Monkspath Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Monkspath Surgery on 1 April 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring and responsive services and for being well-led. It was also good for providing services for the six population groups.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of those relating to legionella.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they did not find it easy to obtain an appointment with their preferred GP and at their convenience. However, systems were in place to enable patients to consult with a GP the same day if needed.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

Importantly the provider should:

Summary of findings

- Develop systems for maintaining specialist staff training records alongside core training so that the practice can be assured that training relevant to staff roles has been completed and any identified development needs are met.
- Ensure legionella risk assessments are up to date and actions identified have been implemented.

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 with the exception of legionella. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and planned. However, training records were not easily accessible to enable monitoring and checks that training was up to date. There was evidence of appraisals and personal development plans for staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed the practice was rated similarly to other practices for their rating of the care received. 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 also saw that staff treated patients with kindness and respect, and maintained confidentiality. Feedback from external stakeholders was very positive and aligned with our findings.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients were able to make an appointment but not always at their convenience or with their preferred GP. However, provision was made to ensure those with urgent needs were able to consult with a GP. The practice had good facilities and was well equipped to treat

Summary of findings

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 took place with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice did not have a formal vision and strategy. However, staff were clear about their responsibilities to deliver a good service. We saw that staff demonstrated good teamwork and values that were open, caring and friendly. There was a clear leadership structure and staff felt supported. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in this population group. The practice offered proactive, personalised care to meet the needs of older people. Those over 75 years had a named GP to ensure continuity of care. The practice worked effectively with other health providers to meet the needs of patients at end of life. The practice had supported one care home to achieve gold standard framework accreditation in end of life care. It was responsive to the needs of older people, and offered home visits. Practice facilities were accessible to those with mobility difficulties and a hearing loop was available for those with hearing impairment. The uptake of flu vaccinations in the older population was in line with other practices.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Clinical staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. In-house services were available for the convenience of patients such as anti-coagulation clinics. Longer appointments and home visits were available if needed. Patients with long term conditions received structured annual reviews to check that their health and medication needs were being met. Those people with the most complex needs had care plans in place and their care was discussed regularly at practice meetings and with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children who were at risk. Regular meetings were held with the health visitor to discuss the needs of vulnerable children. Immunisation rates were in line with other practices in the CCG area for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. Young children were seen as a priority. Antenatal care was provided by the midwives on the premises.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. There was a high demand for services and the practice provided a good skill mix of staff to meet patients' needs, offered extended opening times and telephone consultations. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group including NHS health checks and travel vaccinations.

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 located in one of the least deprived areas in the country. The practice had identified and had registers for patients living in vulnerable circumstances including those with a learning disability, drug and alcohol dependency and carers. It had carried out annual health checks for 63% of patients with a learning disability. Longer appointments were available if needed for patients who needed them.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had provided information to vulnerable patients 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 normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Practice data showed 94% of people experiencing poor mental health had received an annual physical health check. The practice had a lead GP for mental health and drug and alcohol addictions. The GP was also a section 12 approved clinician. This is a clinician who can make decisions as to whether someone should be detained under the Mental Health Act (1983). The practice worked with other health professionals in the management of people experiencing poor mental health.

Summary of findings

The practice supported patients experiencing poor mental health to access various support services such as counselling and advocacy services. Data from the practice showed that 90% of patients diagnosed with dementia had received a health review in the last 12 months to ensure their health needs were being met.

Summary of findings

What people who use the service say

As part of the inspection we spoke with 14 patients who used the practice. We also sent the practice comment cards prior to the inspection inviting patients to tell us about the care they had received. We received 16 completed comment cards. Our discussions with patients and feedback from the comment cards told us that patients were happy with the service they received at the practice. Patients spoke highly of the practice staff and found them helpful and caring. They told us that they were treated with dignity and respect and that they felt listened to.

The practice had an active patient participation group (PPG) with 124 members. PPGs are a way for patients and GP surgeries to work together to improve the service and to promote and improve the quality of the care. We spoke with two members of the PPG they told us that the group was listened to and that action was taken in response to issues raised at the meetings.

We also looked at data available from the GP national patient survey 2014. Results from the national patient survey showed that patient satisfaction with the service was in line with other practices in all most aspects including overall satisfaction and consultations with doctors and nurses. The practice scored higher than average for the proportion of respondents who said they had confidence and trust in their GP but below the national average for access. The practice carried out annual in-house patient surveys as well as various surveys for specific areas such as the warfarin clinic and extended hours. The latest survey was undertaken in February 2014 which showed patients were satisfied with the service received.

Areas for improvement

Action the service SHOULD take to improve

- Develop systems for maintaining specialist staff training records alongside core training so that the practice can be assured that training relevant to staff roles has been completed and any identified development needs are met.
- Ensure legionella risk assessments are up to date and actions identified have been implemented.

Monkspath Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP, a practice manager and an expert by experience (a person who has experience of using this particular type of service, or caring for somebody who has).

Background to Monkspath Surgery

Monkspath Surgery is registered to provide primary medical services with the Care Quality Commission (CQC) and is located in Solihull in the West Midlands in a purpose built premises. The practice has a registered list size of approximately 12,000 patients. It is located in an area with low levels of deprivation and among one of the least deprived areas nationally. It is part of NHS Solihull Clinical Commissioning Group (CCG). CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

The practice consists of five GP partners (two male and three female) and four salaried GPs (all female) . There is also an advanced nurse practitioner (female), three practice nurses (all female), two health care assistants (both female) a practice manager and a team of reception and administrative staff.

As of the 1 April 2015 the practice holds a General Medical Services (GMS) contract to deliver essential primary care services.

The practice is open Monday to Friday 8am until 6.30pm. Appointments are available between 8.30am 6pm daily. Extended opening hours are available on Mondays and Thursday evenings between 6.30pm and 8pm. When the practice is closed during the out of hours period (6.30pm and 8am) patients are able to receive primary medical services through another provider (BADGER).

The practice was a GP training practice and a teaching practice for medical students as part of their undergraduate training.

The practice has not previously been inspected.

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.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

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

- Is it safe?

Detailed findings

- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew about the service. We carried out an announced inspection on 1 April 2015. During our visit we spoke with staff on duty. This included four GPs, a practice nurse, a health care assistant, the practice manager and three reception/administrative staff. We also spoke with 14 patients. We looked at a range of documents that were made available to us relating to the practice and patients' care and treatment. Prior to the inspection we sent the practice a box with comment cards so that patients had the opportunity to give us feedback. We received 16 completed cards where patients shared 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. The practice gave us examples of incidents that had occurred and how these were managed. For example, in one incident important information from a test result had been missed because the reporting form was similar to one used for normal results. This was discussed with the hospital and changes made to practice processes to minimise future risk of reoccurrence.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last four years and we were able to review these. The practice also held an incident reporting book in reception for minor issues that occurred. Significant events were a standing item on the weekly practice meeting agenda. 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. Although there was clear evidence of action taken to manage reported incidents and significant events the practice did not hold a review of past actions to follow up or check changes implemented had been maintained.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager or one of the GP partners to action. There were 11 significant events reported in the last 12 months. We reviewed these and saw that records were completed in a comprehensive and timely manner. These had been summarised to identify any emerging themes. We saw evidence of action taken as a result of incidents such as the printing of next day patient appointments following a recent system failure.

National patient safety alerts were discussed routinely at the weekly practice meetings. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. This ensured staff were aware of any that were relevant to the practice and the action required.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received 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 and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible on the practice's intranet. We saw evidence of a recent referral demonstrating that staff knew what to do.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been appropriately trained and could demonstrate they had the necessary skills and knowledge to enable them to fulfil this role. All staff we spoke with were aware who these leads were and that they could speak with them if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments. The practice held a register of vulnerable patients and relevant information was discussed during multi-disciplinary team meetings.

There was a chaperone policy in place. A notices were displayed on the waiting room notice-board and in clinical rooms to ensure patients were aware that they could request a chaperone to be present during their consultation. A chaperone is a person who acts as a safeguard and witness for a patient and health care

professional during a medical examination or procedure. Only clinical staff (nursing and health care assistants) undertook chaperone duties. They had not received any specific chaperone training but understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

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 policy in place for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy and were able to describe appropriate action they had taken when the fridge thermometer had failed.

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. The practice told us that they did not hold any controlled drugs on site (medicines that require extra checks and special storage arrangements because of their potential for misuse).

The practice took part in prescribing benchmarking with other practices in the local CCG area. This showed the practice was average compared with other practices locally and in some areas better for safe prescribing. We saw evidence of a prescribing audit in which the practice had reviewed their repeat prescribing to ensure patients on a particular drug remained safe.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. Up-to-date copies of directions were made available to us. We saw evidence that nurses had received appropriate training to administer vaccines. We were unable to verify the training for the healthcare assistant. They told us that they had received training to administer vaccinations but did not have their certificates with them and the practice did not maintain these records.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. We checked seven anonymised patient records which confirmed that the procedure was being followed and that appropriate action was taken based on the results.

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

The practice had recently undergone refurbishment and we observed the premises to be visibly 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 for infection control to support staff in this area. An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. There was also a policy for needle stick injury for staff to follow in the event of an injury.

We saw evidence of infection control audits that had been carried out over the last two years. Where actions had been identified these had been completed in a timely way. Minutes of practice meetings showed that the findings of the audits undertaken by the practice were discussed.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice did not have a clear policy for the management, testing and investigation of legionella (a bacteria which can contaminate water systems in buildings). A legionella risk assessment had been undertaken in May 2013 which had identified areas for action but it was not clear from information available that it had been acted on. The practice manager who was new in post told us that they undertook temperature checks but was not clear why they were doing it and had received no training.

Equipment

Good

Are services safe?

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 records that confirmed this. All portable electrical equipment had been tested for electrical safety within the last 12 months. Calibration of relevant equipment; for example weighing scales and blood pressure monitoring equipment had also been undertaken in the last 12 months.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and checks through the Disclosure and Barring Service (DBS). DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us there were enough staff to maintain the smooth running of the practice and keep patients safe. They told us the main difficulty was when there was unexpected leave due to sickness. When this occurred staff told us that practice staff were very supportive of each other and would do extra sessions in order to provide cover. Many of the staff worked part-time and were able to fill in when needed.

The registered manager showed us how over the last 10 years the number of consultations had nearly doubled while the list size had remained the same. They explained how they had tried to manage this increased demand. The practice had employed an advanced nurse practitioner who was able to take on some of the GPs' roles such as the management of patients on warfarin (a blood thinner used to prevent heart attacks, strokes and blood clots in veins and arteries) and one of the practice nurses was due to undertake an independent prescribers course. Flu vaccinations had been undertaken outside regular opening hours to lessen the impact on the service and the GPs would undertake extra sessions where needed.

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. We saw risk assessments in place for identified risks to the service with mitigating actions recorded to reduce and manage the risk. Daily checks of the building and premises were undertaken and we saw evidence of action taken as a result of these checks. Various monitoring arrangements were in place for managing risks such as those in relation to the safe storage of vaccinations, infection control and dealing with emergencies. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Practice meetings were the main forum for discussing and managing risks such as those identified through audits, complaints and other incidents.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. The practice offered a triage service daily for patients with urgent needs. This service was operated daily and consisted of a GP and nurse team. The practice nurse took calls and was able to offer telephone advice and if needed would make appointments for the patient to be seen with the on call doctor.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment. Records were available which showed the emergency equipment and medicines were checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. Emergency medicines included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice such as power failure, adverse weather, unplanned sickness and access to the building. The

Good

Are services safe?

practice told us how they had reviewed the business continuity plan following an incident in which there had been disruption to the electronic patient record system. Action was put in place to print out appointments for the next working day should this reoccur.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff had received 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. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Staff told us that they discussed latest guidance at practice meetings. Information relating to NICE and other guidance was placed on the practice's intranet for staff to access for example, guidance on codeine (pain relief medication) prescribing in children. The practice's intranet was updated on a regular basis by one of the GP partners. We found from our discussions with the GPs and nurses that staff referred to guidance when assessing patients' needs.

Clinical staff took lead roles in specialist clinical areas such as diabetes, asthma and dementia. We spoke with clinical staff who told us about local networks they attended in their specialist areas which enabled them to keep up to date. One member of staff showed us the care plans they had implemented to support patients with asthma.

The senior GP partner showed us data from the local CCG of the practice's performance for antibiotic prescribing, which compared well to similar practices. The practice's referral rates to secondary and other community care services were mostly lower than or in line with other practices. The practice told us that it regularly reviewed referrals and where there had been higher numbers of referrals they had undertaken reviews to identify whether the services could have been provided within primary care.

The practice had identified patients with complex needs who required multidisciplinary care planning. We saw examples of care plans for patients identified as having complex needs documented in their case notes. Multidisciplinary team meetings were held enabling patients care needs to be regularly assessed.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with staff showed that the culture of 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 across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, managing child protection alerts and medicines management.

The practice showed us clinical audits that had been undertaken in the last 12 months. Audits seen included a review of 27 patients with chronic obstructive pulmonary disease (COPD). The aim of the audit was to ensure the management of patients was in line with the latest guidance from NICE. Although the audit had undergone a re-audit from the baseline it was not clear from the report what the overall impact was for patient outcomes. Other examples of audits included an audit of minor surgical procedures undertaken to confirm that the GPs who undertook these did so in line with their registration and guidance. The results of this audit did not raise any concerns in relation to minor surgical procedures undertaken at the practice.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of analgesics and non-steroidal anti-inflammatory drugs. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with guidance. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice also used the information collected for the QOF to monitor outcomes for patients. For example, the latest practice data told us that 70% of patients with asthma and 100% of patients with COPD had received an annual medication review. The latest national data available from QOF 2013/14 showed that the practice achievement was in line with other practices nationally. The practice was able to demonstrate improvements where QOF data had highlighted an area of performance which was below other practices nationally.

There was a protocol for repeat prescribing. Staff checked that patients receiving repeat prescriptions had been

reviewed by the GP. Patients were reminded when they needed to be seen. Patients we spoke with on repeat prescriptions confirmed they received regular reviews of their medicines.

The practice had arrangements in place to support patients receiving 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. There was a lead GP for elderly care who worked closely with two care homes. They explained how patients at end of life were managed. We saw advanced care planning in place for patients receiving end of life care. We spoke with the manager of one of the care homes supported by the practice. They told us that their care home was one of the few gold standard framework accredited homes and that this was achieved through their close working and support from the GP practice.

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 core training such as annual basic life support. We noted a good skill mix among the clinical staff with the doctors and nurses each managing particular specialist areas. We saw staff with additional qualifications in areas such as family planning, minor operations, diabetes and mental health. All GPs were up to date with their yearly continuing professional development requirements and all either have 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 (GMC) can the GP continue to practise and remain on the performers list with NHS England.

All staff undertook annual appraisals that identified learning needs. Our interviews with staff confirmed that the practice was supportive of training, for example staff told us that they received protected learning time and learning events were held at the practice. One practice nurse told us that they were due to start on an independent prescribing course to support the needs of the practice. The practice was a training practice and doctors who were training to be GPs had access to a senior GP throughout the day for support.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles for example seeing patients with long-term conditions such as asthma and COPD were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage patients with complex needs. It 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. Staff we spoke with were aware of their responsibilities in passing on, reading and acting on any issues arising from communications with other care providers when received. The GP who saw these documents and results was responsible for the action required. We saw that the practice was up to date in processing information received.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw examples where patients had been contacted following their discharge from hospital.

The practice held multidisciplinary team meetings every three months to discuss the needs of complex patients, for example those with end of life care needs. These meetings were attended by district nurses and palliative care nurses. Monthly meetings were also held with the health visitor to discuss vulnerable children.

We spoke with the managers from two care homes supported by the practice. They told us that they had a good working relationship with the practice and that they were very satisfied with the care that their residents received from them.

Information sharing

The practice used various systems to communicate with other providers. For example, the practice showed us faxes that they sent to the local GP out-of-hours provider so that they were aware of patients who may need to use the service and to support continuity of care. The practice did

Good

Are services effective?

(for example, treatment is effective)

not routinely use the Choose and Book system for making referrals. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Patients' referrals were faxed although the practice told us that from the 1 April 2015 they would be using Choose and Book in line with changes to their contract.

Patients who required emergency care were given a summary letter to take with them to A&E. We saw an example of a recent letter which contained details about the patient's medicines, recent consultations and allergies. This ensured important information was shared with other health care providers. The practice told us that the electronic Summary Care Record was in place and now fully operational at the practice. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. Staff we spoke with were confident in its use. The software enabled scanned paper communications to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. One of the GPs was a section 12 approved clinician. This is a clinician who can make decisions as to whether someone should be detained under the Mental Health Act 1983. Another GP at the practice was the local Clinical Commissioning Group lead for mental health. The practice's consent policy in place made reference to the mental capacity act so that it would be taken into account when obtaining consent.

All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. Where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to assist staff. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

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. 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. We saw alerts were placed on patient records for those with advance directives or lasting power of attorney so that the GPs were aware of patients' wishes. The mangers from the two homes we spoke with told us how the practice discussed do not attempt resuscitation orders with the patient's family.

Clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Minor surgical procedures were carried out at the practice. We saw evidence that formal written consent was obtained and recorded in the patient's notes.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant or practice nurse to all new patients registering with the practice. The practice also offered NHS Health Checks to its patients aged 40 to 74 years. These helped identify any new or existing conditions that needed to be addressed. Staff who carried out the reviews told us that they would escalate any health concerns detected to either the practice nurse or GP to be seen.

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. The practice told us that there were 11 patients on their learning disability register and that 62.5% had received an annual physical health check in the last 12 months.

A variety of health promotion and prevention services were available on site. This included clinics for patients with long term conditions, diet and exercise and counselling services for patients with anxiety and mild depression. The practice had a blood pressure monitor in the waiting area which patients could use. The practice told us that they had blood pressure recording for 88.5% of their patients over 45 years.

The practice's performance for cervical smear uptake was 81%, which was in line with other practices nationally. The practice told us the process in place for following up patients who did not attend for cervical smears.

The practice offered a full range of immunisations for children, travel vaccines (including yellow fever) and flu

Good

Are services effective?

(for example, treatment is effective)

vaccinations in line with current national guidance. Last year's performance for immunisations was in line with other practices in the CCG area. Children who did not attend were discussed with the health visitor.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP patient survey (2014) and in-house patient surveys undertaken in conjunction with the practice's patient participation group (PPG) in 2013 and 2014. The evidence from all of these sources showed that patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was in line with other practices nationally for patients who rated the practice as good or very good. The practice was also in line with other practices nationally for its satisfaction scores on consultations with doctors and nurses with 88% of practice respondents saying the GP was good at listening to them and 87% saying the GP gave them enough time.

We spoke with 14 patients during the inspection and reviewed 16 CQC comment cards that patients had completed to tell us what they thought about the practice. The majority were positive about the service experienced. Patients said they were happy with the service that they received and found it efficient, helpful and caring. They said staff treated them with dignity and respect. A small proportion of patient told us that access to appointments was the main difficulty they experienced.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Privacy screens 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 saw that reception staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private. Patients told us that they could overhear conversations at the reception desk but none said they were concerned by this. The practice had tried to address this with background music in the waiting area and staff told us about a room they could use if a patient wished to speak in private.

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 79% of practice respondents said the GP involved them in care decisions and 86% felt the GP was good at explaining treatment and results. Both these results were similar to the national average. The results from the practice's own satisfaction survey showed that patients said they were sufficiently involved in making decisions about their care.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and in a way they could understand. They also told us that they felt listened to and felt involved in discussions about their care and treatment. Patient feedback on the comment cards we received was also positive and aligned with these views.

We saw examples of patient care plans which showed evidence of patients' involvement in their care. This included care plans for patients with learning disabilities and dementia where there was involvement from the patient and their carers. There were alerts on patient records where lasting power of attorney was in place. This helped ensure patients' wishes were taken into account when providing care.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were satisfied with the emotional support provided by the practice and rated this area similar to other practices nationally. For example, 86% of respondents to the GP national patient survey said the GP was good at treating them with care and concern and 90% said the nurses were good at treating them with care and concern. Feedback from patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. Most patients told us that they found staff were caring.

Good

Are services caring?

Staff told us that they would print information for patients about support groups and organisations for patients. The practice had a carer's register in place. The practice's computer system alerted GPs if a patient was also a carer. This enabled the GPs to ask the patient if they required any support and signpost them as appropriate to support services.

Staff told us that if families had suffered bereavement a card would be sent to them. Any deaths would be discussed at weekly practice meetings so that staff were aware.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

At the start of the inspection a senior GP partner delivered a presentation to us about the practice. This included information about the needs of the practice population which the practice clearly understood. The practice population was predominantly white British and situated in one of the least deprived areas in the county. There was a high demand for services provided and the practice was able to demonstrate that while the list size had remained stable the number of consultations had increased from 40,000 in 2005 to 90,000 in 2014. The practice sought ways to manage this demand through the use of telephone triage and an on-call doctor to see urgent patients and through extended opening hours. A range of in-house services were provided for the convenience of service users such as minor surgery and warfarin clinics as well as clinics for patients with long term conditions. The practice reviewed referral data to look at whether there was a potential to provide further services in-house.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice regularly engaged with them and other practices to discuss local needs and service improvements. The practice was able to show a positive impact on the end of life care through its close working with local care homes.

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). A PPG is a a group of patients registered with a practice who work with the practice to improve services and the quality of care. The practice had put in place measures to try and improve patient confidentiality around the reception area such as the installation of glass screens, signs to inform patients that they could speak privately if they wished to and altering the seating in the waiting area.

Tackling inequity and promoting equality

The practice was located in purpose built single story premises. The entrance to the building was through automatic doors and there were parking spaces available for patients with a disability. The practice was sufficiently wide to allow access for patients who used wheelchairs and those with pushchairs. However, we noticed that the reception desk was too high for patients who used a wheelchair to speak easily with receptionists. Practice staff told us that in this situation they would stand to speak. Accessible toilet facilities were available for all patients attending the practice. Baby changing facilities were also available.

The practice told us that they had only needed to use an interpreter in the last two years. They told us patients tended to bring relatives with them and two of the GPs spoke a second language. Contact details were available to staff to enable them to book an interpreter if needed. We were told if an interpreter was needed this would be requested by the clinician and organised through the practice manager.

Patients had access to both male and female clinical staff which helped remove any potential barriers to patients who preferred to see a clinician of the same gender for their health problem. The practice had a hearing loop installed for those who had hearing difficulties. The text size on the practice website could also be enlarged to support patients with visual impairment to access the information.

An alert system was in place so that staff were aware of patients who were potentially vulnerable for example those with learning disabilities or carers who may need additional support.

The practice supported patients who had been on long-term sick leave to return to work and were able to give examples of a patient who had undertaken a phased return to work following consultations with their employer.

Access to the service

The practice was open from 8am to 6.30pm on weekdays with appointments available throughout the day. Appointments could be booked up to four weeks in advance and those who wished to see their preferred GP could do so if they were willing to wait. A duty doctor and a practice nurse was available daily to triage and see patients whose needs were urgent.

Comprehensive information was available to patients on the practice website and leaflet about the appointment system. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were arrangements in place to ensure patients received urgent medical assistance when the

Good

Are services responsive to people's needs?

(for example, to feedback?)

practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring to access the out-of-hours service provider.

Staff told us that longer appointments were available if advised by the GP and for certain appointments which were likely to take longer. For example asthma reviews. Home visits were made to two local care homes on a specific day each week, by a named GP and to those patients who needed one.

Patients gave mixed feedback about the appointments system. Patients confirmed that they could speak to a doctor on the same day if they needed to via the triage system. However, they told us that there were usually long waits for the next appointment if their needs were not urgent. Results from the national GP patient survey 2014 showed that the overall experience of making an appointment and the ability to get an appointment was in line with both the CCG and national averages.

- 70% of patients rated the overall experience of making an appointment as good compared to the CCG average of 69% and national average of 73%.
- 86% of patients were able to get an appointment compared to the CCG average of 84% and national average of 86%.

However the practice results were lower than the CCG and national averages for patients who were able to see their preferred doctor and for convenience of appointments.

- 74% of patients were able to see their preferred doctor compared to the CCG average of 90% and national average of 91%.
- 86% of patients were able to make an appointment that was convenient to them compared to the CCG average of 91% and national average of 92%.

The practice offered extended opening hours on Monday and Thursday evenings from 6.30pm to 8pm for the convenience for patients who worked or had other commitments during the day. Online booking of appointments and repeat prescriptions were also available and text reminders were sent to patients to attend their appointment.

Listening and learning from concerns and complaints

Prior to our inspection we had received a number of complaints from patients who used the service. These mainly related to access to treatment and were shared with NHS England who are involved in commissioning GP services. There were no specific themes identified in relation to the complaints received.

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

We saw that information was available to help patients understand the complaints system. This was displayed in the waiting area, practice website and leaflet. Information available included details of where to escalate the complaint to if the patient was not satisfied with the response received from the practice. None of the patients we spoke with the day of the inspection said they had made a complaint about the practice and only one said they had wanted to.

We looked at 20 formal complaints received in the last 12 months and found that these had been appropriately handled in a timely way. Complaints were discussed at practice meetings and staff confirmed that these were discussed with them and any learning shared. The practice also kept a record of verbal complaints which were also discussed at the practice meetings.

The practice had reviewed complaints received to detect themes or trends. We looked at the report for the last review but no specific themes had been identified. However, lessons learned from individual complaints had been acted on for example improving the availability of reception staff at busy times.

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 vision for the future. Although this had not been formally documented this focused on building a workforce to meet patient need for the service.

There practice charter was displayed in the waiting room and available on the practice's website which set out its commitment to patients. For example, to provide clean and accessible premises to all and to assess urgent requests for appointments on the same day.

We spoke with several members of clinical and non-clinical staff. Although they were not specific as to what the practice vision and values were, staff displayed values that were caring, friendly and helpful. There was a desire to deliver high quality care and promote good outcomes for patients. Staff worked well as a team and supported each other to deliver services when needed.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the practice's intranet on any computer within the practice. The practice's intranet was maintained by the senior GP partner and contained information to be shared amongst staff. The practice manager who had recently been appointed was currently in the process of updating practice policies and procedures to ensure they were up to date.

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 a GP lead for safeguarding. Clinical staff also had lead roles for supporting patients with various long term conditions. Staff we spoke with 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. We found staff that we spoke with were open about their experiences.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. 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 for example diabetes and implementing preventative measures. The results are published annually. The QOF data for this practice showed it was performing in line with national standards. The practice QOF achievement for the year 2013-14 was 93% which was in line with the national average.

The practice had robust governance structures for managing risks to the practice. Weekly practice meetings were held which provided a forum for discussing complaints ,incidents and patients with complex needs. This enabled any action required to be addressed promptly.

Leadership, openness and transparency

We saw from minutes available to us that staff meetings were held regularly and at least monthly. Staff told us that there was an open culture within the practice and they were happy to raise issues at team meetings. We spoke with a locum GP who had worked at the practice for several months. They told us that they felt supported. They told us that they had received an induction pack and that one of the GPs had gone through the computer system with them. They also received copies of practice meeting minutes so that they were aware what was going on.

Practice staff described how the practice worked together as a team to support each other and maintain services when needed for example, when there had been an unexpectedly high number of staff absences. Staff spoke openly about incidents and complaints that had occurred and how they were managed.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, complaints and comments received. We looked at the results of the annual GP patient survey 2014 this showed that patients were satisfied with the quality of consultations received but were less satisfied with the access to appointments and opening hours. We saw as a result of this the practice had introduced various measures to try and improve access. For example, telephone triage for patients who were unable to obtain an appointment..

The practice had an active patient participation group (PPG) which had increased in size over the last 12 months. The practice consulted with the PPG through meetings and via email. The PPG had been involved in conducting the annual practice patient surveys. The latest was carried out during 2014. Minutes of meetings and results from the

Are services well-led?

Good

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

patient survey were available on the practice website. The practice manager showed us the analysis of the latest patient survey which showed patients were satisfied with the service received but raised issues around patient privacy at reception. We spoke with two members of the PPG who told us about action the practice had taken. This included notices alerting patients to a private room if they wished to speak in private and a radio playing in the waiting area. The members of the PPG we spoke with told us that they felt listened to and that the practice was receptive to the views of patients.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us about issues that had been raised such as requests for equipment and managing staff workloads which had been acted on.

The practice had a whistleblowing policy which was available to all staff. Although the policy had recently been reviewed we saw that some of the information within the policy was out of date and contained details of external organisations which no longer existed.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development. Staff told us they received regular appraisals in which they discussed learning needs. Staff told us that the practice was very supportive of training and that they received protected learning time to keep up to date.

The practice was a GP training practice and a teaching practice for medical students as part of their undergraduate training.

The practice had completed reviews of significant events and other incidents which were shared with staff at meetings and away days to ensure the practice improved outcomes for patients. For example, following a health and safety incident staff had received refresher training and daily checks were undertaken of the environment.