Dr Stephen Haywood (also known as Adderlane Surgery)

Quality Report

The Adderlane Surgery
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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?	Outstanding
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

This is the report of our findings of the inspection at of Dr Stephen Haywood's practice. The practice is registered with the Care Quality Commission to provide primary medical services.

We undertook a planned, comprehensive inspection on the 23 Oct 2014. We talked to patients, staff and members of the practice management team.

Specifically, we found the practice to be outstanding for providing caring services. It was good for providing safe, effective and responsive services and was well led. It was good for meeting the needs of the population groups it serves. Our key findings were as follows:

- Patients who use the service are kept safe and protected from avoidable harm. The building is well maintained and clean.
- All the patients we spoke with are positive about the care and treatment they receive. The CQC comment cards and results of patient surveys show that patients are consistently pleased with the service they receive.
- There is good collaborative working between the practice and other health and social care agencies that ensures patients receive the best outcomes. Clinical decisions follow best practice guidelines.
- The practice meets with the local Clinical Commissioning Group (CCG) to discuss service performance and improvement issues.
- There are good governance and risk management measures in place. The leadership team are visible and staff we spoke with say they find them very approachable.

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

In addition the provider should:

- Ensure oxygen is available for use in a medical emergency.
- Ensure all staff undertaking chaperoning duties receive appropriate training.

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 to staff to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Staff were aware of safeguarding procedures, and took appropriate action when concerns were identified. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Care and treatment was being considered in line with current guidelines. This included assessing patients' capacity and promoting good health. Patient's needs were consistently met and referrals to other services were made in a timely manner. Staff worked with multidisciplinary teams. The practice undertook clinical audit and monitored the performance of staff. Staff received training appropriate to their roles.

Are services caring?

Outstanding

The practice is rated outstanding for providing caring services. Data showed that patients rated the practice higher than others for almost all aspects of care. Feedback from patients was consistently and strongly positive. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. 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 Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and the practice responded to complaints and comments appropriately.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well led. The leadership team was visible and they had a clear vision and purpose. Governance arrangements were in place and there were systems for identifying and managing risks. Staff were committed to maintaining and improving standards of care. Key staff were identified as leads for different areas in the practice and they encouraged good working relationships amongst the practice staff. Staff were well supported by the GPs and practice manager.

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. The practice was knowledgeable about the number and health needs of older patients using the service and actively reviewed the care and treatment needs of these patients. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. Patients over the age of 75 had a named GP. The practice was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The GP supported the local care homes and community hospital and visited them weekly.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Staff had a good understanding of the care and treatment needs of these patients. The practice closely monitored the needs of this patient group. We heard from patients that staff invited them for routine checks and reviews. We found staff had a programme in place to make sure no patient missed their regular reviews for conditions, such as diabetes, respiratory and cardiovascular problems. Staff were skilled and regularly updated in specialist areas which helped them ensure best practice guidance was being followed.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. The practice offered comprehensive vaccination programmes which were managed effectively. Immunisation rates were relatively high for all standard childhood immunisations. The practice monitored any non-attendance of babies and children at vaccination clinics and worked with the health visiting service to follow up any concerns. Appointments were available outside of school hours and the premises were suitable for children and babies. All of the staff were responsive to parents' concerns and ensured children who were unwell could be seen quickly by the GP or nurse.

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

Summary of findings

to ensure these were accessible, flexible and offered continuity of care. The practice provided a range of options for patients to consult with the GP and nurse, including on-line booking and telephone consultations. Useful information was available in the practice and on the website as well as a full range of health promotion and screening that reflected the needs for this age group.

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 was aware of patients in vulnerable circumstances and actively ensured these patients received regular reviews, including annual health checks. We found that all of the staff had a very good understanding of what services were available within their catchment area, such as supported living services, care homes and families with carer responsibilities. Staff were knowledgeable and proactive when safeguarding vulnerable adults and children. They had access to the practices' policy and procedures and discussed vulnerable patients at the clinical meetings.

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). 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 medicines review. The Community Psychiatric Nurse attended the practice once a week to provide support for patients experiencing poor mental health. Information was available for patients on counselling services and support groups.

Summary of findings

What people who use the service say

As part of this inspection we had provided CQC comment cards for patients who attended the practice to complete. We received responses from 49 patients all of which were positive about the total experience they received from the practice. Patients said staff were polite and helpful and always treated them with compassion, dignity and respect. The nurses and GPs were praised for their compassion, professionalism and effective treatment.

We spoke with 12 patients during the inspection and they also confirmed that they had received excellent care and attention and they felt that all the staff treated them with dignity and respect. Feedback from patients showed that staff involved them in the planning of their care and were good at listening and explaining things to them. They felt the doctors and nurses were knowledgeable about their treatment needs.

We looked at the results of the national GP survey for 2013/2014 and which showed that patients were positive about the service they received.

We found that the practice valued the views of patients and saw that following feedback from surveys, and from patients attending the practice; changes were made to improve the service.

Areas for improvement

Action the service SHOULD take to improve

- Ensure oxygen is available for use in a medical emergency.
- Ensure all staff undertaking chaperoning duties receive appropriate training.

Dr Stephen Haywood (also known as Adderlane Surgery)

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector and the team included a GP specialist advisor, a Practice Manager specialist advisor and an Expert by Experience.

Background to Dr Stephen Haywood (also known as Adderlane Surgery)

Adderlane Surgery is situated in Prudhoe Northumberland and provides primary medical care services, which includes access to GPs, minor surgery, family planning, ante and post natal care to patients living in the Prudhoe area. The practice is small, providing services to 1978 patients of all ages. There is a higher percentage of the practice population in the 65 to 74 years age group than the CCG and England average but a lower percentage in the 75 and over age group than the CCG and England average.

The practice has opted out of providing out of hours services for their patients. Information for patients requiring urgent medical attention out of hours is available in the waiting area and on the practice website. When the practice is closed patients access Northern Doctors Out of Hours Services.

The practice has two GP partners, one male and one female. One GP works full time and one works four mornings a week. There is one practice nurse who works 25 hours per week and a practice manager who works 12 hours per week.

The practice provided services to their patients through a General Medical Services (GMS) contract.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to patient'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

Detailed findings

- 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

Before visiting, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. We reviewed policies, procedures and other information the practice provided before and during the inspection. We carried out an announced visit on 23 October 2014.

During our visit we spoke with five staff including the GPs, practice nurse, the practice manager and secretary/ receptionist. We also spoke with the Community Psychiatric Nurse. We spoke with 12 patients who used the service and observed how staff spoke to, and interacted with patients when they were in the practice and on the telephone. We also reviewed 49 CQC comment cards where patients were able to share their views and experiences of the service.

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, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example staff had recently reported an incident where patient confidentiality could have been breached and incorrect information would have been given to a patient.

The practice had a record of the incidents that had occurred in the practice. However, an annual review of all the incidents to identify any themes or trends, for example how many medicines related incidents had occurred, would enable the practice to confirm the measures they had taken to prevent any recurrence were continuing to work.

There was a GP lead for incident reporting and staff we spoke with were aware of this.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We saw there was an incident reporting policy in place which outlined why incidents should be reported, how to report them and how they would be investigated. We spoke with staff and they were able to describe the incident reporting procedure. They confirmed that the practice had an open culture for reporting incidents and they looked at what happened, why it happened and what could be done to prevent it happening again.

The practice had recorded 15 incidents during the past 12 months and we saw evidence that internal investigations were conducted when any incidents occurred. Staff confirmed that investigations were undertaken and changes made to prevent them happening again. We looked at the investigation reports for seven of the incidents and saw they identified learning points, actions required and who was responsible for completing the actions. For example, we saw that following an incident, when a call was made to the practice about a child being unwell a GP now always rang back to discuss the issues with the parent.

Significant events was a standing item on the practice meeting agenda and a meeting was held every six weeks where actions from past significant events and complaints were reviewed. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. The GPs, nurse and reception staff told us that if they were involved in an incident then they took part in the investigation. Staff we spoke with told us the practice encouraged them to openly review the service and determine where they could improve.

We discussed the process for dealing with safety alerts with the practice manager. Safety alerts inform the practice of problems with equipment or drugs, or give guidance on clinical practice. The practice manager told us the alerts came into the practice via e-mail and were then disseminated them to the GPs and nurse. They checked to see if the alert was applicable to the practice and if it was, then any action required was taken. Staff confirmed they were made aware of relevant safety alerts and action was taken in response to alerts. However; we found no written record of actions taken was available.

Reliable safety systems and processes including safeguarding

The practice had 'child protection' and 'vulnerable adult' policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were easily available to staff both in paper and electronic format. Staff had access to contact details for both child protection and adult safeguarding teams at the local authority. Staff were knowledgeable about the actions they needed to take if they suspected abuse and described how they would report and discuss issues with the GPs in the practice. The GPs explained how they worked with the Health Visiting and Social Services teams when they had concerns about children. For example they had liaised with them when concerns were identified about a child's parents who were misusing drugs. We found that staff followed procedures and reported any safeguarding concerns they had.

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Are services safe?

GPs were appropriately using the required codes on their electronic records system to ensure risks to children and young people who were on looked after or child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services. Staff were proactive in monitoring if children or vulnerable adults attended accident and emergency or missed appointments frequently. These were brought to the GPs attention, who then worked with other health professionals such as health visitors, midwives and district nurses. We saw minutes of meetings where vulnerable patients were discussed.

We saw that staff had received training in child and adult protection. The practice had appointed a dedicated GP as the lead in safeguarding vulnerable adults and children. They had attended level 3 training to support them in carrying out this role. The GPs, nurse and receptionists we spoke with were knowledgeable about the types of abuse, the signs they might see in an adult or child being abused and how to raise concerns.

The GPs, nurse and practice manager told us that the nurse usually acted as a chaperone but occasionally a receptionist had done this. Staff we spoke with understood when a chaperone was required however there was no policy which clearly outlined when a chaperone may be required and which staff would undertake this role. There was no information displayed in the practice informing patients that they could ask for a chaperone. We found that reception staff who may be asked to chaperone had not received any training. We were told the GP would remind them of what they had to do if they were going to act as a chaperone. One of the GPs told us they asked the receptionist to stand outside the privacy curtain when they chaperoned however this would not reduce the risk of abuse for patients and assist in protecting the clinician against false allegations.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear procedure for ensuring that medicines were kept at the required temperatures and the action to take in the event of a potential failure. We found there were some gaps in the temperature monitoring records and discussed this with the practice manager who said they would ensure that temperatures would be checked when the nurse was on holiday.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw evidence the practice took action in response to reviews of prescribing data. For example, prescribing patterns of antibiotics, sedatives and anti-psychotic prescribing within the practice was monitored. We also saw that the GPs were liaising with the diabetes consultant for advice on their use of diabetic medication.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw that the nurse had received appropriate training to administer vaccines.

There was a system in place for the management of high risk medicines, for example Warfarin. This included regular monitoring of patients in line with national guidance and appropriate action being taken based on the results of blood tests to ensure patients received the correct dose of medication.

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.

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.

Infection prevention and control (IPC) procedures had been developed which provided staff with guidance and information to assist them in minimising the risk of infection. There was a nominated lead for IPC who was responsible for ensuring good practice was followed. No IPC audits had been completed and the practice did not monitor the standards of cleaning, so any areas for improvement could not be identified and actioned.

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Are services safe?

Staff told us there was always sufficient PPE available for them to use, including masks, disposable gloves and aprons and staff were able to describe how they would use these to comply with the practice's infection control policy. For example staff told us they wore disposable gloves when handling specimens such as blood or urine. We saw that hand wash; disposable towels and hand gel dispensers were also readily available for staff. We observed that there was hand gel in the waiting area for patients to use. Staff confirmed they had completed training in infection prevention and control. Sharps bins were appropriately located, labelled, closed and stored after use. There was a contract in place for the removal of all household, clinical and sharps waste and we saw evidence that waste was removed by an approved contractor. Staff told us that equipment used for procedures such as cervical smear tests and for minor surgery were disposable. Staff therefore were not required to clean or sterilise any instruments, which reduced the risk of infection for patients. We saw that other equipment used in the practice was clean.

Staff told us how they would respond to needle stick injuries and blood or body fluid spillages and this met with current guidance.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was checked six monthly by the practice manager and we saw records that this was completed. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example we saw that the weighing scales and BP machines had been checked in January 2014.

Staffing and recruitment

We found that staffing levels and skill mix were monitored to ensure they continued to meet the needs of patients. This was reflective of the information on the practice website about the number and skill mix of GPs, nursing and administration staff. There were arrangements in place for staff to cover each other for annual leave or sickness.

Feedback from patients we spoke with and on the CQC comment cards and surveys confirmed they could get an appointment to see a GP or nurse when they needed to. Staff told us there was enough staff to maintain the smooth running of the practice and there was always enough staff to keep patients safe.

The practice had a recruitment policy in place which outlined the process for appointing staff, and the pre-employment checks that should be completed for a successful applicant before they could start work in the practice. The staff in post had all been employed for a number of years. We discussed the recruitment process with the practice manager and they confirmed that all appropriate checks would be undertaken for any staff employed in the future.

The GPs and nurse were registered with their respective professional bodies such as the General Medical Council. However, there was no process in place to check that doctors and nurses remained registered. This increased the risk of registration lapsing for those staff that should only provide care and treatment whilst registered with a professional body.

Monitoring safety and responding to risk

We found that staff recognised changing risks within the service, either for patients using the service or for staff, and were able to respond appropriately.

The practice regularly monitored risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice manager took the lead for health and safety in the practice.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example staff told us about referrals they had made for patients with respiratory problems whose health had deteriorated suddenly and how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We found the practice had emergency airway equipment and medicines available to be used in an emergency; these included those for the treatment of

Good

Are services safe?

cardiac arrest, anaphylaxis and hypoglycaemia. Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. The practice did not have oxygen or an automated external defibrillator (used to attempt to restart a person's heart in an emergency) however they told us they had assessed the risks and decided they were not required as ambulances responded quickly in the event of an emergency.

Records showed that all staff had received training in basic life support and the staff we spoke with were able to describe what action they would take in the event of a medical emergency situation. They all knew the location of the emergency airway equipment and medicines. Records confirmed that it was checked regularly.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice; the plan was last updated in 2009. Risks identified included power failure, adverse weather, unplanned staff 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 that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. We discussed with the practice manager, GP and nurse how National Institute for Health and Care Excellence (NICE) guidance was received into the practice. They told us that this was downloaded from the website, disseminated to staff and then discussed and required actions agreed. They also said the computer system they used for patient records helped them adopt best practice guidelines, as the system incorporated NICE endorsed templates to guide diagnosis, care and treatment. It also provided in built guidance on prescription of medicines. Staff we spoke with all demonstrated knowledge of NICE guidance.

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 our discussions with the GPs and the nurse that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

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

Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. The GPs told us they supported all staff to continually review and discuss new best practice guidelines, for example for the management of high blood pressure. Our review of the clinical meeting minutes confirmed that this happened.

The practice used the CCG electronic system to identify patients who were at high risk of admission to hospital and they were reviewed regularly to ensure their needs were met to reduce the need for them to go into hospital.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients, for example for patients with suspected cancers who were referred and seen within two weeks. We saw evidence that regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Staff from across the practice played a role in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling and medicines management. The information staff collected was then used by the practice to identify clinical audits required. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool.

The practice showed us four clinical audits that had been undertaken in the last 18 months. Two of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example we saw that in 2013 prescribing data showed the practice was a high prescriber for one particular type of antibiotic. An audit was undertaken to review cases where it had been used to see if GPs were prescribing in line with current guidelines which identified some areas for improvement. A re-audit was completed which demonstrated that the prescribing rates for the anti-biotic had reduced and it was being used in line with current guidelines.

The practice used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. The QOF report from 2013-2014 showed the practice was supporting patients well with conditions such as, asthma, diabetes and heart failure. For example, in 2013/14 100% of patients

Good

Are services effective?

(for example, treatment is effective)

with diabetes had received their flu vaccination. GPs told us this reflected their commitment to maintaining and improving outcomes for patients. The practice was not an outlier for any QOF (or other national) clinical targets.

The team was making use of clinical audit tools, peer supervision and staff meetings to assess the performance of the practice. The staff described how as a group they reflected upon 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, noting that there was an expectation that all clinical staff should participate in audit.

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 evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

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

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

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as basic life support and safeguarding. There was no training matrix in place which outlined what training each member of staff required, when they had attended, or were due to attend and when any refresher training had taken place. This would support the practice in ensuring all staff attended required training.

We noted a good skill mix among the doctors with one specialising in care of the elderly and one specialising in gynaecology. Both GPs were up to date with their yearly continuing professional development requirements and both either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

The nurse had also completed training in areas specific to their role, for example asthma, cervical smears and immunisations. The staff we spoke with confirmed they had access to a range of training that would help them function in their role. The practice had protected learning time so staff were able to receive training on a regular basis. Staff received appropriate professional development which meant they had the skills and knowledge to care for patients attending the practice.

There was an induction programme in place for new staff which covered generic issues such as fire safety and infection control. Staff told us that role specific induction, for example immunisation training for nurses would be available for new staff.

All the staff we spoke with confirmed they had received an appraisal and we saw records confirming that appraisals had been done in the previous four years. However we found that not all the appraisals due in 2014 had taken place. The lead GP and practice manager confirmed that they were scheduling appraisals for all staff. Staff told us the appraisal was an opportunity to discuss their performance, any training required and any concerns or issues they had.

The nurse told us that they did not have formal clinical supervision sessions. However they said they could discuss their clinical practice at any time with the GPs. All the staff we spoke with said they felt supported in their role and they felt confident in raising any issues with the practice manager or the GPs.

Good

Are services effective?

(for example, treatment is effective)

The practice manager told us that there had been no performance issues identified with any of the staff but described the process they would follow if there was an issue that needed addressing.

Working with colleagues and other services

Staff told us that they met regularly with staff from the CCG, palliative care and community services to discuss how general services and individual patients' needs would be met. We saw evidence that the practice staff worked closely with other professionals. Minutes from meetings confirmed that community nurses, health visitors, palliative care nurses and social workers attended to discuss treatment and care to ensure it was meeting the needs of patients. Practice staff described how they worked with the community nursing and health visiting teams to ensure patients received appropriate and timely care.

There was a system in place to ensure the out of hour's service had access to up-to-date information about patients who were receiving palliative care which helped to ensure that care plans were followed, along with any advance decisions patients had asked to be recorded in their care plan.

The community psychiatric nurse (CPN) held a clinic once a week in the practice for patients experiencing poor mental. We spoke with the CPN and they told us the practice staff worked with them to ensure that patients received the care, treatment and support they needed.

The practice had written guidance 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. The GPs were responsible for checking blood test results and X ray results and adding any instructions for follow up. Staff would then phone patients to give additional instructions or request they attend the practice. Patients we spoke with confirmed they received their test results either by telephone or when they visited the practice.

We saw that when letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service were received both electronically and by post they were scanned into the patient's record and the GP reviewed them. The GP then sent an electronic 'task' to the administration staff and they would arrange appointments for any follow up care or for any prescriptions to be issued.

All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries that were not followed up appropriately.

The practice held multidisciplinary team meetings every two months to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in the patients' care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. The practice had also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

Good

Are services effective?

(for example, treatment is effective)

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

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it). When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures a patient's written consent was obtained and then documented in the electronic patient notes. We saw the consent form outlined the relevant risks, benefits and complications of the procedure and the clinician and patient both signed the form. Staff told us how they explained procedures to patients and checked their understanding before any procedure or treatment was carried out.

Health promotion and prevention

The provider offered all new patients a consultation to assess their past medical and social histories, care needs and assessment of risk. We saw that the practice promoted this in the practice information leaflet and on the web site. The needs of new patients were assessed and a plan of the person's on-going needs to stay healthy was developed. We found that the staff proactively assessed patients to identify any potential problems that may develop.

We saw the practice took steps to identify which patients attending the practice had a caring role and there was information about carers support groups available in the waiting area for patients.

There was a good range of health promotion information in the waiting room and on the practice web site. Some of the leaflets in the waiting area were stored under magazines and were not clearly visible to patients. We saw that there were posters around the practice promoting services that may help support patients, such as smoking cessation and support with mental health.

Staff used their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18-25 and offering smoking cessation advice to smokers.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and they were offered an annual physical health check. Similar mechanisms of identifying 'at risk' groups were used, for example patients who were obese or those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 79.5%, which was in line with others in the CCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend annually. The nurse was responsible for following up patients who did not attend screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG, and again there was a clear policy for following up non-attenders by the practice.

Outstanding ☆

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available from the national patient survey for the practice on patient satisfaction. This showed that patients were satisfied with how they were treated and that this was with compassion, dignity and respect. The data from the national patient survey showed the practice scored higher than others for almost all aspects of care. Data showed respondents said the last GP they saw or spoke to was good at treating them with care and concern, the local CCG average was 86%. The data for the last nurse they saw or spoke to was good at treating them with care and concern was 97%, the local CCG average was 92%. The practice also scored highly for its satisfaction scores on consultations with GPs and nurses with 97% of practice respondents saying the GP was good at giving them enough time and 98% saying the nurses gave them enough time, the CCG local average was 88% for GPs and 93% for nurses.

We received 49 completed CQC comment cards and spoke with 12 patients during the inspection. All of the feedback was positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. Patients said staff always treated them with dignity and respect and the nurses and GPs were praised for their compassion, professionalism and effective treatment. We also spoke with 12 patients on the day of our inspection.

Staff were familiar with the steps they needed to take to protect patient's dignity. Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Privacy curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed reception staff treating patients with respect and being extremely tactful when triaging requests. The practice had an open plan reception area and we observed that reception staff were discreet and quiet when speaking with patients. There was a room available if patients wished to discuss a matter with the reception staff in private, and there was a notice informing patients that this was available. There was a room next to the reception desk which staff used to make confidential phone calls which helped keep patient information private.

Information was available to signpost people to support services. This included MIND for help with mental health issues, the Macmillan service for support following bereavement and carers support groups.

Feedback from patients expressed their satisfaction with the approaches adopted by staff and they felt clinicians were extremely empathetic and compassionate. They told us care was personalised which enabled them to maximise their health and well-being and enable a good quality of life.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

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 rated the practice well in these areas. For example, data from the national patient survey showed 90% of practice respondents said the GP involved them in decisions about their care and 92% said nurses involved them in decisions about their care, the local CCG averages were 85% for GPs and 86% for nurses. The data showed 97% of respondents felt the GP was good at explaining treatment and results and 96% said the nurses were, the local CCG averages were 88% for GPs and 91% for nurses.

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

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this

service was available. One of the GPs and the nurse both gave examples of when an interpreter had been used to support a patient during a consultation so the patients could be involved in decisions about their care. The practice website also had the facility for information to be translated into languages other than English.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. Feedback from the comment cards and the patients we spoke with on the day said they had received help to access support services to help them manage their treatment and care when it had been needed. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

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

Staff told us that if families had suffered bereavement their usual GP contacted them to express their sympathy and offer support. This was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find support services. Feedback from patients who had had a bereavement confirmed they had received this type of support and said they had found it very helpful. One person said that the GP had visited the family at home and it had been very helpful.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The NHS Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and any service improvements that needed to be made.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patients. For example patient feedback said that they found it difficult to get through to the practice between 11.30am and 12.00pm when telephone consultations were in progress. The practice had put measures in place to free up the telephone lines between 11.30 and 12.00pm. The practice did a survey after changing the procedure and found that satisfaction levels had gone up.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example they gave longer appointment times for patients with learning disabilities. The practice had a population of 99% English speaking patients but did have access to online and telephone translation services if they were needed.

The premises and services had been designed to meet the needs of people with disabilities. We found that the practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were accessible for patients with mobility difficulties and there was also access enabled toilets. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

Staff told us that the building had been designed to provide a homely environment. However there were no signs on doors so patients who were unfamiliar with the building would not be able to identify the enabled access toilet. We found no evidence this had caused any problems for patients

Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

There was a male and female GP in the practice; therefore patients could choose to see a male or female doctor.

We saw that access to interpreting services was available and information could be obtained in other languages and formats when necessary. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients. All patients could be involved in decisions about their care, for example when English was not their first language.

Access to the service

Patients could make appointments in different ways, either by telephone, face to face or online, via the practice website. The practice was open from 8.30am to 6.00pm Monday, Tuesday, Wednesday and Friday and 8.30am to 1.00pm on Thursdays. The practice worked on a rota with two local practices to provide GP cover on Thursday afternoons. Morning sessions were an open surgery where patients could just turn up and be seen and the afternoons sessions were for booked appointments. Patients who did not need an urgent appointment could book them in advance which freed up slots for patients who needed to be seen quickly.

Patients we spoke with, feedback from CQC comment cards and the national patient survey confirmed that patients were able to get appointments when they needed them, this included same day appointments. We found that patients were very satisfied with the appointment system at the practice. The GP said if a patient needed an urgent appointment during the afternoon and all the slots had been taken then they spoke with the patient on the telephone to determine if they needed to be seen that day. Reception staff told us they felt this system worked well and they felt they could always offer the patient an appointment or discussion with the GP.

Longer appointments were also available for older people, those experiencing poor mental health and patients with long-term conditions. This also included appointments with a named GP or nurse. The lead GP made visits to the local care homes each week and to the elderly care ward at

Good

Are services responsive to people's needs?

(for example, to feedback?)

the local hospital. Home visits were available for housebound patients and for those too ill to attend the surgery. Appointments were available outside of school hours for children and young people.

The practice also provided telephone consultation appointments. Patients who worked during the day or were unable to get to the practice had a choice of how they made their appointment and how and when they wanted to see the GP or nurse.

Patients could order repeat prescriptions via their local pharmacy, in person or by telephone. This meant the practice was using different methods to enable patients' choice and ensure accessibility for the different groups of patients the practice served.

Comprehensive information about appointments was available to patients on the practice website and in the waiting area. This included what to do in an emergency, in hours and out of hours, how to arrange urgent appointments and home visits and how to book appointments. 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.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. The policy needed to be updated to reflect current organisational arrangements in the area. Information on how to make a complaint was on the practice website, in the patient information leaflet and displayed in the waiting room. We saw that the complaints policy had details of who patients should contact and the timescales they would receive a response by.

Patients we spoke with told us they were not aware of the complaints procedure but if they were not happy with something they would raise it with a member of staff. None of the patients we spoke with had ever needed to make a complaint about the practice. Staff told us they were aware of the practice complaints policy and described how they would support someone who was not happy with the service.

The practice had not received any complaints in the previous two years. We saw that the practice had received a number of cards and letters thanking staff for their kindness, support and care.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice vision and values included offering a friendly, caring good quality service that was accessible to all patients.

We spoke with five members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding and governance. There were a number of policies and procedures in place to govern activity, for example infection control, medicines management and incident reporting, which supported staff to deliver high quality care.

We spoke with eight 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 if they had any concerns.

The practice used the Quality and Outcomes Framework (QOF) and data from the CCG to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF and CCG data was regularly discussed at the bi-monthly team meetings and action agreed where necessary to maintain or improve outcomes.

The GP and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. For example there were processes in place to frequently review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff.

We saw evidence that they used data from various sources, including incidents, complaints and audits to identify areas where improvements could be made. The practice regularly submitted governance and performance data to the CCG.

The practice had carried out risk assessments where risks had been identified, for example fire safety. The practice monitored risks on a weekly basis to identify any areas that needed addressing. However they did not document the findings.

Leadership, openness and transparency

We saw from minutes that practice meetings were held bi-monthly. All the staff told us that informal meetings were held each day and these were used for staff to raise concerns and to share information and lessons learned from incidents. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource procedures. We saw that there was an induction procedure in place however there were no documented policies or procedures for disciplinary issues or management of sickness. We saw that mechanisms were in place to support staff and promote their positive wellbeing. The staff we spoke with told us they were well supported, the practice was a lovely place to work and it was a lovely team.

The senior partner told us they reviewed the needs of the practice to ensure it continued to deliver a good effective service for patients, for example the part time GP had become a partner recently which secured the future of the practice.

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

The practice had not established a Patient Participation Group (PPG). However there was information on the practice website encouraging patients to become involved in the PPG. We found that the practice had undertaken surveys to gather feedback when patients had raised concerns about access to the telephone lines. We also saw evidence that the practice had reviewed its' results from the national GP survey to see if there were any areas that needed addressing. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice.

There was a suggestion box on the reception desk in the surgery and patients could also provide feedback through the practice website. We found that the practice was very open to feedback from patients.

Are services well-led?

Good

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

We did not see any evidence that staff surveys were undertaken but staff told us they could raise any issues at team meetings or with the GPs and practice manager. Two of the receptionists we spoke with confirmed that they made suggestions that had contributed to improvements in the practice.

Management lead through learning and improvement

The practice had a clear understanding of the need to ensure staff had access to learning and improvement opportunities. Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us they had good access to training. We looked at appraisal records and saw they included a personal development plan. Staff told us that the practice supported them to undertake training.

The practice had completed reviews of significant events and other incidents and shared the lessons learned with staff at meetings to ensure the practice improved outcomes for patients. For example when a patient had not been taking their thyroxine medication it was identified through the investigation that it had not been put as a repeat medicine on their prescription request form. The practice now put thyroxine for hypothyroidism onto repeat straight away so that it was obvious when a patient wasn't requesting it.