Sid Valley Practice

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected Sid Valley Practice on 15th April 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.

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 service 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. Sid Valley Practice is a training practice, with two GP partners approved to provide vocational training for GPs, second year post qualification doctors and medical students.
- The practice implemented suggestions for improvements and made changes to the way it

Summary of findings

- delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).
- The practice premises is an old building with facilities that need improving. However the practice managed well and was well equipped to treat patients and meet their needs.
- 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.

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.

There were arrangements for the efficient management, storage and administration of medicines within the practice. There were clear processes to follow when dealing with emergencies. Staff had received basic life support training.

Recruitment procedures and checks were completed as required to help ensure that staff were suitable and competent. The practice was clean, tidy and hygienic.

Are services effective?

Good

The practice is rated as good for providing effective services. Supporting data showed the practice had systems in place to make sure the practice was effectively run.

The practice had a clinical audit system in place and audits had been completed. Care and treatment was delivered in line with national current practice guidance. The practice worked closely with other services and strived to achieve the best outcome for patients.

Supporting data showed staff employed at the practice had received appropriate support, training and appraisal. GP partner appraisals and revalidation of professional qualifications had been completed. The practice had extensive health promotion material available within the practice and on the practice website.

Are services caring?

Good

The practice is rated as good for caring. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. Staff treated patients with kindness and respect, ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The needs of the local population were reviewed and the practice engaged with the NHS England Area Team and Clinical

Summary of findings

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 92% of patients said they were able to get an appointment to see or speak to someone the last time they tried. 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.

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG).

The practice building itself was old and not fit for purpose. However the practice was opening a new medical centre which would deliver the majority of patient services, reducing the load on the current health centre building. The practice was also working with NHS property services to upgrade the current premises. It 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.

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. The practice had an active patient participation group (PPG). The PPG were proactive in improving services for patients and influenced changes at the practice. Staff had received inductions, regular performance reviews and had attended staff meetings and events.

Summary of findings

Staff said they felt well supported and enjoyed their work. They said communication was good amongst each other. The practice used its own intranet to cascade and share information to all staff. This included a daily blog and a thanks page which was used by all staff to say thank you to one another for any particular work or assistance that had been helpful.

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

Outstanding ☆

The practice is rated as outstanding for the care of older people. The practice had a large elderly population (40% of the patients were over 65) and was particularly focused on addressing their needs. All patients had their own named GP and this provided valued continuity of care. However, they did not always get to see their own GP without booking in advance. Care plans were in place for patients at high risk of unplanned admission and these were shared with local out–of-hours providers, the ambulance services and emergency department. Regular hospital avoidance of admission meetings were held. The community hospital was situated next door to the practice. The GPs undertook a daily ward round at the hospital during the week and were responsive to urgent requests from the hospital for things such as medicine changes and X ray requests.

The practice offered home visits when needed and automatic same day access to telephone advice and if needed GP appointments.

The practice worked closely with the hospiscare nurses to provide responsive end of life care. They held a quarterly palliative care meeting with the hospiscare and community nurse teams. They also worked closely with the complex care team with one of the GPs meeting each week with them to discuss patients with complex care needs. The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and also had regular internal meetings to discuss the care and support needs of patients and their families.

The prescriptions team at the practice worked closely with local pharmacies to ensure blister packs were provided for older people with memory problems and delivered to a location of the patient's choice. A GP partner was a dementia champion and used their knowledge and experience to make early diagnosis and referrals as necessary, they also sat as a trustee on a voluntary basis at the local memory café. This was a useful link for those patients with early onset dementia.

The practice had responsive systems in place for the care of their patients in care homes. The practice manager and one of the GPs visited six care homes in the area to discuss and review the care provided to their patients with a view to find ways to continually improve the service provision. As a result of these meeting the care homes were given a direct line telephone number so that they could contact the practice without delay when needed.

Summary of findings

People with long term conditions

Good

Sid Valley Practice is rated as good for the care of people with long-term conditions. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

The practice identified patients who might be vulnerable, have multiple or specific complex or long term needs and ensured consultations or reviews were offered where needed. Particular clinics operated for patients with diabetes, heart failure, hypertension, high cholesterol and asthma. The nurses attended educational updates to make sure their knowledge was up to date.

The practice computerized patient record system was accessed by out of hours service providers if the patient had given permission for this to happen. GP's and out of hours doctors were then aware of any treatment that they had been given to people with long term conditions or those at the end of their life.

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 90% of two years old had received all 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 worked with the health visitors and the school nurse to safeguard children. A joint child protection meeting was held every 3 months and one of the GPs met with the health visitors at least monthly for more frequent liaison. A GP partner was the lead for safeguarding and the practice had just introduced a lead nurse for safeguarding.

The midwife team provided antenatal care at the local community hospital and liaised with the practice as needed. The practice provided unlimited same day telephone access so that children needing same day appointments were able to do so.

Woman had access to a full range of contraception services and sexual health screening including chlamydia testing and cervical screening.

Working age people (including those recently retired and students)

Good

The practice is rated as good for working age people.

Summary of findings

Advance appointments (up to six weeks in advance) were available for patients to book. There was an online appointment booking system, which patients said was useful. For those patients who required urgent access and where appointments were not available on the day the practice offered the option of a telephone consultation with a GP. This was particularly useful to patients with other commitments who were not able to make it to the practice.

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.

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 with a learning disability and had carried out annual health checks for just fewer than 50% of these patients. The others that had not attended were re invited and this was followed up by the nurses. Longer appointments were offered to those patients with long term illnesses or learning disabilities.

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.

There were a small number of patients whose first language is not English. A translation service was available.

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).

Summary of findings

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 review.

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

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had in place advance

care planning for patients with dementia. They actively screened patients who were displaying signs of, or who were at risk of developing dementia, using a professionally recognised tool. For example the diagnosis rate increased from 26% in year 2009-10 to 51.8% in 2014-5. This meant that advice and some treatments had been offered at the early onset of the illness. One GP partner was a dementia champion and they also sat as a trustee on a voluntary basis at the local memory café. This was a useful link for those patients with early onset dementia.

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 30 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.

Waiting times were acceptable, generally no more than 15 minutes. Patients said they did not feel rushed during their consultations. 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 getting through on the phone.

The results were:

GP Patient Survey score showed 92% of patients were able to get an appointment to see or speak with someone on that day this is above the local CCG) average of 90%.

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 – 68% compared to the local (CCG) average of 84%

Percentage of patients rating their experience of making an appointment as good or very good – 74% compared to the local (CCG) average of 82%.

These results were based on 584 surveys. Following this survey the practice put actions into place to improve the outcomes for patients by making appointments easier to access. They did this by increasing staffing levels, including call handlers, introduced a new phone system and the introduction of a prescriptions triage system.

Sid Valley Practice

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 Sid Valley Practice

Sid Valley practice was inspected on Tuesday 15th April 2015. This was a comprehensive inspection.

The main practice is situated in the seaside town of Sidmouth and covers a five mile radius of the surrounding villages. The practice provides a primary medical service to approximately 14500 patients. The practice is a training practice for doctors who are training to become GPs.

There is a team of ten GP partners and one salaried GP within the organisation. Partners hold managerial and financial responsibility for running the business. There are seven male and six female GPs. The team are supported by a senior management team which consists of a practice relations manager, a facilities and administration manager and a finance manager. Together they share the role of the traditional practice manager. The practice employs seven female practice nurses and seven health care assistants. The clinical team are supported by additional reception, secretarial and administration staff.

Sid Valley Practice is a training practice, accredited by the South West Deanery of Postgraduate Medical Education.

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

The practice is open from Monday to Friday, between the hours of 8.15am and 6.30pm. There is also a branch practice open five days a week between the hours of 8.30am and 5.30pm, but is closed on a Tuesday afternoon. Appointments are available to be booked up to six weeks in advance and take place between 8.30 and 17.30 but telephone consultations are available from 8.00am. The surgery closes for lunch between 1pm and 1.45pm.The practice has an ethos of never turning anyone away and offers a telephone consultation service every day. This is used when a patient telephones the practice and requests to see a GP that day. A GP will telephone the patient and discuss their concerns within two hours of the initial request from the patient. An appointment is offered to the patient that day if it is needed. Patients told us they felt the appointment system was good.

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

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Detailed findings

How we carried out this inspection

Before conducting our announced inspection of Sid Valley Practice, 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 Cornwall 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.

We carried out our announced visit on 15th April 2015. We spoke with 11 patients, seven GPs, three of the nursing team and members of the management, reception and administration team. We collected 30 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.

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?
- 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

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, the practice used reported incidents and national patient safety alerts as well as comments and complaints received from patients. All staff we spoke with were aware of the procedure for reporting concerns and incidents, and were actively involved in quarterly significant event meetings, to discuss incidents and take forward learning. We saw the practice had managed these consistently over time which evidenced a safe track record over the long term. For example we saw where a member of staff had failed to record a visit in a timely way which led to a delay in the visit being undertaken. The practice learned from this and provided further education for its staff and changed the way requests were handled and requested. We saw staff had access to multiple sources of information to enable them to maintain patient safety and keep up to date with best practice.

Learning and improvement from safety incidents

The practice had robust systems in place for reporting, recording and monitoring significant events, incidents and accidents. We asked for and saw records were kept of significant events that had occurred during the last year, and these were made available to us. Staff were able to give examples of the action taken as a result of significant event. For example improvements in communication between the practice and the community nurse team had been made following an incident where a patient did not receive timely care due to the GP and nursing team mis-communicating with each other.

Dedicated significant event meetings were held every four to six weeks and all staff were encouraged to attend. One in every three meetings was held at lunchtime in an attempt to make the meetings accessible to as many staff as possible. Significant events were discussed and any actions taken or to be taken as a result were discussed and agreed. The practice operated a no blame culture and staff were encouraged to be open and to talk issues through.

National patient safety alerts were disseminated by email to practice staff and accessible on the practice intranet. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. They also told us alerts were discussed at daily meetings between doctors and the nursing team to ensure all were aware of any relevant to the practice and where action needed to be taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received, or were booked to receive, relevant role specific training on safeguarding. We asked members of

medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. We saw contact details were easily accessible. The practice had a dedicated GP appointed as lead in safeguarding vulnerable adults and children who had been trained to level three for safeguarding children to enable them to fulfil this role. As part of their role they had developed links with a number of external organisations who had regular contact with younger people. These included counselling services, youth services and school nursing services.

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 a chaperone policy in place and notices were displayed in the patient waiting areas to inform patients of their right to request one. Clinical staff carried out chaperoning duties during minor surgical procedures when patients requested this service. Administrative staff did not act as chaperones for GP examinations. We saw all staff who acted as chaperones had completed training on this.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system which collated all communications about the patient, including scanned copies of communications from hospitals.

Medicines management

Good

Are services safe?

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 not held at the practice. Some medicines and vaccines were required to be kept in a fridge. The fridge temperature was monitored twice daily and records showed they were stored within the correct temperature limits.

The nurses and the health care assistant 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 and the health care assistant had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber and she received regular supervision, appraisal and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

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 February 2015 and that all areas were checked and were in good order.

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.

The practice had processes in place for the management, testing and investigation of legionella (bacteria found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy in order to reduce the risk of infection to staff and patients. 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

The practice had a suitable and clear recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment including proof of qualification and registration with the appropriate professional body. We saw reference numbers confirming that criminal records checks via the Disclosure and Barring Service (DBS) had been carried out in respect of all GPs and nurses, they also included staff in administrative roles where risk assessment had determined the need.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff and patients to see.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage medical emergencies. Emergency equipment was available on both floors and included access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly and working.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest and anaphylaxis. All the medicines we checked were in date and fit for use.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and medical emergencies. For example, all staff who worked in the practice were trained in cardio-pulmonary resuscitation (CPR) and basic life support skills. The practice also had a protocol and equipment to deliver care outside the practice building. For example they had first aid/emergency grab bags available for staff who had been appropriately trained to use if an emergency occurred in the community.

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

The practice had carried out a fire risk assessment and provided evidence that staff had attended fire safety training and had practiced 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 treatment approaches. They were familiar with current practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners,

We saw minutes of practice meetings where new guidelines were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them.

We found from discussion with GPs and nursing staff, that they completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they led in specialist interests, for example in skin cancer and dementia. One GP had special surgical expertise and operated on patients with the approval of local dermatologists and the CCG. This provided a service for local patients with a Basal Cell Carcinoma and some elderly patients with a Squamous Cell Carcinoma.

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 continually review and discuss new best practice guidelines, for example in the management of hypertension. The practice proactively engaged in research and clinical studies to inform good practice and looking at new ways to improve outcomes for patients.

The practice nurses explained to us how they reviewed patients with chronic diseases such as asthma and chronic obstructive pulmonary disease (COPD) on an annual basis.

We noted all patients' with learning disabilities had access to annual reviews with a nurse who had a special interest in learning disabilities, using the nationally recognised template. We saw 13 of 27 of patients had had their formal annual reviews, the others had declined but these patients were followed up and encouraged to attend again.

The 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).provided evidence the practice were above local and national averages when responding to the needs of people with dementia, including those newly diagnosed with dementia. For those patients with dementia 76% had their care reviewed in a face-to-face review in the preceding 12 months.)

We saw from QOF 100% of child development checks were offered at intervals that were consistent with national guidelines and policy. To date 91% of children aged up to two years had received all their vaccinations and 90.37% were up to date with their pre school boosters.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice showed us four clinical audits that had been undertaken in the previous12 months. A wide range of clinical audits in a rolling audit programme had been undertaken which showed the practice was measured against current best evidence and demonstrated adherence to current guidelines. For example, an audit of patients receiving anticoagulation treatment and had atrial fibrillation (AF) made recommendations including the setting up a search via the IT system. This was an annual medicine check and review which optimised anticoagulation therapy appropriately for patients with AF.

Clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). For example, we saw an audit regarding the prescribing of steroids in the treatment of osteoporosis. This audit has been running annually since 2008. It had been through multiple completed cycles and after each cycle actions had been taken to improve outcomes or maintain improvements. In September 2014 the practice met the standard, but was not satisfied with this since there were still some patients still

Good

Are services effective?

(for example, treatment is effective)

missed from the audit. The practice concluded that they needed to maintain GP alertness to this and decided to generate lists of patients every six months on Prednisolone and check that they had been reviewed.

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

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

The practice had achieved and implemented the gold standards framework for end of life care. They kept a palliative care register and had regular internal as well as quarterly multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice were keen to ensure that staff had the skills to meet patient's needs. For example, nurses had received extensive training including immunisation, diabetes care, cervical screening and travel vaccinations.

GPs at the practice undertook minor surgical procedures and joint injections in line with their registration and NICE guidance. The staff were appropriately trained and kept up to date. There was evidence of regular clinical audit cycles in this area, which was used by GPs for improving patient care as well as revalidation of their professional qualifications and personal learning purposes.

Effective staffing

We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support, medical emergencies, infection control and information governance. Staff also attended mandatory updates appropriate to their role, for example, wound care and flu. All GPs were up to date with their yearly continuing professional development requirements and had either 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 practice and remain on the performers list with NHS England). The practice manager kept of record of appraisals and revalidation dates.

All staff underwent an annual appraisal with a GP and the practice manager. During this meeting learning needs were identified and action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example attendance at a study day about diabetes.

All the staff we spoke with told us they felt well supported by the GPs and nursing team as well as by the practice manager and each other. Patients told us they felt staff were appropriately skilled and knowledgeable in whichever role they provided.

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. It had a particularly good relationship with the community hospital and had daily contact through ward rounds and telephone conversations. The GPs at the practice worked hard at ensuring that patients in the hospital got timely care by ensuring that requests for things such as X rays and change of medicine were acted upon on the same day of the request.

The practice was involved in various multidisciplinary weekly 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 hours 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. The practice manager and at least one GP attended all CCG meetings. Information and learning from those meetings was shared with all partners and where appropriate staff during meetings.

The practice used its own intranet to cascade and share information to all staff. This included a daily blog and a thanks page which was used by all staff to say thank you to one another for any particular work or assistance that had been helpful.

There was a practice newsletter and the practice website provided a wide range of information for patients and links to other services available locally and nationally. Information was also kept up to date on the website with the latest practice news and links to the work of the patient participation group (PPG).

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

New patients looking to register with the practice were able to find details of how to register on the practice website or by asking at reception. New patients were provided with an appointment for a health check. New patient assessments were carried out by the practice nurse. The GP was informed of all health concerns detected and these were followed up in a timely way.

The practice had a range of written information for patients in the waiting area. Information was available for patients to take away on a range of health related issues, local services and health promotion. A wide range of information was available on the practice website, with links to local and national support groups patients could access.

We were provided with details of how staff actively promoted healthy lifestyles during consultations. The clinical system had built in prompts for clinicians to alert

Good

Are services effective?

(for example, treatment is effective)

them when consulting with patients who smoked or had weight management needs. We noted a culture among the clinical staff to use their contact with patients to help maintain or improve mental, physical health and wellbeing.

We were told health promotion formed a key part of patients' annual reviews and health checks and included discussions and assessments of a patient's mental health. The practice provided NHS health checks for patients aged 40-74 which aimed to keep people well for longer. This was

a risk assessment and management programme to prevent or delay the onset of diabetes, heart and kidney disease and stroke.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. The practice's performance for cervical smear uptake was 82.46% compared to the national average of 81.89%. The practice sent reminders for patients who did not attend for cervical smears and the practice audited this data. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients were treated with dignity and respect at Sid Valley Practice. Patients told us they felt all conversations with GPs and nursing staff were confidential and told us conversations were always conducted behind a closed door.

Reception staff were respectful and patient. There was a genuine and friendly connection between the reception staff and patients of all ages. Patient experience feedback showed a high degree of satisfaction with the service provided and the attitude towards them by the staff. Patients told us that all their families, children and grandchildren, used the same practice.

There were curtains in consultation rooms which provided a screen between the treatment couch and door to maintain privacy and dignity. However due to the nature of the building being old and not fit for purpose nurse consultations were sometimes undertaken in one room divided into four treatment areas. These areas were screened by way of privacy curtains but conversations could be easily heard. The staff tried hard to protect patient's privacy and dignity but this was not always possible. The main practice was due to move into a new purpose built building within one month leaving the existing building to be the branch surgery. The practice should give consideration to how this will be managed in the future.

The feedback we received from patients and carers showed that the staff and GPs knew the majority of their patients. Patients felt able to go to the practice without fear of stigmatisation or prejudice. The nursing team and the GPs were able to make longer appointments for those patients they knew may need longer because, for example, they had complex needs, were anxious or likely to become agitated if they felt they were being rushed. Patients we spoke with confirmed that they never felt rushed.

The practice registered patients who had no fixed address and were homeless, examples we were given demonstrated that the GPs were prepared to visit patients regardless of where they were residing.

During our inspection the GPs and nursing staff spoke to patients politely. All the patients, carers and family members we spoke with confirmed this was the case on all occasions.

We spoke with 11 patients during the inspection and received 30 comment cards

We also spoke with a representative of the patient participation group (PPG). All the patients we spoke with were extremely positive about all aspects of the service they received. They told us reception staff were always helpful and accommodating with regards to appointments and GPs and nurses provided compassionate care.

All staff had received training on information governance and signed a confidentiality agreement at the start of their employment. Staff had a good understanding of confidentiality and how it applied to their working practice. For example, during the inspection we witnessed numerous caring and compassionate interactions between staff and patients which demonstrated how staff treated patients with dignity and respect.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 80% of practice respondents said the GP was good at involving them in decisions about their care.

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

Staff told us that translation services were available for patients who did not have English as a first language. However, staff confirmed the facility was very rarely used as the majority of patients could speak English.

GPs and nurses were aware of what action to take if they judged a patient lacked capacity to give their consent. They told us they recorded best interest decisions, consulted carers with legal authority to make healthcare decisions

Good

Are services caring?

and sought specialist advice if needed. One of the GPs told us they involved patients and their families in discussions before completion of the do not attempt cardiopulmonary resuscitation form.

Patient/carer support to cope emotionally with care and treatment

We looked at 30 CQC comments cards that had been completed and spoke to 11 patients. All comments were positive. Comments stated that they were pleased with the service, were treated with respect and said that the GPs went above and beyond what was required to make sure the care offered was appropriate. Patients said they always had enough time to discuss their problems and could make longer appointments if they needed them.

Notices in the patient waiting room told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. Information was available for carers to ensure they understood the various avenues of support available to them. The practice had links with a carer support worker. Appointments were available each month for carers to have a health check.

There was information on what to do in times of bereavement and patients we spoke with told us they were supported through all emotional circumstances. 84% of patients who responded to the most recent GP survey said that the GPs treated them with care and concern. 89% of patients said they were given enough time during their appointment to talk through their concerns.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). We reviewed the minutes from the latest PPG meeting (February 2015). Suggestions included improvements for communication with patients about the new practice being built. We saw that this had been actioned and a DVD was playing on the television in the waiting room showing the latest developments on the site. We also saw that discussions had taken place following the latest survey undertaken by the PPG. This survey showed that patients found it difficult to get through to the practice by telephone on Monday mornings. The practice had taken steps to alleviate this by giving care homes a dedicated phone line instead of coming through to the main desk and by having a dedicated prescription service.

The practice said they never turned anyone away. Patients seeking help and treatment urgently were guaranteed a call back from a GP within two hours of ringing the practice. From this they would be offered an appointment the same day if it was needed. A patient told us they really valued this service.

The community hospital was situated next door to the practice. The GPs undertook a daily ward round at the hospital and were able to respond quickly to requests from the hospital staff for things such as medicine changes and X ray requests.

The practice manager and one of the GPs visited seven care homes in the area to discuss and review the care provided to their patients with a view to find ways to continually improve the service provision. As a result of these meeting the care homes were given a direct line telephone number so that they could contact the practice without delay when needed.

The practice was pro-active in contacting patients who failed to attend vaccination and screening programmes and worked to support patients who were unable to attend the practice.

The practice team were actively involved in fundraising for the local carers group and were involved in community events. One of the most recent is being a swimathon which raised money for the self-using blood pressure machine in the waiting room.

Tackling inequity and promoting equality

The practice had recognised the needs of different population groups in the planning of its services. Temporary residents were welcomed.

The number of patients with a first language other than English was very low and staff said they knew these patients well and were able to communicate well with them. The practice staff knew how to access 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 level access to the front door. Inside the GP consultation rooms and the treatment rooms were on the ground floor, providing level access for patients with limited mobility. The corridor and toilets were not fit for patients who used a wheelchair. Toilets were inaccessible for these people as a wheelchair would not fit through the door. Doors were not automatic and people who used wheelchairs struggled to get to consulting rooms easily.

The main practice was about to relocate to a new purpose built building nearby which would be fully equipped for people with disabilities. However, the present site was to continue to be used as a branch surgery and consideration would need to be given to those patients that continue to use the present building.

The seats in the waiting area were of different heights and size. There was variation for diversity in physical health and all had arms on them to aid sitting or rising. The practice premises belonged to NHS property services and they were responsible for variations to the building. An audio loop was not available for patients who were hard of hearing. There was an area for children to wait which had toys and books for them to use. However there was no space for privacy to breastfeed.

Access to the service

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patients told us if they needed to see a GP there were urgent and emergency appointments available on the same day. Patients were able to book appointments by telephone or the practice online appointment service. The practice opening hours were clearly displayed in the practice and on their website and patient information leaflet. If patients required GP assistance out of practice hours then details of who to contact were clearly displayed in the practice, on their website and in the practice information leaflet.

Most patients, especially younger people, were not worried which GP or nurse they saw, but those with complicated and/or long-term conditions usually tried to see their preferred GP. These patients were appreciative of the reception staff and told us they really helped patients who were regular and known to them.

Patients told us they were happy with the appointment system. They made and contacted the practice easily for an appointment, were given an appointment when needed, although it was sometimes difficult to see the GP of their choice. Patients said that sometimes their appointments were late but were informed if there was a delay by reception staff. Longer appointments were also available for patients who needed them, such as for those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to seven local care homes, by a named GP and to those patients who needed one.

A transport service, via a local voluntary group was situated in the practice building. This was available for patient's resident in the town and nearby villages, without their own transport.

Annual flu clinics were scheduled on Saturdays, this had increased the attendance of patients who were eligible for the flu vaccination.

Listening and learning from concerns and complaints

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

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

The practice had received 36 complaints in the past year. These included small concerns but all were treated with the same importance. We found they were satisfactorily handled and dealt with in a timely way, the practice apologised when mistakes had been made. The practice showed openness and transparency in dealing with the compliant.

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 senior GP had a vision for the practice, and the practice had a business plan and strategy. All the staff we spoke with told us they aimed to provide high quality care and promote good outcomes for patients.

All staff shared the practice objectives to deliver high quality person centred care. The practice website included a live well section to advise people on health promotion. The practice held twice yearly away days for all staff. These were in place to reward and encourage staff for team working.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. All staff had completed a cover sheet to confirm that they had read the policies and when. This meant that all staff had a point of reference when needing advice or information.

There was a clear leadership structure with named members of staff in lead roles. For example, one partner was the lead for safeguarding adults and there was a lead nurse for infection control. Another GP partner was a dementia champion and they also sat as a trustee on a voluntary basis at the local memory café. This was a useful link for those patients with early onset dementia.

The practice operated a democratic partnership system with a rotating chair person that changed every 12 months. The GP partners held monthly business planning meetings to discuss practice events and future planning.

We spoke with 13 members of 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 practice had carried out a range of risk assessments reviewing environmental and personal risks, to ensure the health and safety of patients, visitors and staff members. The practice had a service continuity plan in place in case of emergency. Relevant contact numbers for staff and resources were recorded in the plan. These were to be used in the event of an incident that effected the operation of the service to ensure, where possible, alternative provision could be made and patients were appropriately informed.

The practice had arrangements for identifying, recording and managing risks. We saw risks were regularly discussed at team meetings and updated in a timely way.

The practice held monthly governance meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

Arrangements were in place to ensure staff were clear about their responsibilities and were familiar with practice procedures. An annual practice meeting schedule was in place which covered administration meetings, clinical meetings and business meetings. The meetings supported staff and ensured they were kept up to date with changes to practice systems. Staff told us they were comfortable to raise issues and concerns when they arose and were confident they would be dealt with constructively.

Every morning a clinical meeting was held which GPs and nurses told us they found very valuable in discussing day to day clinical issues and obtaining support from colleagues.

The practice operated a buddy system for GPs and nurses to ensure suitable cover was provided when their buddy colleague was on leave. This included checking correspondence and test results. Unchecked test results were highlighted on the screen and could only be closed when a GP had reviewed the result and recorded the action to be taken. The practice regularly reviewed its policies and procedures and implemented changes as a result of learning from serious events.

Leadership, openness and transparency

Staff said they were proud of the practice as a place to work and spoke highly of the quality of the leadership, culture and support provided. There were consistently high levels of constructive staff engagement.

Discussion with staff and records we saw demonstrated clinical and staff meetings were held regularly. Staff told us that they had the opportunity and were comfortable to raise issues at staff meetings, at individual appraisal meetings or any other time if necessary.

Human resources policies and procedures were in place to support staff. We saw these were available to all staff

Are services well-led?

Good

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

electronically. Polices regarding equality and bullying and harassment at work were included. Staff told us they were aware of the policies and how to access them. All staff had an annual review of their performance during an appraisal meeting. This gave staff an opportunity to discuss their objectives, any improvements that could be made and training that they needed or wanted to undertake. Clinicians also received appraisal through the revalidation process. Revalidation is where licensed GPs are required to demonstrate on a regular basis that they are up to date and fit to practice.

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

The practice valued the role of their patient participation group (PPG) and meetings were attended by one of the GP partners. The PPG had been in place for 23 years and was well established. The PPG is a forum for patients of the practice to share their experience and engage in improving the service for all patients. They were all patients of the practice and were actively involved in the practice. The PPG was made up of mainly older patients. However, they were actively trying to recruit younger and working age patients, so had scheduled evening meetings to encourage attendance of these groups of patients.

The practice had gathered feedback from staff through staff meetings, appraisals and informal discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us that the practice was very supportive of training. We saw extensive evidence which showed staff had been supported to develop and learn new roles.

Sid valley Practice is a training practice, with two GP partners approved to provide vocational training for GPs, second year post qualification doctors and medical students. When we inspected there were no placements ongoing but some were planned for this year. All the GPs mentioned the practice's focus on education. GP trainees were expected to present an evidence base to support treatment and referral decisions to their GP trainer. All staff had been appraised in the last year. Staff told us they felt the appraisal was a meaningful process and identified areas for future personal development.