Kirklands Surgery

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Kirklands Surgery on 8 January 2015, which is situated at 111 Copner Road, Copner, Portsmouth PO3 5AF.

Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services for all 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.
- 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.
- A range of appointments were available for patients. A standard appointment time was 15 minutes and 10 minutes for same day appointments.
- 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

- Consider logging verbal complaints received by the practice in order to assist in identifying themes.
- Have a system in place for managing the risk of Legionella.

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 report incidents and near misses. Information about safety incidents was recorded, monitored, appropriately reviewed and addressed. Lessons were learnt and areas identified for action as requiring improvement were communicated to all staff members. Staff demonstrated understanding of their roles and responsibility to report safeguarding concerns. Appropriate recruitment checks were carried out prior to staff commencing employment.

Are services effective?

Good

The practice is rated as good for providing effective services. Patients were treated in line with best practice and current national guidance. The practice had identified areas where action was needed to make sure reviews of patients with long term conditions were carried out and had implemented arrangements to manage and to encourage patient attendance. Staff were able to receive training appropriate to their roles and further training needs were identified and planned for through the appraisal system. Patients who had complex needs, such as those at the end of life, were discussed at multidisciplinary meetings.

Are services caring?

Good

The practice is rated as good for providing caring services. We found that patients were treated with compassion and respect and their privacy was maintained. Patients said they were involved in care and treatment decisions. Staff were observed treating patients with dignity and respect. The practice provided information in accessible formats to assist patients in understanding the care and treatment options available to them.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Patients reported that they were able to be seen on the same day if their concerns were urgent. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for being well led. The vision and values of the practice had been communicated well to all staff members. There were effective day to day working arrangements

Summary of findings

within the practice, with staff having clear roles and responsibilities. The practice monitored activity and regular governance meetings had taken place, which included systems to monitor and improve quality and identify risk. The practice proactively sought feedback from its patient participation group and staff and patients and this had been acted upon.

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 offered proactive, personalised care to meet the needs of the older people in its population and had a range of services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits. All patients over the age of 75 years had a named GP. The practice had effective communication with other healthcare professionals to provide care for older patients such as the community matron. Palliative care meetings were held six weekly and care plans were in place which were shared with other providers.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Longer appointments and home visits were available when needed. All these patients were offered a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the GP worked 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 working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services and screening that reflected the needs for this age group. Extended hours appointments were available, along with telephone appointments. The practice had a text reminder service for appointments for those who wished to use it.

Working age people (including those recently retired and students)

Good

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screening that reflected the needs for this age group. Extended hours appointments were available, along with telephone appointments. The practice had a text reminder service for appointments for those who wished to use it.

People whose circumstances may make them vulnerable

Good

The practice was rated as good for people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability.

It had carried out annual health checks for patients with a learning disability and these patients had received a follow-up. It offered longer appointments for people with a learning disability. There were suitable arrangements in place to ensure information was communicated in a manner that this group of patients understood. The practice proactively referred patients with substance misuse to appropriate support services.

People experiencing poor mental health (including people with dementia)

Good

The practice was rated as good for people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

Summary of findings

What people who use the service say

We spoke with seven patients during our inspection and reviewed 33 comment cards which patients had completed during the two weeks prior to our inspection. All respondents considered that they were treated with respect and their privacy maintained. Words used included courteous, helpful and polite. Many of the cards singled out particular staff teams or staff members for praise about how they treated patients. Patients told us during our visit that they found staff helpful and polite. Many of the patients had been registered with the practice for a number of years, some as many as 67 years and had different generations of the family registered at the practice.

Areas for improvement

Action the service SHOULD take to improve

- Consider logging verbal complaints received by the practice in order to assist in identifying themes.
- Have a system in place for managing the risk of Legionella.

Kirklands 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 and a practice manager.

Background to Kirklands Surgery

Kirklands Surgery is situated at 111 Copner Road, Copner, Portsmouth PO3 5AF. The practice has just under 8000 patients registered with it and the population consists of families and has a higher percentage of patients in the 40-54 age groups compared to the national average.

Kirklands Surgery has four GPs, three of who are male and one female. The GPs provide a total of 30.5 sessions a week. The practice also employs a female locum GP who is long term. In addition to GPs the practice has a practice manager who works 32 hours per week, a triage nurse who works 32 hours a week; two practice nurse who work a total of 48 hours per week between them and two health care assistants who work a total of 21 hours. In addition to clinical staff the practice employs reception and administration staff who provide a total of 144.5 hours per week and a reception manager who works 33.5 hours per week. There is also one medical secretary who work 33.5 hours.

The practice has a General Medical Services contracted with the clinical commissioning group. Out of hours services are provided via the 111 service.

The CQC intelligent monitoring placed the practice in band 6. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality and Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. Including local NHS England, Healthwatch and the clinical commissioning group. We carried out an announced visit on 8 January 2015 at Kirklands Surgery. During our visit we spoke with a range of

Detailed findings

staff which included GPs, nurses and reception staff. We spoke with patients who used the service. We reviewed 33 comment cards where patients and members of the public shared their views and experiences of the service.

We asked the practice to send us some information before the inspection took place to enable us to prioritise our areas for inspection. This information included practice policies and procedures and some audits. We also reviewed the practice website and looked at information posted on NHS Choices website.

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

The practice had a system in place for reporting, recording and monitoring significant events. The practice was able to demonstrate the process for recording incidents with the practice manager and the GPs. All serious events were discussed at GP meetings. This provided senior staff with the opportunity to discuss the incident and to record any learning points. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term. Records we viewed confirmed this.

The practice had a system in place for managing alerts received from agencies such as Medicines and Healthcare Regulatory Agency (MHRA). The practice manager received MHRA alerts via email and was responsible for printing out the information and placing copies on the GP visit book on a daily basis for staff to read and act on.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. There was a specific proforma for staff to complete when a significant event occurred. The practice manager would collate these forms and the information was discussed at weekly partners meetings. Any action needed was put into place and recorded; there was on going monitoring of significant events to ensure actions taken were effective. An example given of a significant event was when a child burnt their hand on an uncovered storage heater in the practice. As a result of this incident a contractor was contacted to ensure the heater was not faulty and the practice bought guards for all heaters in the practice.

Information from significant events was also discuss at monthly training meetings with all staff and an annual meeting was held for staff to discuss concerns, complaints, significant events and review action taken when needed. Staff we spoke with confirmed this and minutes of meetings held showed that the process was in place and effective.

Reliable safety systems and processes including safeguarding

We reviewed the practice's policies and procedures for safeguarding adults and children. Both policies detailed types of abuse and signs that staff should be aware of which might indicate that a patient was at risk. There was information on who to report concerns to and what should be documented.

The practice had a system of alerts that could be placed on patients' records to make a GP or nurse aware of any specific health or social needs. These included information on whether there were any safeguarding concerns. There was a nominated safeguarding lead, who had completed training on safeguarding children at the appropriate level and safeguarding adults training. Training records showed that all practice staff had completed online training on safeguarding adults and children at a level appropriate to their role. Staff said that they had also received some face to face training at their monthly training afternoon.

Staff were able to demonstrate the process to be followed if they suspected a patient was at risk of abuse. An example given related to a child and concerns were reported to relevant authorities, such as the police and social services. Weekly meetings were held to enable staff to share safeguarding concerns and suspected non-accidental injuries to children were discussed at clinical meetings. A GP told us that there were no regular meetings with other health care professionals, such as health visitors, but information was shared with them when needed. An example given of safeguarding related to a to a child, we found the process was followed and reported appropriately to relevant authorities such as local authority and the police.

A chaperone policy was in place and there was information on the television screen in the waiting room about this and on notices displayed in consulting rooms. (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.) Chaperones were either clinical staff such as nurses or health care assistants. These members of staff had a criminal record check carried out via the Disclosure and Barring Service (DBS). Some receptionists carried out chaperone duties and had received training to do this. These members of staff had not had a DBS check, but there was a risk assessment in place detailing what they were able to do when chaperoning patients.

Medicines management

There were systems in place for managing medicines within the practice. Suitable lockable cupboards were provided for medicines to be stored securely. There was a

designated refrigerator for storing medicines which needed to be kept at a low temperature. Records we looked at showed the refrigerators were operating within safe limits. There were clear instructions detailing what actions staff should take if there was an interruption in the cold chain of vaccines. The practice used a 'tiny tag' which monitored the temperature inside the refrigerator. A record of temperatures could be printed out to show when the temperature of the refrigerator rises, for example, when a delivery of vaccines was received and how long it took for the temperature to return to an acceptable level. A nurse gave an example of when this had been useful, when a plug had been accidently removed from the socket, which resulted in a temperature rise. They were able to check how long the refrigerator had been without power and determine what to do with the medicines stored to ensure they were still safe to use.

GPs said they used a specific emergency bag for home visits, whose contents, which included medicines, were checked monthly to ensure they were suitable for use and within their expiry date. The emergency bag was kept in a locked safe when not in use.

The practice held controlled drugs (these are medicines which require specific storage facilities and a register is maintained of the amount held). We found these were stored securely and checked on a monthly basis to ensure they were within their expiry date. The practice did not have a controlled medicine disposal kit available and there were four ampoules of controlled medicines which had expired. We noted that controlled drugs had last been used in August 2014. A GP said that they required a small stock, for example, for patients who were receiving end of life care, prior to anticipatory medicines being obtained.

The practice had systems in place for managing repeat prescriptions. They informed us that 60% of prescriptions were received on line and if needed an alert was placed on the request. For example, if the medicines requested was not on the patients known list of repeat medicines, or if the repeat prescription required re-authorising by a GP. If the repeat prescriptions required re-authorising then this would be actioned by a GP once the patient's records had been reviewed. If a prescription was not re-authorised then reception would contact the patient and arrange an appointment with a GP to discuss the situation. Patients were encouraged to use a repeat prescription request sheet if they submitted a paper based request. Reception staff said that if the request was handwritten, and they were unable to read the writing, they would contact the patient for clarification, prior to the request being actioned.

The pharmacist employed by the practice carried out an annual polypharmacy review of a sample of patients who were on 10 or more medicines. The review covered whether the medicines were still necessary and beneficial.

Cleanliness and infection control

The practice had a designated infection control lead and policies and procedures were in place for staff to adhere to, to minimise the risk of cross infection. Liquid soap, paper towels and hand gel were available in the practice in areas such as consulting and treatment rooms. Staff said they had sufficient personal protective equipment, such as gloves and aprons to use. We observed that treatment and consulting rooms had sharps bins for used needles and syringes. The practice had a clinical waste contract in place to dispose of any contaminated items safely.

The practice was visibly clean and tidy and there were cleaning schedules in place which were monitored regularly.

The practice did not have a risk assessment or system in place for managing the risk of Legionella (a bacteria found in water supplies which can cause serious illness). However, heating boilers had been serviced and checked to ensure they were operating safely.

The practice had an infection control audit carried out in 2013/14 and there were areas which needed improvement, as the overall score was 81%. The practice had implemented many of the recommendations and a subsequent audit in October 2014 found that the results had improved to 91%. We saw evidence of on-going work to maintain and improve the standards of infection control within the practice. The main area which needed work was the environment. Plans were in place to replace the flooring in the consulting rooms as well as replacement of fabric chairs in the downstairs waiting area to ones which could be cleaned more easily.

Equipment

There was sufficient equipment for staff to carry out diagnostic examinations, such as blood pressure monitors.

Good

Are services safe?

Equipment was maintained, tested and calibrated by an external company and records viewed confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date.

Staffing and recruitment

The practice had systems in place to recruit staff safely. The recruitment policy had recently been reviewed and updated to ensure that evidence of satisfactory conduct in the form of references was obtained from previous employers. All GPs, nurses and healthcare assistants had criminal records checks carried out via the Disclosure and Barring Service (DBS). For those staff that did not have a DBS check, risk assessments were in place to demonstrate why this was not needed.

Staff files we looked at included those of a long term locum GP, checks had been made to make sure they were suitable to work at the practice and included a check on the performers list for GPs. This was to ensure they were registered to practice.

Monitoring safety and responding to risk

The practice had systems in place for managing and responding to risk. A fire assessment had been carried out in 2009. Actions needed from this assessment included fitting of smoke detectors, which had been done. The practice had commissioned a health and safety consultant to carry out a fire risk assessment for 2015. We found that fire extinguishers had been serviced and checked in October 2014. The practice had organised a fire drill in 2014 and had recorded this event, however, they had not recorded the time taken to evacuate the building safely.

We saw examples of risk assessments for staff that used computers which included a workstation. This assessment covered use of computer screens and correct positioning of chairs. There were also risk assessments for general hazards, such as cleaning chemicals and trip hazards.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records and staff confirmed that they had received basic life support training. Emergency equipment was available including access to oxygen and an automated external defibrillator (a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm.). Staff were able to tell us where this equipment was located and how to use it, records confirmed that the equipment was checked regularly.

Emergency medicines were held securely in the practice and all staff knew where this was. The medicines included those used for the treatment of cardiac arrest, abnormal heart rhythms and low blood sugar levels. 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 had an emergency plan in place which detailed staff responsibilities should an incident occur, for example a power failure. There were details of emergency contacts for power supplies in the event of a power failure. Procedures were also in place to 'back up' the computer server system to ensure information was not lost in the event of a power failure.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients' needs were assessed and treatment was delivered in a way which followed national standards and guidance. Patients confirmed that they received an assessment of their symptoms before GPs and nurses recommended treatment. Nursing staff at the practice were responsible for patients' chronic disease management, for example diabetes and asthma.

The practice used a software system that had assessment and treatment templates based on best practice guidance. 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 and from local commissioners. Information was discussed at practice meetings and current guidance was disseminated to staff. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The triage system used by the practice for same day appointments assisted in directing patients to the correct health care professionals. For example, long term conditions were directed to the triage nurse, who was also an independent prescriber.

Patients who were diagnosed with long term conditions, such as, asthma and chronic obstructive pulmonary disease, (COPD is a condition which causes breathing difficulties), had care plans in place detailing the care and support they needed. We were shown an example of a care plan for a long term condition. We saw that the contents were reviewed and verbal consent form the patient had been obtained. A GP said that the plans are reviewed at least once a year or more often if needed, for example if a patient has had a hospital admission.

The practice undertook audits of the referral rates to secondary providers, such as hospitals, to see whether this was effective and appropriate. Results showed that there was a low number of referrals which showed that patients' needs were effectively managed in the primary care setting and the community. A cardiac monitor had been purchased and staff were trained in its use to reduce the number of cardiology referrals. An analysis of the patients that were referred under the two week wait for cancer referrals showed that there was a high rate of appropriate referrals.

One of the GPs had recently completed a course on dermoscopy (this is where photographs are taken of skin conditions and sent electronically to a hospital for an opinion). This assisted in diagnosing skin conditions without the need for a hospital appointment.

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 employed a part time pharmacist who also worked for the National Institute for Clinical Excellence (NICE) and they were responsible for updating all clinical staff on the most recent NICE guidance on medicines. One of the GPs was responsible for storing NICE guidance on clinical practice on the computer system and informing the other GPs that they needed to read this.

Patients were able to access the computer system via a personal log in to access their tests results. One of the GPs offered acupuncture for patients experiencing chronic neck and back pain. Patients self-referred for this and other GPs informed patients of the service. The GP providing acupuncture had undertaken personal audits of the service provided to determine how effective the treatment was.

Information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool showed that the practice achieved 97.5% in its QOF results, which was slightly higher than the practice average across England. Specific areas where the practice was above the national average for QOF areas included: patients who were diagnosed with dementia having a face to face review annually; patients who received the flu vaccination; and patients with an enduring mental condition had an agreed care plan in place.

The practice had a system in place for completing clinical audit cycles. We saw examples of these, which included one on minor surgery carried out at the practice. The audit focused on ensuring consent for minor surgery had been obtained prior to the procedures. The first cycle showed that this was not consistently achieved. Changes were

made and the second cycle showed that 98% of procedures had been correctly consented for; there were no wound infections identified; and when excisions (removal of body tissue) were made these were complete.

The pharmacist who was employed by the practice had completed five prescribing audits and worked with the clinical commissioning group on these. Results showed that the practice was managing prescribing in a cost and treatment effective manner. An example of this was an audit on the use of Domperidone (a medicine used to treat nausea and vomiting). At the time of our inspection two prescribing audits were in progress, related to inhaler use for patients with asthma and medicines used to treat diabetes.

GPs in the surgery undertook minor surgical procedures in line with their registration and NICE guidance. The staff were appropriately trained and kept up to date. They also regularly carried out clinical audits on their results and used that in their learning.

Effective staffing

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. Those with extended roles for example seeing patients with asthma and diabetes were also able to demonstrate that they had appropriate training to fulfil these roles.

Health care assistants who worked at the practice carried out NHS health checks for all patients over 40 years of age following training. They also assisted in supporting patients to reduce benzodiazepine (for example diazepam) use, by using alternative medicines such as lorazepam. Each patient had an individualised programme to reduce their dose and were supported to access psychological services if needed.

A practice nurse had completed training to be a nurse prescriber and was responsible for chronic obstructive pulmonary disease (COPD-a disease that causes breathing problems) management. As part of their role in managing COPD they liaised with outreach nurses who were community based to provide support and treatment for patients.

A GP led on a primary care research network and was involved in a pilot regarding older patients and aspirin use; this has been rolled out as a national project. Training had been provided to staff on areas such as fire safety, moving and handling and infection control. GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. Every GP was appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council. Other staff who worked in the practice received an annual appraisal; learning needs were identified and planned for. Staff said they found this process was useful and they considered that their training needs were met.

Working with colleagues and other services

The practice accessed the 'care closer to home' service which was a local project to care for frail older patients who were on the 2% admission avoidance register. The service carried out home visits with a community matron and each week protected time was available for a GP from the practice to support those patients. The practice had 25 care plans in place and continually reviewed and updated them for this group. The practice only had a few patients who had a learning disability with care plans in place, due to local support services in the area. Care plans were shared with the out of hour's service when needed.

Each GP received emails about patients admitted to or discharged from hospital and these were reviewed prior to meetings. The GP was responsible for follow up actions needed, such as referrals to social services, a telephone call to a patient or arranging a visit by the community matron. The GP was expected to take action within 48 hours of the email being received, if they were absent then suitable cover arrangements were in place to ensure information was followed up. This protocol applied to blood test and diagnostic test results, with actions taken included referral to hospital or prescription of medicines.

Referrals to secondary care service, such as a hospital, were audited on a three monthly basis according to clinical commissioning group (CCG) requirements, for example neurology and gynaecology. Part of this review ensured adherence to guidance and outcomes. Meetings where referrals were discussed in the practice were minuted; the findings and learning were shared with the CCG.

The practice access a Portsmouth wide on line service which had referral pathways and patient information

Good

Are services effective?

(for example, treatment is effective)

sources for all conditions patient might present with at a GP practice. This information included safeguarding contacts and local support services with contact details, such as a group for Military Veterans.

Information sharing

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. All staff were fully trained on the system and said they were able to use it easily and there was scope for adding addition information when needed. Paper communications, such as those received from hospitals, were scanned and saved into the system on the individual patient record.

A medical secretary was responsible for choose and book referrals and updating care pathways. Summarising of medical records was carried out by designated administration staff that followed a protocol.

The practice had a range of meetings to discuss care and treatment provided by them. These included Monday and Tuesday meetings of the GPs and practice manager; meetings to discuss finances and forward planning; and nurse meetings once a month. All these were minuted and learning and actions were shared with relevant staff groups.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. 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. A GP gave us an example of where a patient was able to consent for health care interventions. The GP was involved in assessing the patient's capacity to make these decisions. A nurse told us about patients who had learning disabilities and said that they were aware of those patients who lived independently and what support the patient needed to make a decision.

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 are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. 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.

GPs said there were various support services in the area which they were able to refer patients to, or patients were able to self-refer. For example, an alcohol and substance misuse advisory service for patients with alcohol or substance misuse. Smoking cessation sessions were offered at the practice by an independent advisor.

The practice website and waiting areas had information on health promotion and self-management of conditions. Such as, sexual health, heart disease sign and symptoms and advice on coughs and colds. We found that patients who were diagnosed with diabetes were provided with a blood sugar monitoring machine, which they were taught to use at home, to monitor their blood sugar levels.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed patients being greeted politely by reception staff. We noted that there was limited privacy at the reception area, but staff were careful about information requested and only asked minimal questions, such as the patients name only. Telephone lines into the practice were situated away from the main reception desk and we found that patients were asked if times and dates for appointments were suitable for them and staff endeavoured to make appointments at a time to suit the patients.

We spoke with seven patients during our inspection and reviewed 33 comment cards which patients had completed during the two weeks prior to our inspection. All respondents considered that they were treated with respect and their privacy maintained. Words used included courteous, helpful and polite. Many of the cards singled out particular staff teams or staff members for praise about how they treated patients. Patients told us during our visit that they found staff helpful and polite. Many of the patients had been registered with the practice for a number of years, some as many as 67 years and had different generations of the family registered at the practice.

Care planning and involvement in decisions about care and treatment

Patients we spoke with and those who completed comments cards said health needs 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.

Information from the NHS England GP patient survey showed the practice was performing either above or on a par with the national average for areas such as being involved in care decision making and being treated with care and concern. Overall, 91% of patients surveyed would recommend the practice to others.

Patient/carer support to cope emotionally with care and treatment

Patients considered that support was provided by the practice to cope emotionally with care and treatment. Comment cards we reviewed also aligned with the views of those patients we spoke with. For example, these highlighted staff responded compassionately when they needed help and provided support when required.

A GP talked about emotional support for patients with depression and/or anxiety and said they liaised with community mental health team and there were psychological therapy services that patients could be referred to. Information packs on self-referral to these services were available in paper format or online.

Child and family therapy services were accessed via the children and adolescent mental health services. Parents of teenagers with behavioural issues were able to access parenting courses to provide them with support and skills to cope. 'Off the record' was a local service for 16-25 year olds to see trained counsellors for lifestyle education and local schools and colleges had their own counselling services.

The practice was proactive in identifying carers for older patients and directing them to community groups for support. Memory clinics for patients with dementia in the area had outreach services for carers.

Patients receiving palliative care were reviewed with other members of the multi-disciplinary team and the practice's end of life care registered was accessible to out of hour's providers.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice used a telephone based interpreting service for its patients if English was not their first language. The facility was able to be used 'hands free' which enabled the conversation to flow freely.

GPs in the practice said they knew older patients well as this population group was stable and had been registered at the practice for a number of years. Patients in the top 2% of the practice population who were at risk of inappropriate hospital admission were discussed at fortnightly meetings attended by GPs. In addition the practice met with a multidisciplinary team of health professionals every six weeks to discuss patients at risk and those with complex care needs. Patients were risk assessed using a traffic light system, with red being most at risk and green being in a stable condition. The practice routinely referred patients with dementia to the integrated care therapy service provided by the local council for support.

The practice provided ante and post natal care which was shared with midwives and when needed carried out post natal checks in the mother's home.

Tackling inequity and promoting equality

The practice had a low threshold rate for patients who could have dementia and they found that this enabled patients to be diagnosed quickly in order that treatment could be offered.

The practice was aware of single parent families who were registered with them and made adjustments to appointment times if needed. . There was a touch screen booking in monitor in the reception area for patients to record their arrival for appointments.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months.

The practice had been adapted to meet the needs of patient with disabilities with accessible toilet facilities and baby change facilities. Consulting rooms were situated on the ground floor and first floor. The practice did not have a passenger lift, but when needed patients were seen in the ground floor consulting rooms, if they had mobility needs.

Access to the service

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

Emergency appointments were available each day both within the practice and for home visits. Information for patients about how to access out of hours and urgent treatment was provided in the practice, on the practice website and through their telephone system. The patients we spoke with told us they were able to access urgent treatment if it was required.

A range of appointments were available for patients. A standard appointment time was 15 minutes and 10 minutes for same day appointments. Appointment times included online booking and cancelling of appointments via the computer system. Extended hours appointments were offered early mornings and late evening for those patients with other commitments, such as work or caring responsibilities. Routine appointments were offered Monday to Friday from 9am until 12.15pm and 4pm to 6.15pm. Extended Hours appointments were available Monday evenings after 6.30pm, Tuesday mornings from 7.30am and Wednesday evenings after 6.30pm. Mobile telephone texts reminding patients of their appointment times were sent if requested.

Reception staff had a list of conditions which needed to be seen by the duty GP, when patients telephoned for same day appointments, for example mental health concerns and abdominal pain. Staff would make same day appointments with the triage nurse for children, respiratory problems and asthma. The triage nurse and duty GP communicated with each other throughout their appointment sessions, to make sure patients received suitable treatment. Both the triage nurse and duty GP had emergency appointment slots available at each session, if they needed to ask a patient to attend the practice following an initial telephone call. The triage nurse was available mornings and afternoons and the duty GP in the mornings only.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns and complaints

The practice has a system in place for handling complaints and concerns. Its 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. During the past year the practice had received a total of three complaints.

We found that each concern had been investigated and a response provided to the complainant. Information on how to make a complaint or comment was available in the practice and on its website.

At the time of our inspection only written complaints were recorded. The practice manager said that they dealt with verbal complaints, but did not routinely record them to identify whether there were reoccurring themes.

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 gave a presentation at the start of our inspection and stated that their vision and values were to provide patient centred care and they were proud of the fact that many generations of a family were registered with the practice. A GP told us about their responsibility as a senior partner to role model expected behaviour and to share values with other staff. They considered the practice to be traditional in its approach, but forward thinking and emphasis on patient centred care and continuity of care.

The practice showed us a copy of their development plan for 2014/15. We found this set out information on the practice population groups and factors affecting healthcare needs, such as a high number of young families within the area. Priority areas identified for action included suitable skill mix, and use of locum GP, alongside an increase in GP hours available. All of the priority areas for 2014/15 had been achieved and the plan covered the aspirations of the practice for 2015/16 which included continuing with on going refurbishment of the premises and further clinical training. The development plan was shared with staff and owned by the GP team.

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 a GP lead for safeguarding. All staff members were clear about their roles and responsibilities. They all said they felt valued, well supported and knew who to go to in the practice with any concerns.

There were suitable systems in place to manage risks associated with health and safety. For example, a fire risk assessment and risk assessments for moving and handling. These were reviewed and changes made when needed to minimise risk.

There was a named Caldicott lead, who was responsible for ensuring information, was shared appropriately and not kept for longer than needed. Staff were aware of the need to protect patients' information and maintain confidentiality. There were systems in place to dispose of confidential waste and computer systems were password protected. GPs said that their rooms were locked when not in use.

Leadership, openness and transparency

Staff told us they found the leadership at the practice was visible and accessible. They told us that there was an open culture which encouraged the sharing of information and learning. All the staff we spoke with told us they felt valued and listened to.

A GP considered the practice was efficient and said that having 15 minute routine appointments helped them to manage their workload. This gave them time to manage their workload and develop a positive GP/patient relationship.

Administration and reception staff found that they could communicate easily with other teams such as GPs and nurses. They said that managers were accessible and were able to go to GPs with any concerns. We found that support had been given to reception staff to assist in situations where they were subject to inappropriate behaviours by patients, such as verbal abuse.

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

The practice had gathered feedback from patients through: patient surveys, comment cards and complaints received. The practice had an active patient participation group (PPG) and we met with a member of the group. They said that they were continuing to campaign for new members of the group, but were fortunate that all age groups were represented in the current group.

The PPG produced a report in March 2014 which had priority areas for action agreed with the practice. These included monitoring of waiting times, online access for patients and refurbishments to the practice premises and equipment. At the time of our inspection improvements had been made to chairs in the upstairs waiting room, which had been replaced with ones that could be cleaned easily. Online access for patients was also available to book appointments and request repeat prescriptions.

The PPG met three times a year and monitored their action plan. The member of the PPG said that the annual survey was written by the group for patients and agreed with the GPs. They considered the practice listen to and acted on suggestions made. GPs regularly attended the PPG meetings and on occasion reception staff had attended to discuss telephone access. As a result of receptionists attending another telephone line was installed and staff

Are services well-led?

Good

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

employed to take calls. The PPG said there had been an improvement in the times patients waited to get through when they telephoned the practice. The PPG was involved with the city wide PPGs to share ideas.

The practice gathered feedback from staff through staff meetings, appraisals and discussions. Staff said they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff said they felt engaged and involved in the practice to improve outcomes for both staff and patients. They said GPs and the practice manager were responsive and listened to their ideas and took action when needed.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and the appraisal system. We looked at staff files and records and found all staff had received an annual appraisal and learning and development plans were in place.

We noted that relevant information from significant events and complaints was shared with staff at their meetings. The practice held quarterly significant event meetings where all staff would attend to sharing actions and learning needed. Other meetings used for learning and improvement included in quarterly in house education meetings, practice meetings and monthly education meetings. Multidisciplinary nurses meetings were held on a quarterly basis with practice nurses and district nurses.