and an expert by experience. Experts by Experience are people who have experience of using care services.

## Background to Stoke Surgery

Stoke Surgery Practice delivers primary care under a Primary Medical Services contract between themselves and NHS England. As part of the Northern, Eastern and Western Devon Clinical Commissioning Group (CCG) they are responsible for a population of approximately 7000 patients.

There is a team of two GP partners (one female and one male), supported by three salaried GPs (two female and one male).

Appointments are available between 8.30am and 5.30pm Monday to Friday. The practice provides a walk in open surgery twice a week between the hours of 8.30am and 11am. This is where no appointment is necessary.

Patients who use the practice have access to community staff including district nurses, community psychiatric nurses, health visitors, physiotherapists, mental health staff, counsellors, chiropodist and midwives.

The practice GPs do not provide an out-of-hours service to their own patients and patients are signposted to the local out-of-hours service when the surgery is closed in the evenings, at night and at the weekends.

There were no previous performance issues or concerns about this practice prior to our inspection.

## 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.

## How we carried out this inspection

Before conducting our announced inspection of Stoke Surgery, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. Organisations included the local Healthwatch, NHS England, and the local Devon Clinical Commissioning Group.

We requested information and documentation from the provider which was made available to us either before, during or 48 hours after the inspection.

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

- Is it safe?
- Is it effective?
- Is it caring?

# Detailed findings

• 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

• Mothers, babies, children and young people

• The working-age population and those recently retired

• People in vulnerable circumstances who may have poor access to primary care

• People experiencing poor mental health

We carried out our announced visit on 2nd June 2015. We spoke with 11 patients, four GPs, two of the nursing team and members of the management, reception and administration team. We collected 15 patient responses from our comments box which had been displayed in the waiting room. We observed how the practice was run and looked at the facilities and the information available to patients.

We looked at documentation that related to the management of the practice and anonymised patient records in order to see the processes followed by the staff.

We observed staff interactions with other staff and with patients and made observations throughout the internal and external areas of the building.

Good

# Are services safe?

## Our findings

### Safe track record

The practice had a strong comprehensive safety system which used a range of information to identify risks and improve quality in relation to patient safety. Staff we spoke to were aware of their responsibility to raise concerns, and how to report incidents and near misses. Staff said there was an individual and collective responsibility to report and record matters of safety. We reviewed safety records, incident reports and minutes of meetings. These showed the practice had managed these consistently over time and so could demonstrate 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 five significant events that had occurred during the last year and saw this system was followed appropriately. Significant events was a standing item on the practice meeting agenda to discuss and decide on any action or learning if it had not taken place already. There was evidence from discussion with GPs and nurses that the practice had learned from events 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 told us that when they were involved in a complaint or incident they filled out an online form which was then sent to the practice manager. Staff explained it was discussed with them but they were also supported through the process and there was a no blame culture, as any event was seen as a way to improve safety and care. We saw evidence of action taken as a result and that the learning had been shared. For example, a patient was telephoned by a member of the administration staff as the GP wanted the patient to come in for a blood pressure test before commencing new medication. The patient asked why this was needed and the staff member told them of their condition, but this was not yet known by the patient. This had happened as the patient had also been treated at another clinic and had bloods taken but they had not yet been advised of the results. The staff member immediately apologised and the GP then telephoned the patient and reassured them.

National patient safety alerts were disseminated by email and through the communications with 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 safety alert that was received concerning the Typhim vaccine. The nurses checked their stocks and found they had a batch that had been identified as unsafe. They took immediate action to return their stocks and re orders more. They then wrote to patients who had been vaccinated to advise them of the limited protection and offer a further vaccination.

### Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed all staff had received relevant role specific training on safeguarding. Staff knew how to recognise signs of abuse in older patients, vulnerable adults and children. They were aware of their responsibilities and knew how to share information. They recorded safeguarding concerns and knew how to contact the relevant agencies, in working hours and out of normal hours. Contact details were easily accessible. The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role.

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

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.

Controlled drugs were held at the practice and were stored securely. Some medicines and vaccines were required to be kept in a fridge. The fridge temperature was monitored daily and records showed they were stored within the correct temperature limits.

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

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 the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. The practice had a lead nurse nominated for infection prevention and control. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that an infection control audit had been undertaken in May 2015 it had identified that sharps bins were not being labelled/dated properly so immediate action was taken and all staff were advised accordingly.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff we spoke with were able to describe how they would use these in order to comply with the practice's infection control policies. There was also a policy for needle stick injuries. Hand hygiene techniques signage was displayed throughout the practice. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

We saw that sharp bins were available along with bins for the disposal of both ordinary and clinical waste, which had lids and foot operated pedals. There was a contract in place for the removal of all household, clinical and sharps waste and we saw that waste was removed by an approved contractor.

**Equipment**

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that

confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. We saw evidence of calibration of relevant equipment; for example, weighing scales and blood pressure monitoring equipment.

**Staffing and recruitment**

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. They told us about the arrangements for planning and monitoring the number and mix of staff to meet patients' needs. Records confirmed that maintaining adequate staffing cover was discussed at practice meetings.

The practice had a recruitment policy in place. We looked at records relating to the most recently recruited clinical and administrative staff. We found appropriate

pre-employment checks such as obtaining references and a criminal record check through the Disclosure and Barring Service (DBS) had been carried out. The practice had arrangements in place to assure them that the clinical staffs' professional registrations were up to date with the relevant professional bodies and that the required staff had medical indemnity insurance in place.

**Monitoring safety and responding to risk**

The practice had a variety of systems, processes and policies in place which were used to manage and monitor risks to patients, staff and visitors to the practice. These risks included dealing with emergencies such as a fire or someone becoming seriously ill at the practice. The

practice also had a health and safety policy. Health and safety information was displayed for staff to see and we saw that the practice had undertaken a health and safety risk assessment.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments. The practice had arrangements in place to manage emergencies. We saw records which showed all staff had received regular training in basic life support. We saw a fire risk assessment had been undertaken. Staff told us that the fire alarms were tested regularly. We saw records confirming annual staff training for fire safety.

**Arrangements to deal with emergencies and major incidents**

The practice had arrangements in place to manage emergencies. Records showed all staff had received training in basic life support at the required time. Emergency equipment appropriate for children and adults was 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 knew the location of this equipment and records confirmed it was checked regularly. Emergency medicines were available in various secure areas of the practice. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place, which staff were aware of, to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure,

incapacity of staff, adverse weather, unplanned sickness and access to the building. The practice had carried out a fire risk assessment. It included actions required to maintain fire safety. Records showed staff were up to date with fire training and they practised regular fire drills.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment**

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that guidance from local commissioners was readily accessible in all the clinical and consulting rooms.

We discussed with the practice manager, GP and nurse how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff. We saw minutes of clinical meetings which showed this was then discussed and implications for the practice's performance and patients were identified and required actions agreed. 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.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were 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 named members of staff and used to support the practice to carry out clinical audits. The practice sent us four clinical audits that had been undertaken in the last two years. All of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit.

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, an audit was undertaken for those patients suffering from Atrial Fibrillation (Atrial Fibrillation is a heart condition that causes an irregular and often abnormally fast heart rate). This audit identified a number of patients for whom anticoagulation should be considered to reduce stroke risk. It also showed using a risk assessment process that a number of patients were inappropriately receiving anti-coagulation treatment. In both cases action were taken to improve outcomes for patients. The data showed that Stoke Surgery was performing well in anti-coagulating the AF patients compared to the estimate national rates.

Good

# Are services effective?

## (for example, treatment is effective)

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.

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 fortnightly multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups. These patient names were listed at the practice so all staff could promptly recognise them and fast track any appointment of prescription request if necessary. Structured annual medicine reviews were also undertaken for people with long term conditions. For example, 287 patients out of the 302 patients (95%) with diabetes had received a review and 77 out of 86 patients (90%) with dementia had received a review.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area.

### Effective staffing

The practice had an experienced team of staff that included medical, nursing, managerial and administrative staff. We saw staff turnover had been very low. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

A supportive and positive culture within staff was evident throughout our inspection. Several staff described the practice as a good team who supported each other well. All clinical staff undertook annual appraisals which identified learning needs and the practice was proactive in providing training in the areas identified. For example one nurse told us they hoped to undertake the diploma in family planning. Nursing staff at the practice had defined duties and were able to demonstrate they were trained to fulfil these duties, for example wound care.

Administration staff were well trained and very experienced with many of them having worked at the practice for many years. They all said they felt well supported and were listened to when concerns were raised. However formal appraisals for administration staff had not been undertaken. The practice manager said they planned to do these in the near future.

### Working with colleagues and other services

The practice had effective working arrangements with a range of other services such as the community nursing team, the local authority, the hospital consultants and a range of local and voluntary groups.

The practice was involved in various multidisciplinary meetings involving palliative care nurses, health visitors, social workers and district nurses to discuss vulnerable patients at risk, those with complex health needs, and how to reduce the number of patients needing hospital admission. The lead GP for safeguarding children attended monthly multidisciplinary meetings with the school nurse, health visitors and midwives to discuss patients on the child protection register and other vulnerable children. Minutes recorded the discussions about these issues. This enabled the practice to have a multidisciplinary approach which ensured each patient received the appropriate level of care.

The practice worked with other service providers to meet patients' needs and manage complex cases. They received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by

post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received.

**Information sharing**

The practice used several electronic systems to communicate with other providers. For example, the GPs described how the practice provided the out of hour's service with information, to support, for example end of life care. Information was scanned onto electronic patient records in a timely manner. Electronic systems were also in place for making referrals. The practice worked within the Gold Standard Framework for end of life care (EoLC), where they provided a summary care record and EoLC information to be shared with local care services and the out of hours health providers .

For the most vulnerable 2% of patients over 75 years of age, and patients with long term health conditions, information was shared routinely with other health and social care providers through multi-disciplinary meetings to monitor patient welfare and provide the best outcomes for patients and their family.

Regular meetings were held throughout the practice. These included all-staff meetings, clinical meetings, partner meetings and significant event meetings. Information about risks and significant events were shared openly at meetings and all staff were able to contribute to discussions.

There was a practice did not have website or a patient participation group (PPG). The website was in the process of being set up and was hoped to be in place in the near future. The practice manager had tried several times to get patients involved in the PPG but had been unsuccessful. They informed us they would continue to try and instigate this. In the meantime the practice used the Friends and Family test as a tool to measure patient satisfaction as well as suggestions made in the surgery and learning from feedback and any more formal complaints.

**Consent to care and treatment**

Staff referred to Gillick competency when assessing young people's ability to understand or consent to treatment, ensuring where necessary young people were able to give informed consent without parents' consent if they were under 16 years of age. Staff were able to describe how they assessed a patient's capacity to consent in-line with the Mental Capacity Act 2005, with guidance available in the Mental Capacity Act policy and consent policy. A pathway was in place to enable appropriate referrals and support packages for patients at the end stages of life. Multi-disciplinary palliative care review meetings were held quarterly with other health and social care providers. Individual cases were discussed regularly between clinical staff to ensure patients and relatives needs were reviewed on a regular basis to meet each patient's physical and emotional needs. For patients nearing the end of life care plans were in place. For those patients nearing the end of life but not imminent, their wishes were recorded and reviewed by the lead GP, with changes communicated and shared with out of hour providers.?

**Health promotion and prevention**

The practice used information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA) undertaken by the local authority to help focus health promotion activity. The JSNA pulls together information about the health and social care needs of the local area.

It was practice policy to offer a health check 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 opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 70% of patients in this age group took up the offer of the health check.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had identified the smoking status of 83 patients over the age of 16 and actively undertaken nurse-led smoking cessation clinics. There was evidence these were having some success as the number of patients who had stopped smoking in the last 12 months was 23, which was above average compared to neighbouring practices and national figures. Similar

Good

# Are services effective?

## (for example, treatment is effective)

mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for the cervical screening programme was 76%, which was below the national average of 81%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. A practice nurse had responsibility for following up patients who did not attend. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was above average for the majority of immunisations where comparative data was available. For example, flu vaccination rates for the over 65s were 69%. These were similar to national averages.

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 results from the national GP patient survey published on 8 January 2015, 15 CQC comment cards and the results of the friends and family test for January and February 2015. The evidence from all these sources showed that patients were satisfied with the way they were treated and that this was with compassion, dignity and respect. The national GP patient survey showed 88% of

patients who responded described their overall experience of the surgery as good. The GP survey showed 96% of patients said the last nurse they saw or spoke to was good at giving them enough time. 95% of respondents also said the last GP they saw or spoke to was good at giving them enough time, this was slightly higher than (the local average (CCG) of 91%. However, only 49% of patients said they had to wait for 15 minutes or less for their appointment. We discussed this with the practice manager and they told us they were aware of this and were proactively planning to try and improve this. For example consideration was being given to better use of the skills of the Registered Nurses and more GP cover.

Patients completed CQC comment cards to tell us what they thought about the practice; 15 were received and all the comments were positive about the service patients experienced. Staff were described as excellent, efficient, friendly, helpful, kind and responsive. The CQC comment cards and feedback from patients showed patients were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted consultation / treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard. We saw staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so confidential information was kept private. Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected that they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff. The practice advertised the practice's zero tolerance for abusive behaviour.

**Care planning and involvement in decisions about care and treatment**

The patients we spoke with told us their diagnosis and proposed treatment options were explained to them. They spoke of feeling reassured and safe in the care of the clinical team. Patients told us they felt involved in their care and treatment decisions. These views aligned with the findings of the most recent national GP patient survey results, which found 84% of respondents had confidence and trust in the last GP they saw or spoke to were good at involving them in decisions about their care, and 93% had confidence and trust in the last GP they saw or spoke to.

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.

For patients with a high risk of hospital admissions, such as some older people and people with long-term conditions, there was evidence of care plans and patient involvement in agreeing these

**Patient/carer support to cope emotionally with care and treatment**

Discussions with staff and feedback from patients' demonstrated staff were highly motivated and were inspired to offer care that was kind, caring and supportive. We observed person centred interactions between staff and patients on the day of our inspection.

Staff knew how to recognise patients and carers who might need additional support to cope emotionally with their care and treatment. Staff were able to give support directly or refer to other health and social care professionals, peer support networks and self-help groups as necessary. The practice ensured that it made the out of hour's service aware of patients who may have out of hour's needs, such as patients receiving end of life care. Clinical staff identified those patients or their carers who might need support through the flag system in the electronic medical records.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting people's needs**

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

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. For example the practice provided a back pain service to Plymouth patients (from other GPs), commissioned by the CCG (Clinical Commissioning Group). An osteopath and one GP triaged and treated patients with back pain. This service included sacral epidural injections and referral for MRI scans and liaison with local neurosurgeons. Patients were usually seen within two weeks.

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.

**Tackling inequity and promoting equality**

The practice had recognised the needs of different groups in the planning of its services. For example, local nursing homes and care homes. As a result the GPs had been allocated to be the named GP for each home in the area. This had resulted in better continuity of care for the patients and staff.

The practice had recognised the needs of different population groups in the planning of its services. Staff said no patient would be turned away. Temporary residents were welcomed.

The number of patients with a first language other than English was considerable and staff said they knew these patients well and were usually able to communicate well with them. The practice staff also used a language translation services if information was not understood by the patient, to enable them to make an informed decision or to give consent to treatment.

The practice had access from the car park to the front door via a concrete slope. Inside the building, the GP consultation rooms and the treatment rooms were located on the ground floor, providing level access for patients with limited mobility or using a wheelchair.

The premises were modern and purpose built. The seats in the waiting area were of a bench style. There was no variation of seating for diversity in physical health and all chairs had arms on them to aid sitting or rising. The practice premises belonged to the GPs themselves and they were responsible for variations to the building. 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 available.

The practice maintained a register of people who may be living in vulnerable circumstances, and there was a system for flagging vulnerability in individual record. Patients with complex needs were discussed at clinical meetings and they were assigned a named GP, to ensure they received continuity of care.

The practice was about to provide equality and diversity training to its entire staff through e-learning.

**Access to the service**

Appointments are available between 8.30am and 5.30pm Monday to Friday. The practice provided a walk in open surgery twice a week between the hours of 8.30am and 11am. This is where no appointment was necessary.

Comprehensive information was available to patients about appointments in the practice itself. 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

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

conditions. This also included appointments with a named GP or nurse. Home visits were made to three local care homes on a weekly basis, by a named GP and to those patients who needed one.

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:

- 77.9% were satisfied with the practice's opening hours compared to the CCG average of 78.6% and national average of 75.7%.
- 80.2% described their experience of making an appointment as good compared to the CCG average of 82.4% and national average of 73.8%.
- 49% 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%.
- 67.9% said they could get through easily to the surgery 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 doctor on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another doctor if there was a wait to see the GP of their choice. Routine appointments were available for booking six weeks in advance. Comments received from patients also showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

For older people and people with long-term conditions home visits and longer appointments were available when needed. The practice ran an open surgery twice a week for patients who found it difficult to attend pre-booked appointments due to their mental health.

**Listening and learning from concerns and complaints**

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

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

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

The practice reviewed complaints to detect themes or trends but no themes had been identified. However, lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result.

# Are services well-led?

Good

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

## Our findings

**Vision and strategy**

The practice had a clear vision to support patients and to provide a high quality service delivered in a friendly and caring manner. The team culture and team behaviours reflected this. The practice took steps to ensure that all patients who needed a service, irrespective of the challenges they faced socially to access services were provided with quality healthcare services in their community.

The practice strategy was reviewed regularly by the partners. The GP partners worked well together to develop short and long term planning. The practice was aware of future NHS developments and any pressures which might affect the quality or range of service and was forward thinking in identifying ways to manage their impact. There was considered and constructive engagement with staff and a high level of staff satisfaction.

**Governance arrangements**

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 one partner was the lead for safeguarding. We spoke with three members of administration staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The 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 also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example seven were completed in the past 12 months, one being an audit completed following a significant event, to identify patients with outstanding blood tests. This instigated a new system of recall for such patients.

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 identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented. The practice monitored risks on a monthly basis to identify any areas that needed addressing.

The practice held monthly staff meetings where governance issues were discussed. We looked at minutes from these meetings and found that performance, quality and risks had been discussed.

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

**Leadership, openness and transparency**

The partners in the practice were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. All staff were involved in discussions about how to run the practice and how to develop the practice. The partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported, particularly by the partners in the practice.

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

# Are services well-led?

Good

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

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the surveys and complaints received. It did not have a PPG (Patient participation Group) although had tried several times to encourage patients to join.

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

Stoke Surgery was a small practice and this had the benefit of a small solid staff group, many of which had been employed for over ten years. The practice gathered feedback from staff through informal discussion in the main but also more formally through the appraisal process and team meetings. Staff said they always felt involved and included and were often asked for their ideas and opinions.

**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 three 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.

The practice was not a GP training practice.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. For example a patient had attended the surgery for blood tests. When the GP checked the results it was found to be abnormal. It was then found that the patient had not had a routine blood test for almost 12 months but had continued to receive prescriptions. The GP took immediate action to safeguard the patient and changed the processes for recalls of patients with repeat medications.