Central Surgery

Quality Report

Corporation Street
Rugby, CV21 3SP
Tel: 01788 524 366
Website: www.centralsurgeryrugby.co.uk

Date of inspection visit: 15 July 2015
Date of publication: 19/11/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Central Surgery on 15 July 2015. Overall, the practice is rated as good.

Specifically we found the practice to be good for providing safe, effective, caring, responsive and well-led services. The practice was good for providing services for older people, people with long term conditions, families, children and young people, working age people, people whose circumstances may make them vulnerable and people experiencing poor mental health.

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

• The practice held a fortnightly vasectomy clinic. The waiting time for this was three to four weeks compared with eight to ten weeks in secondary care. The practice also accepted referrals from other practices for the vasectomy clinic.

• 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.

• Risks to patients were assessed and well managed

• Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff received training appropriate to their roles and further training needs were identified and planned.

• Patients said they were treated with respect and involved in decisions about their treatment and care.

• Information about services and how to complain was available and easy to understand.

• There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients and acted on this.

We saw an area of outstanding practice:

Summary of findings

The practice ran an eye clinic three to four days per week. Having the eye clinic meant that most eye emergency cases for Central Surgery patients were managed entirely by the primary care ophthalmologist. In addition to this the practice accepted referrals from other practices.

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

Importantly the provider should:

Review the consent protocol to ensure they are satisfied they adequately document consent for all procedures

Professor Steve Field CBE FRCP FFPH FRCGP
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff received training appropriate to their roles, further training needs were identified and appropriate training was planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked in partnership with other professionals involved in providing care and treatment to patients.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients felt that there was continuity of care with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Summary of findings

The practice provided a minor surgery service reducing the need for secondary care referrals. This provided a convenient, quick and local service to patients. The practice had a small operating suite which was well equipped and clean. The practice audited minor surgery activity and outcomes.

The practice held a fortnightly vasectomy clinic. The waiting time for this was three to four weeks compared with eight to ten weeks in secondary care.

The practice ran an eye clinic three to four days per week. Having the eye clinic meant that most eye emergency cases for Central Surgery patients were managed entirely by the primary care ophthalmologist. The practice accepted referrals from other practices. Many macula pathology cases (an eye disease that progressively destroys the macula, the central portion of the retina, impairing central vision) could be accurately diagnosed so that referral into the medical retina service was not required.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and acted on this. The practice had and active patient participation group (PPG). Staff had received induction training, regular performance reviews and attended staff meetings.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services for example, for patients living with dementia and for end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

The practice ran an eye clinic three to four days per week. Having the eye clinic meant that most eye emergency cases for Central Surgery patients were managed entirely by the primary care ophthalmologist. The practice accepted referrals from other practices. Many macula pathology cases (an eye disease that progressively destroys the macula, the central portion of the retina, impairing central vision) could be accurately diagnosed so that referral into the medical retina service was not required.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Practice nurses had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver the care and treatment people needed.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. The practice had systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency attendances.

Immunisation rates were comparable to the national average for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with school nurses.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability and 94% of these patients had received a follow-up. It offered longer appointments for people with a learning disability.

Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Seventy six per cent of people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients living with dementia.

The practice had told patients experiencing poor mental health how to access various support groups and voluntary organisations and referred patients to Improving Access to Psychological Therapies (IAPT).

Summary of findings

What people who use the service say

We gathered patients' views by looking at eight Care Quality Commission (CQC) comment cards patients had filled in. On the day of the inspection we spoke with 18 patients one of whom was a member of the practice's patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice team to improve services and the quality of care. Data available from the NHS England GP Survey in January 2015 showed that the patients who responded had reported positive views about the practice. The practice had a higher than average score in respect of overall satisfaction with the care they received (87% compared with the national average of 85%). However, their score for getting through on the telephone was lower than the national average. The practice had worked with the PPG to implement a new telephone system and patients had commented this was an improvement.

Information from patients gave a positive picture of their experiences. Patients told us they were happy with the services they received and included all staff groups within the practice's team in their praise.

Areas for improvement

Action the service SHOULD take to improve

• Review the consent protocol to ensure they are satisfied they adequately document consent for all procedures

Outstanding practice

The practice ran an eye clinic three to four days per week. Having the eye clinic meant that most eye emergency cases for Central Surgery patients were managed entirely by the primary care ophthalmologist. In addition to this the practice accepted referrals from other practices.

Central Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) inspector**.** The team included a GP specialist advisor, a practice manager specialist advisor, an expert by experience and a second CQC inspector.

Background to Central Surgery

Central Surgery is located in Corporation Street close to the centre of Rugby. The practice also has a branch surgery at Bilton Green. We had no specific information about Bilton Green to lead us to visit there and this inspection therefore focussed on the main site. Car parking for patients with disabilities is available at the rear of the building. Pay-and-display parking is available nearby. Sheltered parking for bicycles and pushchairs is available and there is ramp access for wheelchairs at the rear of the building.

Those with difficulty walking have access to waiting areas, consultation and examination rooms and lavatories on the ground floor. Patients can let the receptionist know if they wish to have their consultation with the GP on the ground floor when they book appointments.

The practice has nine partners and three salaried GPs. Seven of the GPs are male and five are female providing patients with a choice. The practice has five practice nurses and four health care assistants. The clinical team are supported by a practice manager, a reception manager and a team of reception staff, medical secretaries and administrative staff.

Central Surgery is a training practice providing training places for up to 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. The practice is also a teaching practice and provides placements for medical students who have not yet qualified as doctors. The practice carries out minor surgery.

The practice has a patient participation group (PPG), a group of patients registered with a practice who work with the practice team to improve services and the quality of care.

The practice has a General Medical Services (GMS) contract with NHS England.

Data we reviewed showed that the practice was achieving results that were in line with national or Clinical Commissioning Group (CCG) averages in respect of most conditions and interventions.

The practice provides information about the telephone numbers to use for out of hours GP arrangements provided by NHS 111.The practice website explains that patients can attend the GP walk in centre based next to Accident & Emergency at Hospital of St Cross.

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 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 the CQC at the time of the inspection.

How we carried out this inspection

Before this inspection, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. These organisations included Coventry and Rugby Clinical Commissioning Group (CCG), NHS England Area Team and Healthwatch. We carried out an announced visit on 15 July 2015. We sent CQC comment cards to the practice before the visit. We received eight completed cards which gave us information about those patients' views of the practice.

During the inspection we spoke with 18 patients including a member of the PPG and 14 members of staff including the practice management and support teams, GPs, practice nurses and health care assistants.

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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. The practice reported incidents and received national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns.

Staff knew how to report incidents and near misses. For example they recorded all clinical complaints as significant events or near misses. Trends were looked at and discussed at clinical governance meetings. Minutes of the meetings were then circulated to all the team. The practice also discussed and circulated good practice.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Significant events were a standing item on the practice meeting agenda and discussed at the monthly clinical governance meetings to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Clinical and non-clinical staff knew how to raise issues for consideration at the meetings and were encouraged to do so. We saw an example of a significant event discussed at the clinical governance meeting. This related to a patient who was unwell when they arrived at the practice. Prompt action was taken and an ambulance was called. The practice shared this at the clinical governance meeting and highlighted the importance of using the panic alarm in an emergency.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. National patient safety alerts were circulated by the practice manager to all the team. These were shared at the monthly clinical governance meetings led by a GP partner.

Reliable safety systems and processes including safeguarding

The practice had a safeguarding policy for children and young people and an adult safeguarding policy. One of the GP partners was the safeguarding lead for both adults and children.

The training records we saw confirmed staff had attended training appropriate to their roles and all certificates were up to date. The GPs had flow charts to help them make decisions about referrals available for safeguarding.The practice had clear systems to highlight patients who may be living in circumstances that made them vulnerable. There was also a summary on the patient records which meant a summary print out could be taken with GPs on home visits.

The practice had a chaperone policy which all staff were fully aware of. A chaperone is a person who acts as a witness to safeguard patients and health care professionals during medical examinations and procedures. Signs were displayed within the practice to inform patients that chaperones were available. All staff carrying out this role had a disclosure and barring service (DBS) check. DBS checks identify whether a person has a criminal record or is on an official list of persons barred from working in roles where they will have contact with children or adults who may be vulnerable. Staff we spoke with confirmed they had been trained and understood what they were expected to do.

The practice shared an example of a domestic violence concern where they had worked in partnership with other agencies to safeguard the individuals involved. They showed us evidence that their positive contribution had been valued by the other agencies.

The practice had a clear system for following up frequent accident and emergency attendances of patients and patients who did not attend appointments. These situations were discussed at clinical governance meetings and the GPs would visit the patient if this was considered appropriate.

Medicines management

We saw there were policies in place for the safe management of medicines. The practice did not have any stocks of controlled drugs.

Good

Are services safe?

The practice stored all blank prescriptions securely and kept records of serial numbers in accordance with national guidance.

All the medicines we checked were within their expiry dates. We checked the contents of GPs' bags. These contained an appropriate range of in date emergency medicines. All clinical rooms were locked when unoccupied and accessed with a keypad system.

The practice aimed for a 24 hour turnaround for issuing requested repeat prescriptions. Patients could request repeat prescriptions on line or in writing. Prescriptions requiring reauthorisation by a GP were automatically flagged on the practice's computer system.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs that were all up to date in July 2015. We saw evidence that practice nurses and health care assistants (HCAs) had received appropriate training and been assessed as competent to administer the medicines referred to under a PGD. They attended regular training days and staff kept themselves updated by reading publications on the internet. The staff monitored the temperatures of vaccines to ensure that they were stored within the required temperature range and kept records of this. Staff were able to explain the process they would follow if the temperature recorded was outside the expected range. We checked a sample of the vaccines and found they were in date. The HCAs checked the expiry dates of medicines each week.

Cleanliness and infection control

The practice was visibly clean and tidy. Patients we spoke with told us they were happy with the cleanliness of the practice.

The practice manager was the lead for infection control and for Legionella precautions. Legionella is a bacterium which can contaminate water systems in buildings. The practice manager had completed a Legionella risk assessment in July 2015. The practice had a policy in place and was carrying out regular checks in line with the policy.

The practice had an up to date infection control policy and staff had completed infection control training relevant to their roles. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The cleaning staff had a cleaning schedule to follow to ensure all areas of the practice were cleaned as necessary. The cleaning equipment and products were kept securely. The practice had plenty of personal protective equipment such as gloves and aprons for staff to use. There were disposable privacy curtains in treatment rooms and staff recorded the date these had been changed on labels provided for this.

There was a sharps injury policy and staff knew what action to take if they accidentally injured themselves with a needle or other sharp medical device. The practice had written confirmation that all staff were protected against Hepatitis B. All instruments used for minor surgery were single use.

The practice had a contract for the collection of clinical waste and had suitable locked storage for this and sharps. We saw that this contract was in date. The HCAs were responsible for emptying bins daily. All transfer of waste from the practice to an authorised contractor was supported by the required documentation.

Equipment

Staff we spoke with confirmed they had the equipment they needed to meet patients' needs safely. Each clinical room was appropriately equipped. We saw evidence that the equipment was maintained and that portable electric appliances were checked and tested. We saw evidence of calibration of equipment used by staff including thermometers, spirometers, scales and nebulizers. This was last carried out in October 2014.

Staffing and recruitment

The practice had a recruitment policy which was personalised for the practice and set out the standards they followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment.

The practice obtained information about staff conduct in previous employment. They did this by taking verbal and written references.

Good

Are services safe?

Staff covered for each other's annual leave and felt there were adequate staffing levels. Staff told us that arranging sufficient GP cover during holiday seasons could be a problem. The practice were looking to recruit more GPs to work the equivalent of one and a half full time post to address this issue.

The practice occasionally used locums to cover GP absences. A service level agreement was in place between the practice and the agency to ensure that only suitably qualified and experienced locums were provided. We saw that all relevant recruitment paperwork was forwarded to the practice from the locum agency.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage risks to patients, staff and visitors to the practice. The practice manager carried out daily inspections of the premises and planned to implement a checklist to help them manage this.

Identified risks were recorded. Each risk was assessed and rated and actions recorded to reduce and manage the risk.

The practice had systems for identifying patients who may be at risk. There were registers in place for patients in high risk groups such as those with long term conditions, mental health needs or learning disabilities. The practice computer system was used to inform staff of individual patients whose circumstances might make them vulnerable.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. The practice had a panic alert button for staff to use on phones and computers if they needed urgent help from other members of the team. All staff were up to date with Cardiopulmonary Resuscitation (CPR) training and the practice had a system in place for monitoring when refresher training was due.

The practice had oxygen and an automated electronic defibrillator (AED – a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). There were appropriate medicines available for use in a medical emergency at the practice. We saw evidence that staff checked these regularly to make sure they were available and ready for use if needed. All medicines we checked were in date.

We saw that there was a fire risk assessment, which was completed in June 2015. Records showed that staff were up to date with fire training and they practised regular fire drills. The practice had a business continuity plan covering a range of situations and emergencies that may affect the daily operation of the practice. The plan was available to all staff. Key members of the practice team held copies off site.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Our discussions with the GPs and the practice nurses showed that they were aware of and worked to guidelines from local commissioners and the National Institute for Clinical Excellence (NICE) about best practice in care and treatment. Clinical staff had access to NICE guidelines on their computer systems and used these to ensure that their clinical decisions were in line with best practice. The practice had monthly meetings led by a GP partner during which information regarding new guidance and changes to guidance were shared. The practice involved all partners with decision making.

The GPs had lead roles such as safeguarding, orthopaedics, drug dependence and gynaecology. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support in order to use the skill mix available to benefit patients. For example a patient with a painful knee would be referred to one of two partners with a special interest in joint problems for initial care and assessment. Any treatment or referrals would then be arranged.

The practice took part in an enhanced service for learning disabilities and had a nurse who specialised in this area. This nurse ensured patients with learning disabilities received annual medical reviews. This included consideration of the carers and their needs in line with the enhanced service protocol.

Patients had a named responsible GP, however the practice had a list of over 20,000 people and it therefore balanced individuals' needs with the skill mix of clinicians most appropriately suited to deal with their needs. Choose and Book referrals were usually completed within 24 hours. Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.

Referral rates were monitored and overall appeared to be average for the Clinical Commissioning Group (CCG) area. The GPs were aware of variations from predicted levels. They had recently analysed their referrals to secondary care under the two week suspected cancer pathway. This identified that the practice had scored well, 57% compared with the national average of 49% for the number of new referrals treated within two weeks.

The practice participated in the unplanned admissions avoidance enhanced service for patients with complex needs. These patients were reviewed regularly to ensure multi-disciplinary care plans were documented in their records and that their needs were being met. A designated member of the administration team maintained the unplanned admissions register. They ensured patients were followed up at appropriate intervals for example after unplanned or emergency admissions to hospital. The practice telephoned patients after discharge to see if they were alright and managing their medicines. If required the practice would book them an appointment with a nurse or GP.

All patients over the age of 75 had a named GP but all partners would see all patients as necessary.

Management, monitoring and improving outcomes for people

Clinical audits are a process by which practices can demonstrate ongoing quality improvement and effective care. The practice had carried out a completed audit cycle of contraceptive implants in order to determine the extent to which NICE guidelines were followed upon removal. The findings of the audits were that there had been a 14% increase in the number of patients treated in accordance with NICE guidance. The results of the audits were shared at clinical governance meetings.

We also saw vasectomy audits and this highlighted the number of vasectomies that had been performed from 2012 to 2013. One hundred per cent of the patients rated their experience as excellent.

There was a monthly multi-disciplinary team MDT meeting involving practice clinicians and outside colleagues to discuss patients receiving palliative care and other patients with complex needs. The practice had a register of all patients receiving palliative care. We reviewed the minutes of the 2014 and 2015 meetings. These were comprehensive and highlighted all the concerns discussed.

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. QOF is a voluntary incentive scheme for GP practices in the UK. The practice was not an outlier for any

Good

Are services effective?

(for example, treatment is effective)

QOF (or other national) clinical targets. It achieved 98.4% of the total QOF target in 2014, which was above the national average of 94.2%. Specific examples to demonstrate this included:

- Performance for diabetes related indicators was 96.9% which was 6.8% above the national average.
- The percentage of patients with mental health problems having blood pressure readings in the preceding 12 months was 86.4% which was 3.5% above the national average
- The dementia diagnosis rate was 74% which was 3.9% below the national average

The practice's prescribing rates were also similar to national figures. The practice had a higher than average prescribing rate for medicines used for anxiety. The senior partner explained that this was because they ran a clinic for patients needing support and treatment due to drug and alcohol misuse. The practice issued weekly prescriptions for these patients to reduce the risks of misuse.

Structured annual reviews were also undertaken for people with long term conditions such as diabetes and chronic obstructive pulmonary disease (COPD). This also ensured the latest prescribing evidence was used.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records which showed staff were up to date with the practice's mandatory training such as annual basic life support. The practice was also using a computer based training system to provide staff with easy access to training materials. Staff could complete this at work or at home and the practice gave them time back for training completed in their own time.

Staff had a comprehensive induction toolkit and this was reviewed during their six month probation review. Return to work interviews were carried out for staff after three absences.

A new practice manager had been in post since February 2015. Staff told us they received annual appraisals and that there was an open door to raise issues with the practice manager or GPs at any time. Some staff appraisals were overdue but the practice manager had put in procedures for staff to be appraised within six months.

Central Surgery 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 practice. Only approved training practices can employ GP trainees and the practice must have at least one approved GP trainer. The practice were proud to share their 100% pass rate and positive deanery feedback. The practice shared some feedback from the 2014 GP trainee questionnaires. Trainees had described the practice as helpful and supportive.

The practice was also a teaching practice and provided placements for medical students who had not yet qualified as doctors. The medical students observed minor surgery procedures with the consent of patients. The practice also provided placements for A-Level students interested in a career in nursing or medicine to gain initial experience in general practice. The practice believed this helped to encourage future doctors to primary care. The practice obtained consent from patients to ensure they were happy for the A-Level students to attend consultations.

The GPs, nurses and healthcare team at the practice had knowledge and skills which enabled the practice to offer a wide range of services to patients. The nurses gave us examples of training they had done such as travel updates, smear updates, immunisation updates and Doppler training which is a form of ultrasound that can detect and measure blood flow. One practice nurse explained that they would be starting an asthma course in November this year followed by a six months Open University Course in asthma care.

The GPs' annual external appraisals and requirements for revalidation were up to date. Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been performed by the General Medical Council can the GP continue to practice and remain on the performers list with NHS England.

All staff we spoke with felt supported by the practice and said they were encouraged to develop their knowledge and skills.

Working with colleagues and other services

The practice worked with a range of health and social care professionals for patients with different circumstances. The

Good

Are services effective?

(for example, treatment is effective)

practice had monthly clinical governance meetings with the multi-disciplinary team and representatives from external organisations such as district nurses, counsellors and family support workers.

Out of hours reports, results and secondary care correspondence were received electronically. Paper letters received were scanned by the administrative team into patients' records. There was a large volume of incoming information and the administration team ensured there was safe and effective document handling. Incoming pathology and radiology reports were handled by the clinicians using the electronic system.

The practice engaged fully with the Coventry and Rugby clinical commissioning group (CCG) and one of the partners represented Rugby on the CCG board.

Information sharing

Information was available for all staff to access on the shared drive of the practice's computer system. All of the staff we spoke with knew this and gave us examples of information they might look for such as policies and procedures and safeguarding information.

The practice used electronic systems to communicate with other providers. Electronic systems were in place for making referrals. Laboratory and radiology results were received electronically. The electronic patient record was used by all staff to co-ordinate, document and manage patients' care. Medical records were summarised in a timely manner using the practice protocols. All investigations, blood results and x-rays were requested and received online.

The practice recognised the importance of confidentiality and had a confidentiality policy. The practice had information on their website to inform patients about their rights regarding how their information was managed. This included information about summary care records and Care Data and how patients could opt out of these if they wanted to. The summary care record (SCR) is an NHS computer system intended to help emergency clinicians with patients' care when their GP practice is closed. This currently only contains information about medications and allergies. Care Data is an NHS England initiative which can extract data from practice records for health research purposes.

Consent to care and treatment

Consent forms were used for minor surgery services and vasectomy.

The practice did not routinely collect written consent for soft tissue injections and tongue tie release and they relied on noted verbal consent that patients/parents had been fully advised. We highlighted this with the practice during the inspection.

GPs we spoke with showed they were knowledgeable of Gillick competence assessments of children and young people. The Gillick test is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Decisions about or on behalf of people who lacked mental capacity to consent to what was proposed were made in the person's best interests in line with the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. All practice staff were due to have formal MCA training arranged by the CCG.

Health promotion and prevention

We saw that the GPs used their contact with patients to help maintain or improve mental and physical health and wellbeing. The practice offered smoking cessation advice to smokers. Smoking cessation advice packs were available in reception and patients had the option of booking an appointment with the smoking cessation nurse for further advice and treatment. The practice offered NHS health checks to all patients aged 40 to 75 years old.

The practice nurses were responsible for the practice's cervical screening programme. The data available showed that the take up of screening at the practice was in line with the national average. Patients could also have long acting contraceptive devices and implants provided at the practice at appointment times to suit them.

Travel health information was available on the practice website and the practice was a yellow fever vaccination centre so patients were able to receive this vaccine on site in addition to the more usual travel vaccinations.

The practice offered a full range of immunisations for children and flu vaccinations in line with current national guidance. Last year's performance was average or above average for the majority of immunisations where comparative data was available. For example:

Good

Are services effective?

(for example, treatment is effective)

- The flu vaccination rate for the over 65s was 71% which was similar to the national average of 73%.
- The flu vaccination rate for at risk groups was 44% which was lower than the national average of 52%.
- Childhood immunisation rates for the vaccinations given to under twos ranged from 98% to 100% and five year olds from 94% to 99%. These were in some cases better than CCG and national averages.

The practice had a system for calling and recalling patients. This covered immunisations, diagnostic screening and reviews for long-term conditions.

The lead GP told us about a CCG-led initiative to improve flu vaccination rates in the area. This included plans to employ district nurses during the following year to cover care homes for flu vaccinations in an attempt to increase uptake. The practice were trying to promote flu awareness and had relevant literature in the waiting areas.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We gathered patients' views by looking at eight Care Quality Commission (CQC) comment cards patients had filled in and we spoke with 18 patients on the day of the inspection. One patient was a member of the Central Surgery Patient Participation Group (PPG). A PPG is a group of patients registered with a practice who work with the practice team to improve services and the quality of care.

Data available from the NHS England GP patient survey results in January 2015 showed that the patients had reported positive views about the practice. Ninety four per cent said the last GP they saw or spoke to was good at giving them enough time compared with the local (CCG) average of 85% and the national average of 87%.

The information written by patients in the comment cards and from patients we spoke with during the inspection gave a positive picture of patients' experiences. Patients told us they found the practice staff to be, friendly, helpful and understanding. They confirmed that they were treated with dignity and respect. The practice had male and female GPs, which gave patients the ability to choose to see a male or female GP if they had a preference.

Some patients we spoke with gave particularly positive accounts of the care and treatment they and their families received. They described being involved in their care and never feeling rushed. People also highlighted the website and telephone system, friendly staff, informative displays and on-site pharmacy.

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

There were posters in the treatment rooms to inform patients about chaperone arrangements. All healthcare assistants and nurses had received chaperone training and were fully aware of how to act as a chaperone. There was also a room available for patients to go to if they wanted to discuss concerns with reception staff in a confidential setting.

Care planning and involvement in decisions about care and treatment

We looked at the GP patient survey information published in January 2015. This showed that most patients responded positively to questions about their involvement in planning and making decisions about their care and treatment.

- 90% per cent said their GP was good or very good at explaining tests and treatments (CCG average 85%; national average 86%).
- 99% had confidence and trust in the last GP they saw or spoke to (CCG average and national average 95%).
- 87% per cent said their GP was good at involving them in decisions about their care (CCG average 79%; national average 81%)

Some patients specifically commented that GPs explained things to them and kept them informed.

Staff told us that agency interpreting services were available for patients who did not speak English as their first language. The practice used the interpreting services quite frequently as they had a large number of Eastern European patients. British Sign Language interpreters were also available from the agency when required for people with hearing loss.

Patient/carer support to cope emotionally with care and treatment

Patient survey results showed that patients were positive about the emotional support provided by the practice and rated it well in this area.

- 90% said the last GP they saw or spoke to was good at treating them with care and concern (CCG average 83%; national average 85%).
- 91% said the last nurse they saw or spoke to was good at treating them with care and concern which was in line with the national average.

Notices in the patient waiting room directed people to a number of local and national carers' organisations and information about respite care services. The practice had leaflets regarding bereavement services in the waiting areas. Staff we spoke with in the practice recognised the importance of being sensitive to patients' wishes.

Patients identified as carers were identified on the practice's computer system so that staff were aware of this.

Good

Are services caring?

The practice did not have a member of staff who had a lead role for carer support. We received positive information from a carer about the advice and support they received from the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Information we obtained before the inspection from the NHS England Area team and Coventry and Rugby Clinical Commissioning Group (CCG) provided a picture of GPs who engaged positively with these organisations. They had a thorough understanding of the wider picture of health provision in the local area. The senior partner was actively involved with the CCG board.

The practice had a dementia service which involved making an opportunistic offer of assessment for dementia to patients considered to be at risk. This involved an initial screening and offer of referral to a memory clinic where appropriate. The practice then offered ongoing reviews for those patients. The practice advertised dementia mornings which ran in Rugby for anyone interested in learning more about dementia.

The practice worked closely with Improving Access to Psychological Therapies (IAPT) workers for patients who experienced poor mental health.

NHS Health checks were provided to patients who met the current criteria. The practice offered a wide range of family planning services including coil fitting and contraceptive implants. A practice nurse ran a minor illness clinic for patients with health concerns such as colds, sore throats and hayfever. Patients were able to order their prescriptions and book appointments online. Patients could register to receive information by text message on their phone regarding appointments and health care.

The surgery provided a minor surgery service reducing the need for secondary care referrals. This included procedures such as tongue-ties, excisions of lesions, nasal cautery for nosebleeds, wart cryo cautery and joint injections. The practice had a small operating suite which was well equipped and clean. The practice audited minor surgery activity and outcomes. There was a fully trained GP surgeon able to offer a wide range of procedures appropriate for primary care. This provided a convenient, quick and local service to patients. The GP surgeon was fully supported by a trained nursing team who were clear in their roles and responsibilities and there was a clear sense of working together.

The practice ran an eye clinic three to four days per week. Having the eye clinic meant that most eye emergency cases for Central Surgery patients were managed entirely by the primary care ophthalmologist. The clinical lead was an advanced qualified practitioner for NHS Warwickshire North, NHS South Warwickshire, NHS Coventry and Rugby and NHS Nene and Northamptonshire. As his waiting times were between one and three weeks many patients chose to wait to see the GP in Rugby, rather than spend a day in eye casualty in Coventry. Eye clinic minor operations were done in a one stop fashion whereby the patient was seen and treated on the same visit. 85% of all referrals were managed within the eye clinic. In the last financial year the practice had 1300 new referrals, of which 90% came from other practices including other towns and cities. Fifteen per cent of patients were referred on to the relevant subspecialist in the hospital, usually with a full diagnosis and treatment started for example glaucoma cases. Patients who were referred to the subspecialty clinic had their visual field tests, optic imaging both digital and optical coherence tomography (OCT) at the practice before going to the clinic.

The OCT imaging meant that many macula pathology cases (an eye disease that progressively destroys the macula, the central portion of the retina, impairing central vision) could be accurately diagnosed so that referral into the medical retina service was not required. The waiting times over 16 years had never been more than 4 weeks and were typically one to two weeks compared to six to eight weeks in secondary care.

The practice held a fortnightly vasectomy clinic. The waiting time for this was three to four weeks compared with eight to ten weeks in secondary care. The vasectomy service was benchmarked against national data and showed that the service was effective and meeting expected outcomes.

In the last financial year there were a total number of 105 referrals. 30 were from Central Surgery and 75 were from other practices.

Histology samples were tracked to ensure anything sent for pathology analysis was reported back to them. 3 in 50 (6%) turned out to be an unsuspected skin cancer.

The practice had a long-standing, active Patient Participation Group (PPG). A PPG is a group of patients registered with a practice who work with the practice team

Good

Are services responsive to people's needs?

(for example, to feedback?)

to improve services and the quality of care. The PPG had 12 members and met every two months. We met with a member of the PPG who felt that the PPG was functioning well. They told us members felt listened to and valued.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice had access to telephone or face to face translation services when required, for those patients whose first language was not English. They used them extensively for a large number of Polish patients living in the area. The practice had fact sheets available in 21 languages on their website.

A member of the nursing team shared an example of making sure a patient was seen by a female GP to be culturally sensitive to the patient's needs.

We saw evidence that all members of staff had completed equality and diversity training through e-learning.

A hearing loop was available in reception to assist patients who used hearing aids. The practice had alerts on the practice computer system so staff were aware of patients who needed help and support due to sight or hearing loss.

Due to the original design of the building access for people with disabilities was a problem. The practice had reduced the impact of this by providing ramps into the building. There were ground floor consulting rooms for patients with mobility problems.

Access to the service

Information from the national patient survey showed mixed results regarding patients' experiences of access to the service.

- Fifty-six per cent found it easy to get through by phone which was lower than the local (CCG) average of 74% and the national average of 73%.
- Eighty-eight per cent were able to get an appointment to see or speak to someone the last time they tried which was higher than the local average of 84% and national average of 85%.
- Seventy-five per cent were satisfied with the surgery's opening hours which was the same as the local and national average.

The practice had worked with the PPG to implement a new telephone system and patients had commented this was an improvement. The PPG carried out a survey and found that 76% of patients found it easy to get through by phone at the end of 2014.

Whilst speaking with patients in the waiting room we observed that they did not have a long wait to be seen by the GP or practice nurses.

The surgery was open Monday to Friday from 8.30am to 6.30pm. Appointments were available daily between 8.30am and 12.30pm and 2pm and 6pm. Patients were able to book appointments in person, by phone or on-line. Patients with an urgent need were seen on the same day and there were dedicated appointments available for this. The practice offered extended hours on Tuesday and Wednesday evening until 7.30pm and one in four Saturday mornings at the branch practice.

Comprehensive information about appointments was available on the practice website. This included information for patients about how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed an answerphone message gave the telephone number they should ring depending on the circumstances.

Information on the out of hour's service was provided to patients. This included information about NHS 111 and the walk-in centre next to Accident and Emergency at the Hospital of St Cross.

There was a 24 hour phone number to cancel appointments. The practice had posters up to show how many patients had missed appointments. There were approximately 500 missed appointments per month. If patients repeatedly missed appointments the practice wrote to them about this. If a patient's attendance did not improve this was discussed at clinical governance meetings and they were invited to the practice to discuss this.

Listening and learning from concerns and complaints

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice had a system for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and the practice manager held the lead responsibility for complaints handling.

Information was available in the reception area to help patients understand the complaints system. There were clear posters on the noticeboards explaining the complaints procedure. There were also complaints and compliments leaflets available. The leaflets provided patients with the names and contact details of the practice manager and informed patients that if they did not wish to contact the practice directly they could complain to NHS England. The practice did not have information about the Clinical Commissioning Group CCG or advocacy services in their response letters. When we highlighted this they said they would add this information.

We looked at 11 complaints and noted that the practice had handled these well. One complaint where the practice reviewed its procedure related to a delay in issuing prescriptions to the pharmacy. This resulted in changes to reception working procedures to ensure prescriptions were issued fully and promptly for closer monitoring.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care in a timely manner and involve patients in all aspects of their health care. At the heart of this was a desire to continue to provide a caring service. All the staff we spoke with were aware of this and wanted to play their part in achieving these aims. The GPs and practice manager intended to discuss succession planning and finance during 2015. The practice always consulted the patient participation group PPG to ask for their opinion in order to continuously improve. A PPG is a group of patients registered with a practice who work with the practice team to improve services and the quality of care

The practice had plans to develop and extend the range of professionals they worked in partnership with. This included appointing a family health worker and working more closely with school nurses. They also wanted to engage with local faith groups and develop social prescribing.

The business plan was in hand and being developed to be shared with the team. This had been a priority for the practice manager who started in February 2015.

Governance arrangements

All policies and procedures were available on all computers at the practice and paper copies were available in the practice manager's office.

Clinical governance meetings took place monthly and the practice planned to increase the frequency of these .They discussed palliative care, vulnerable and elderly patients, accident and emergency admissions, Quality and Outcomes Framework (QOF) and significant events (SEs) at these meetings. Staff were able to describe how changes had been made to the practice as a result of reviewing SEs.

We saw an example of an issue which was resolved through discussion at the clinical governance meeting. It was found a GP's test results were being misdirected at the hospital. This meant that some results were not received by the practice and the GP had to check for reports on the computer system. The practice contacted the hospital to get this resolved.

During the clinical governance meetings and the practice meetings the practice looked at risk to business and carried out risk assessments where it was considered appropriate.

The practice manager was responsible for human resource (HR) policies and procedures. Staff we spoke with knew where to find these policies if required.

Leadership, openness and transparency

There was a leadership structure in place and clear lines of accountability. Staff had specific roles within the practice, and clinical and managerial staff took the lead for different areas.

One member of staff we spoke with informed us that they had previously worked at the practice for a number of years and left for a short time. They returned to the practice because the GPs treated staff with respect.

Staff told us there was an open culture within the practice. They told us they had the opportunity and were happy to raise issues at meetings or with their line managers.

There was a communication book in place to share issues, concerns and ideas and system for sharing information with individual staff when necessary.

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

The practice had gathered feedback from staff through meetings, appraisals and informal daily discussions. Staff felt there was an open door policy and would not hesitate to raise concerns. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. For example as a result of staff feedback the practice were doing a trial of five minute urgent appointments after lunchtime to see how effective this would be.

The practice worked well with PPG. The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from them. For example, previously the car park at the practice had been used by shoppers which reduced parking for patients. As a result of recommendation from the PPG the car park was now restricted to use by patients.

The practice had previously used a patient survey which patients often did not fully complete. The PPG felt that this

Are services well-led?

Good

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

was because it was too long. As a result of a recommendation from the PPG this was made in to a concise single page document which more patients completed.

The PPG also helped to improve the phone system. Previously when patients called the practice there was a premium rate number and patients were not aware how many patients were ahead of them in the queue. As a result of feedback from the PPG there was now a local rate number and patients were told their place in the queue.

Feedback to patients was given on the noticeboards in reception, the website and in newsletters.

Management lead through learning and improvement

Staff we spoke with said the practice supported them to maintain their continuous professional development through training and mentoring. Staff told us that the practice was very supportive of training and development opportunities. The GP partner who specialised in vasectomies delivered presentations to staff regarding this during the practice meetings.

The practice was a GP training practice providing GP training places for up to two 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 GP registrars spoke very highly of the practice and could not fault the training they had received. The GP registrars were given timetables for their induction by one of the GP partners.

The practice completed reviews of significant events and shared these at meetings. Staff meeting minutes showed these events were discussed, with actions taken to reduce the risk of them happening again.