Enys Road Surgery

Quality Report

5-7 Enys Road,
Eastbourne,
BN21 2DQ
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Website: www.enysroadsurgerysurgery.nhs.uk

Date of inspection visit: 2 December 2014
Date of publication: 23/04/2015

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

Ratings

Overall rating for this service	Good
Are services safe?	Requires improvement
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 of Enys Road Surgery on 2 December 2014. We visited the practice location at 5-7 Enys Road, Eastbourne, BN21 2DQ.

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 required improvement for providing safe services. It was also good for providing services for 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 and people experiencing poor mental health (including people with dementia).

The inspection team spoke with staff and patients and reviewed policies and procedures. The practice understood the needs of the local population and engaged effectively with other services. There was a culture of openness and transparency within the practice and staff told us they felt supported. The practice was committed to providing high quality patient care and patients told us they felt the practice was caring and responsive to their needs.

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

- 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. However, staff had not always received training and guidance in the safeguarding of vulnerable adults.
- There was a culture of continuous learning and improvement within the practice.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- All patients had a named GP and GPs managed their own personalised lists.

Summary of findings

- The practice engaged effectively with other services to ensure continuity of care for patients.

There were also areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- Ensure that all staff are trained in safeguarding of vulnerable adults.
- Ensure staff have appropriate policies and procedures for safeguarding vulnerable adults.
- Ensure criminal record checks are undertaken via the Disclosure and Barring Service for staff trained to provide chaperone services.
- Ensure all remedial works and ongoing monitoring recommendations are implemented in order to reduce the risk of exposure of staff and patients to legionella bacteria.

In addition the provider should:

- Undertake risk assessment of nursing positions not subject to retrospective criminal records checks via the Disclosure and Barring Service.

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?

Requires improvement

The practice is rated as requires improvement 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 generally well managed. However, the practice had identified the risks associated with potential exposure to legionella bacteria which is found in some water systems but had not taken steps to reduce those risks. There were enough staff to keep patients safe. The practice was clean and tidy and appropriate hygiene standards were maintained. Emergency procedures were in place to respond to medical emergencies. In the event of an emergency the practice had policies and procedures in place to help with the continued running of the service. Staff had a good understanding of procedures relating to the safeguarding of children. However, there was no policy to support staff in the safeguarding of vulnerable adults and the majority of staff had not received training in the safeguarding of vulnerable adults. Chaperone training had been undertaken by some reception staff. However, those staff undertaking chaperone duties and nurses recruited by the practice prior to 2013 had not been subject to a criminal records check via the Disclosure and Barring Service. The practice had not undertaken a risk assessment to support this decision.

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 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 appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams to provide patient centred care.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with

Summary of findings

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 witnessed staff interacting with patients in a way that was respectful, friendly and maintained confidentiality. We observed a patient-centred culture. The practice promoted local support groups so that patients could access additional support if required.

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 reported good access to the practice, with continuity of care and urgent appointments available the same day. There was a proactive approach to understanding the needs of different groups of patients. The practice had developed initiatives to support the high number of elderly patients and students in the local population. The practice was well equipped to treat patients and meet their needs, although the practice premises and a complex layout presented some challenges to staff and patients. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and patients.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt well supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted upon. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.There was an open culture and staff knew and understood the lines of responsibility and accountability to report incidents or concerns.

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 patients. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice provided support to high numbers of older patients in the local population. The practice offered proactive, personalised care to meet the needs of the older people in its population. It was responsive to the needs of older people and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver 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 living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice provided regular services to students within the local university. The practice provided Chlamydia testing kits and

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participated in the C card scheme to support patients' sexual health. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless patients, those who were housebound and those with a learning disability. Annual health checks were provided for patients with a learning disability. The practice offered longer appointments for patients with learning disabilities.

The practice worked closely with district nurses and the community matron which enabled an improved continuity of care for their housebound patients. The practice had identified those housebound patients who had not recently engaged with the practice in order to improve the level of care provided to this vulnerable group. Protected time had been made available to enable practice nurses to provide home visits to these patients. The practice regularly worked with multi-disciplinary teams in the case management of adults and children who were vulnerable. The practice had sign-posted these patients to various support groups and voluntary sector 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 and out of hours. However, many staff had not received training in the safeguarding of vulnerable adults.

People experiencing poor mental health (including people with dementia)

Good

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

Summary of findings

What people who use the service say

Patients told us they were satisfied overall with the practice. Comments cards had been left by the Care Quality Commission (CQC) before the inspection to enable patients to record their views on the practice. We received 23 comment cards all of which contained positive comments about the practice. We also spoke with three patients on the day of the inspection.

The comments we reviewed were overwhelmingly positive and described the professional, friendly service received by patients. One of the comment cards described the excellent care received in managing a long term condition. Two of the comment cards commented on the late running of some clinics but this was not reflected in other comments we received. All of the patients we spoke with on the day of inspection told us that all staff were helpful, caring and professional. They told us they felt listened to and well supported.

We reviewed recent GP national survey data available for the practice on patient satisfaction. The survey showed that 92% of respondents described the overall experience of the practice as good, compared with a national average of 85%. The survey found that 86% of patients said the last nurse they saw was good at involving them in decisions about their care, compared with a national average of 85%. Over 89% of patients found it easy to get through to the practice on the phone, compared with a national average of 75%.

The practice provided us with a copy of their own practice patient survey results from 2014. Responses were received from 263 patients. The findings indicated that 79% of patients had reported being fully satisfied with the services provided by the practice.

Areas for improvement

Action the service MUST take to improve

- Ensure that all staff are trained in safeguarding of vulnerable adults.
- Ensure staff have appropriate policies and procedures for safeguarding vulnerable adults.
- Ensure criminal record checks are undertaken via the Disclosure and Barring Service for staff trained to provide chaperone services.
- Ensure all remedial works and ongoing monitoring recommendations are implemented in order to reduce the risk of exposure of staff and patients to legionella bacteria.

Action the service SHOULD take to improve

- Undertake risk assessment of nursing positions not subject to retrospective criminal records checks via the Disclosure and Barring Service.

Enys Road Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector. The team included a GP Specialist Advisor.

Background to Enys Road Surgery

Enys Road Surgery provides primary medical services to just over 8,400 registered patients. The practice delivers services to a higher number of patients who are aged 65 years and over, when compared with the local clinical commissioning group (CCG) and England average. Care is provided to over 400 patients living in residential and nursing home facilities. The practice also provides services to students within the local university. Data available to the Care Quality Commission (CQC) shows the number of registered patients suffering income deprivation is similar to the national average.

Care and treatment is delivered by six GP partners. Five of the GP partners are female and one is male. The practice employs a team of three practice nurses and two healthcare assistants. GPs and nurses are supported by the practice manager and a team of reception and administration staff. The practice has not been subject to a previous inspection.

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 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.

Services are provided from:

5-7 Enys Road, Eastbourne, BN21 2DQ

The practice has opted out of providing out of hours services to its own patients and uses the services of a local out of hours service.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was 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.

How we carried out this inspection

Before visiting the practice we reviewed a range of information we hold. We also received information from local organisations such as NHS England, Health watch and the NHS Eastbourne, Hailsham and Seaford Clinical Commissioning Group (CCG). We carried out an announced visit on 2 December 2014. During our visit we spoke with a range of staff, including GPs, practice nurses and administration staff.

Detailed findings

We observed staff and patient interaction and spoke with three patients. We reviewed policies, procedures and operational records such as risk assessments and audits. We reviewed 23 comment cards completed by patients, who shared their views and experiences of the service, in the two weeks prior to our visit.

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

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

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

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

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

Requires improvement

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 to were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

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 and we were able to review these. Significant events were discussed at monthly meetings. 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.

Records of significant events and complaints were completed in a comprehensive and timely manner. Evidence of action taken as a result was shown to us. For example, one complaint had resulted from an error in medicine administration. The practice had sought advice from a specialist centre and shared the learning with the patient's family and the staff team. Nurses were supported in accessing additional training as a result of the incident.

National patient safety alerts were disseminated to practice staff. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. They also told us alerts were discussed at monthly clinical meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. A designated GP partner was the practice lead for safeguarding children and for safeguarding of vulnerable adults. The GP partners had undertaken training at a level appropriate to their role. However, other staff within the practice, including some nursing staff, told us they had not received training in the safeguarding of vulnerable adults. All staff within the practice had undertaken training in the safeguarding of children.

The practice had a policy to support the safeguarding of children but did not have a policy in relation to safeguarding vulnerable adults. However, we noted that contact details for local authority adult and child safeguarding teams were easily accessible within the practice. Without policies and procedures for staff to refer to there was a risk that staff may be unaware how to share information or properly record documentation of adult safeguarding concerns.

We spoke with GPs, nurses, healthcare assistants, reception and administration staff about safeguarding. They were able to demonstrate they had the knowledge to enable them to identify concerns, despite not undergoing training. All of the staff we spoke with knew who the practice safeguarding lead was and who to speak to if they had a safeguarding concern. Some staff were able to give examples of safeguarding alerts which had been raised within the practice.

The practice had a chaperone policy. A chaperone is a person who can offer support to a patient who may require an intimate examination. The practice policy set out the arrangements for those patients who wished to have a member of staff present during clinical examinations or treatment. All nursing staff, including health care assistants, could be asked to be a chaperone. We were told that some reception staff had also been trained to undertake chaperone duties. However those staff had not been subject to a criminal records check via the Disclosure and Barring Service and the practice had not undertaken a risk assessment to support this decision.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators. We found they were stored securely and were only accessible to authorised staff. There was a clear process for ensuring medicines were kept at the

required temperatures. We reviewed records to confirm this. The correct process was understood and followed by the practice staff and they were aware of the action to take in the event of a potential power failure.

The practice had processes to check medicines were within their expiry date and suitable for use. All the medicines we checked at the time of inspection were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

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

The practice implemented a comprehensive protocol for repeat prescribing which was in line with national guidance. The protocol complied with the legal framework and covered all required areas. For example, how staff who generate prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary. Reviews were undertaken for patients on repeat medicines. 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 and kept securely at all times.

The practice had identified a lead GP for medicines management. The practice prescribing lead worked closely in conjunction with the local Clinical Commissioning Group (CCG) and the practice participated in prescribing audits and reviews.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and that 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.

Hand washing notices were displayed in all consulting and treatment rooms. Hand wash solution, hand sanitizer and paper towels were available in each room. Disposable gloves were available to help protect staff and patients from the risk of cross infection.

The practice had a lead nurse for infection control who had received training to enable them to provide advice on the practice infection control policy and to carry out staff training. The lead had recently provided an infection control update for staff within the practice.

The practice had carried out a comprehensive audit of all infection control processes in February 2014. We saw that an infection control action plan had been developed as a result of this audit. Many of the required actions identified within the audit had been completed. All completed actions and reviews had been clearly recorded. Outstanding actions had been assigned to a team member with responsibility for the action.

We saw that the practice had arrangements in place for the segregation of clinical waste at the point of generation. Colour coded bags were in use to ensure the safe management of healthcare waste. An external waste management company provided waste collection services. Sharps containers were available in all consulting rooms and treatment rooms, for the safe disposal of sharp items, such as used needles.

The practice had identified the risks associated with potential exposure to legionella bacteria which is found in some water systems but had not taken steps to reduce those risks. A legionella risk assessment had been undertaken by an external organisation. However, the practice manager told us that the required actions resulting from the findings of the risk assessment had not yet been responded to. For example, we saw that the risk assessment identified several areas requiring action, such as chlorination of the cold water tanks and regular temperature and water sample testing. Required remedial works to rectify those findings had not yet been planned by the practice.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. A schedule of testing was recorded. We saw evidence of calibration of relevant equipment which had been carried out in February 2014. For example, digital

blood pressure machines and weighing scales. Portable electrical equipment was routinely tested and we saw evidence that this had last been carried out in February 2014.

Records showed essential maintenance was carried out on the main systems of the practice. For example the boilers and fire alarm systems were serviced in accordance with manufacturers' instructions.

Staffing and recruitment

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

We examined the personnel records of six members of staff and found that appropriate recruitment checks had been undertaken prior to employment. The practice manager told us that current recruitment procedures for nurses ensured that a criminal records check was obtained via the Disclosure and Barring Service. We reviewed the personnel records of a nurse recruited in 2013 and noted that a criminal records check had been obtained. However other nurses employed prior to 2013 had not been subject to a criminal records check and the practice had not undertaken a risk assessment to support this decision.

Monitoring safety and responding to risk

We observed the practice environment was organised and tidy. However, the practice was located within premises with a complex layout, with a number of small waiting areas and consultation rooms on different levels. Stair lifts were available to support patients in accessing first floor waiting areas and consultation rooms. An alert on the practice's computer software system ensured staff were aware of patients who always needed to be seen in a ground floor consulting room.

The practice had considered some of the risks of delivering services to patients and staff and had implemented some systems to reduce risks. The practice had employed the services of an external advisor to conduct a health and safety risk assessment and provide advice and appropriate tools to ensure the ongoing assessment and monitoring of risks within the practice. We reviewed the risk assessments in place. These included assessment of risks associated with fire safety arrangements and staff work stations. Safety equipment such as fire extinguishers and emergency oxygen were checked and sited appropriately.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For patients with long term conditions and those with complex needs there were processes to ensure these patients were seen in a timely manner. Staff told us that these patients could be urgently referred to a GP and offered double appointments when necessary.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that 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 and records confirmed that it was checked regularly. The practice computer system included a panic button feature which staff were able to use in an emergency.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. 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. Risks identified included power failure, adverse weather, unplanned sickness and access to the building.

Records showed that fire alarms were routinely tested. The practice had very recently carried out a full evacuation of the premises.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff were familiar with current best practice guidance, accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

GPs within the practice held lead roles in specialist clinical areas such as diabetes, chronic obstructive pulmonary disorder, mental health and asthma. The practice nurses supported this work which allowed the practice to focus on specific conditions. A practice nurse told us how the practice ensured they had identified an external clinical advisor for many of the long term conditions they routinely managed. For example, the practice had strong links with a specialist diabetic nurse at a local diabetes centre in order to provide optimum care for diabetic patients. The nurses also worked closely with a specialist tissue viability nurse in order to ensure the appropriate management of patients with venous leg ulcers.

Nurses described a culture of continuous learning and improvement with regular clinical meetings attended by the GPs and nurses. External speakers were regularly invited to those meetings in order to support regular updating of knowledge of the GPs and nurses. For example, the practice had recently invited a speaker in to review new information relating to the medicines management of chronic obstructive pulmonary disease (COPD). On another occasion the team was visited by a clinical psychologist who provided support services to the large number of students registered with the practice.

National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. GPs used national standards and best practice for all referrals to secondary care. For example, patients requiring a referral into secondary care with suspected cancers were referred and seen within two weeks.

The practice ensured that patients had their needs assessed and care planned in accordance with best practice. We saw that patients received appropriate treatment and regular review of their condition. Patients with palliative care needs were supported using the Gold Standards Framework. The practice used computerised tools to identify and review registers of patients with complex needs. For example, patients with learning disabilities or those with long term conditions.

The practice was providing enhanced services to identify those patients most at risk of unplanned hospital admissions. Nurses were providing home visits to patients in order to provide appropriate support and manage and unmet healthcare needs.

GPs and nurses were clear about how they would apply the Mental Capacity Act 2005 (MCA) and how they would assess mental capacity. Patients who were either unable or found it difficult to make an informed decision about their care could be supported appropriately.

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input and quality, clinical review scheduling, long term condition management and medicines management. The information staff collected was used to determine clinical audits.

The practice had systems in place for completing clinical audit cycles. 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 review of the prescribing of medicines for patients with asthma and chronic obstructive pulmonary disease (COPD) and patients' response to treatment. Examples of other clinical audits undertaken included the review of patients receiving blood thinning medicines and an audit review of patients referred for physiotherapy treatment.

The practice achieved 98.46% of the maximum Quality and Outcomes Framework (QOF) results 2012/13. The practice also used the information they collected for the QOF and

Good

Are services effective?

(for example, treatment is effective)

their performance against national screening programmes to monitor outcomes for patients. QOF data showed the practice performed well in comparison to the regional and national average. For example, the number of patients with diabetes who had received an influenza immunisation was recorded as 95.4%, with the national average being 90%. The practice was not an outlier for any QOF clinical targets.

The GPs we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved. Regular clinical and educational meetings provided GPs and nurses with the opportunity to regularly review outcomes, new guidance and alerts and for the dissemination of information. The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. Staff spoke positively about the culture in the practice around education, audit and quality improvement.

Effective staffing

Practice staffing included GPs, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff were mainly up to date with attending mandatory training courses. However, most nursing and administration staff had not received training in adult safeguarding procedures.

A good skill mix was noted amongst the GPs. The practice had identified GPs to undertake lead roles in clinical areas such as palliative care, diabetes and mental health. All GPs were up to date with their yearly continuing professional development requirements and had either been revalidated or had a date for revalidation. (Every GP is appraised annually and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

Staff we spoke with told us they had participated in regular appraisals which gave them the opportunity to discuss their performance and to identify future training needs. Personnel files we examined confirmed this. A practice nurse told us they last had an appraisal with a GP partner and the practice manager in July 2014. This had included a detailed review of performance and the setting of objectives and learning needs. We saw evidence which confirmed this.

Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses. We spoke with the lead nurse who told us the practice supported education and ongoing professional development. The nursing team were able to attend additional training in specialist areas such as spirometry, cervical screening and immunisations. Those nurses with extended roles had undertaken advanced training in the management of conditions such as chronic obstructive pulmonary disease, asthma and diabetes. We spoke to a healthcare assistant who told us they felt well supported in their role and had been provided with relevant training. The healthcare assistant had been supported by the practice in completing a Level 3 National Vocational Qualification (NVQ) in Care.

Working with colleagues and other services

The practice worked with other service providers to meet patient needs and manage complex cases. The practice effectively identified patients who needed ongoing support and helped them plan their care.

For example, the practice demonstrated they had developed effective working relationships with a large number of local residential and nursing care homes. A named GP carried out weekly visits to one of the homes to conduct ward rounds. Other care homes were visited by request to see individual patients. Care plans were in place for those patients with complex needs. Practice nurses also made visits to many of the care homes to provide flu vaccinations to patients and monitor any unmet healthcare needs. Nurses reported the strong relationships they had developed with the homes as a result of these visits. The practice had been working collaboratively with other local practices to review the most effective way of providing care to patients within such a large number of homes, whilst ensuring they maintained patient choice.

Blood results, X ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received both electronically and by post. All relevant staff were clear on their responsibilities for passing on, reading and acting upon any issues arising from communications with other care providers on the day they were received. The GP seeing these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system worked well. The practice had a policy for communicating with the out of hours service via a system of special notes.

Good

Are services effective?

(for example, treatment is effective)

The practice held regular multidisciplinary team meetings to discuss patients with complex needs. For example, those patients requiring end of life care or those with a cancer diagnosis. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record.

GPs in the practice worked closely with the mental health team to refer patients for counselling or cognitive behavioural therapy.

The practice supported a register of 50 patients with a learning disability. A designated anaesthetist provided support to the practice to coordinate care for this group of patients at times when they may require hospitalisation. For example, the anaesthetist could be requested to take blood for routine testing at the same time as administering an anaesthetic to a patient.

Information sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patient care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

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

Consent to care and treatment

The GPs we spoke with told us they always sought consent from patients before proceeding with treatment. GPs told us they would provide patients with information on specific conditions to assist them in understanding their treatment and condition before consenting to treatment. Patients consented for specific interventions for example, minor surgical procedures, by signing a consent form. Patient's verbal consent was also documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure discussed with the patient.

Patients with more complex needs, for example dementia or long term conditions, were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions.

Health promotion and prevention

It was practice policy to offer a health check with the healthcare assistant 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. GPs we spoke with told us that regular health checks were offered to those patients with long term conditions and those experiencing mental health concerns. We also noted that medical reviews took place at appropriately timed intervals.

The practice had ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities, for whom they carried out annual health checks.

We noted a culture amongst the GPs and nurses of using their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering smoking cessation advice to smokers. Young patients' sexual health was well supported by the practice. Chlamydia testing kits were available to patients within the practice. The practice also participated in the C Card scheme which enabled card carriers under the age of 25 years to access free of charge contraception and relevant advice. Members of the practice nursing team had received training in the support of patients participating in the C Card scheme.

The practice offered a full range of immunisations for children, travel vaccines, flu, pneumococcal and shingles vaccinations in line with current national guidance. We reviewed our data and noted that 98% of children aged up to 24 months had received their mumps, measles and rubella vaccination, compared with a regional average of

Good

Are services effective?

(for example, treatment is effective)

93.8%. Data we reviewed showed that 95% of patients with diabetes had a flu vaccination within the six month period between September and March. This was higher than the national average of 90%.

We noted that a wide range of health promotion information was available in leaflets in the waiting rooms and on the practice website. Such information was also given to patients during consultations and clinics. The practice had developed an extensive child health and wellbeing notice board to provide information for parents and carers.

Patients were enabled to monitor their own weight, height and blood pressure in a designated area adjacent to the main reception. Patients could use these facilities independently or by seeking assistance from a member of the staff team.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients completed CQC comment cards to tell us what they thought about the practice. We received 23 completed cards and all were positive about the service experienced. Patients said they felt the practice offered a caring service and staff were efficient, helpful and took the time to listen to them. They said staff treated them with dignity and respect. We also spoke with three patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. One patient told us how well supported they had been in managing their long term condition.

We reviewed GP national survey data available for the practice on patient satisfaction. The evidence from the survey showed patients were satisfied with how they were treated and this was with compassion, dignity and respect. Data from the national patient survey showed that 92% of patients rated their overall experience of the practice as good. The practice was also above average for its satisfaction scores on consultations with doctors and nurses, with 91% of practice respondents saying the GP was good at treating them with care and concern. We also noted that 92% of patients had responded that the nurse was good at treating them with care and concern.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff were careful to follow the practice's confidentiality policy when discussing patient treatment in order that confidential information was kept private. The main reception area and waiting room were combined but patients were requested to wait before coming forward to the reception desk. We noted that music was played in the waiting area to ensure that conversations at the front desk could not be overheard. Some telephone calls were taken away from the reception desk so staff could not be overheard. Staff were able to give us practical ways in which they helped to ensure patient confidentiality. This included not having patient information on view, asking patients if they wished to discuss private matters away from the reception desk.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 84% of practice respondents said the GP involved them in care decisions and 86% felt the nurse was good at involving them in decisions about their care.

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

Staff told us that translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

The results of the national GP survey showed that 91% of patients said the last GP they saw or spoke to was good at treating them with care and concern and that 92% of patients said the nurses were also good at treating them with care and concern. Patients we spoke with on the day of our inspection and some of the comment cards we received gave examples of where patients had been supported.

The practice held a register of patients who were carers and new carers were encouraged to register with the practice. The practice computer system then alerted GPs and nurses if a patient was also a carer. We saw written information was available for carers to ensure they understood the various avenues of support available to them. Notices in the patient waiting room and patient website signposted patients to a number of support groups and organisations.

Good

Are services caring?

The practice had developed a carer's resource display within the waiting area which provided extensive information to support patients and their carers to access support groups.

The practice had developed a close working relationship with Care for the Carers, an independent charity providing support to carers in the local area. The practice had also accessed funding from the Royal College of GPs to provide carers clinics within the practice in order to provide additional support to carers.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, the practice provided care and support to over 400 patients within 63 nursing and residential homes in the area. These included one home providing care for patients with advanced dementia and another providing sheltered accommodation for older patients. The practice carried out a weekly ward round in one of the homes and provided individual visits to patients in the other homes at their request. Practice nurses also made visits to many of the care homes to provide flu vaccinations to patients and monitor any unmet healthcare needs. Nurses reported the strong relationships they had developed with the homes as a result of these visits. The practice had been working collaboratively with other local practices to review the most effective way of providing care to patients within such a large number of homes, whilst ensuring they maintained patient choice.

The practice also worked closely with the local university in providing care for students. The practice provided services to approximately 1500 university students and held four clinics per week from the university campus. Students were able to book appointments to be seen either within the practice or within a clinic held on campus. The practice worked in close conjunction with the university nurse who had recently provided a talk to practice staff on the services and clinics available to the students.

Young patients' sexual health was well supported. Chlamydia testing kits were available to patients within the practice. The practice also participated in the C Card scheme which enabled card carriers under the age of 25 years to access free of charge contraception and relevant advice. Members of the practice nursing team had received training in the support of patients participating in the C Card scheme.

The practice supported patients with either complex needs or who were at risk of hospital admission. The practice had been working to identify those housebound patients who had not recently engaged with the practice in order to improve the level of care provided to this vulnerable group and reduce the rate of unplanned hospital admissions. Protected time had been made available to enable practice nurses to provide home visits to these patients. Personalised care plans were produced and were used to support patients to remain healthy and in their own homes. The practice worked collaboratively with other agencies and regularly shared information to ensure good, timely communication of changes in care and treatment. The practice held multidisciplinary team meetings monthly to discuss the needs of complex patients, for example those with end of life care needs. The practice invited representatives from social services, mental health, district nursing, the community matron and local hospice teams.

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

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from patients and through the patient participation group (PPG). For example, the practice had reviewed the distribution of appointments and how improvements could be made. They planned to provide extended hours telephone consultations for patients from January 2015.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The number of patients with a first language other than English was low. However, staff knew how to access language translation services if these were required.

Staff within the practice were able to give examples of how they supported individual patient needs in order to promote equality. For example, the practice staff had identified a support organisation to provide assistance to deaf patients when attending their appointments. The practice also made use of a hearing loop to support patients who were hard of hearing. Text messaging rather than the telephone was used for basic communications with these patients. Alerts highlighted on the practice computer software system ensured staff were aware when hard of hearing or visually impaired patients were attending the practice and required additional assistance.

Patients were able to enter the practice via a sloping pathway. The practice was located within premises with a

Good

Are services responsive to people's needs?

(for example, to feedback?)

complex layout, with a number of small waiting areas and consultation rooms on different levels. The practice was accessed via a manual opening door which made entry to the practice difficult for patients with wheelchairs and prams. Although space was limited, the reception and waiting areas were large enough to accommodate wheelchair users and prams and allowed for access to the treatment and consultation rooms on the ground floor. Stair lifts were available to support patients in accessing first floor waiting areas and consultation rooms. Patients who were unable to access upper floor facilities were able to be seen in ground floor consulting rooms. Accessible toilet facilities and baby changing facilities were available for all patients attending the practice.

Access to the service

The practice was open from 8.30am to 6.00pm on weekdays. Telephone lines were open daily from 8am to 6.30pm. The practice operated a flexible appointment system to ensure all patients who needed to be seen the same day were accommodated.

Appointments were available in a variety of formats including pre-bookable appointments, urgent same-day appointments and telephone consultations. The practice also offered a daily drop-in clinic each afternoon. Routine appointments could be booked up to 12 weeks ahead. Patients could book appointments and organise repeat prescriptions via the practice website. Patients could also make appointments by telephone, speaking to a member of the practice team or using the automated appointment booking service available and in person, to ensure they were able to access the practice at times and in ways that were convenient to them.

Patients we spoke with and those who provided feedback on the comment cards we received reported being generally satisfied with the appointment system. The practice planned to make improvements to appointment access by offering telephone consultations within extended hours from January 2015.

There were also arrangements to ensure patients received urgent medical assistance when the practice was closed at weekends, after 6:30pm Monday to Friday and on bank holidays. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out of hours service was provided to patients on the practice website and in appointment information advertised in the practice.

Listening and learning from concerns and complaints

The practice had 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. The practice manager handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system on the practice website. Information was available within the practice to describe the process should a patient wish to make a suggestion or complaint. Comment boxes were available to patients within the practice waiting areas. Reception staff were able to clearly describe the process they would follow if a patient raised a complaint directly with them. Patients we spoke with were aware of the process to follow should they wish to make a complaint. One of the patients we spoke with had raised a complaint with the practice several years previously and had received a satisfactory response.

We reviewed the practice complaints log. We found there had been 13 complaints within the last 12 months. The practice had investigated all the complaints and implemented appropriate actions. Learning points had been discussed at staff meetings, ensuring information was disseminated to all members of the team and recorded fully.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. All the staff we spoke with told us there was a 'no blame culture' in the practice and they felt that senior staff members were always available to talk with. We found details of the patient charter on the practice website.

The practice's statement of purpose outlined its' aims and objectives which included providing the highest standard of medical services available under the NHS; ensuring that patients are seen by the most appropriate healthcare professional as quickly as possible; focusing on prevention of disease by promoting good health and prophylactic medicine and understanding and meeting the needs of patients, involving them in decisions about their care and encouraging them to participate fully.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff. All policies and procedures we looked at had been reviewed annually and were up to date.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with or above national standards.

A series of regular meetings took place within the practice which enabled staff to keep up to date with practice developments and facilitated communication between the GPs and the staff team.

These included weekly and monthly GP partner meetings, clinical review meetings with GP's, nurses and healthcare assistants and regular team meetings which included administration and reception staff. We looked at minutes from the most recent meetings and found that performance, quality and risks had been discussed. Significant events and complaints were shared with the practice team to ensure they learned from them and received advice on how to avoid similar incidents in the future. Meetings enabled staff to keep up to date with practice developments and facilitated communication between the GPs and the staff team.

The practice had systems in place for completing clinical audit cycles. 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). For example, we saw an audit review of the prescribing of medicines for patients with asthma and chronic obstructive pulmonary disease (COPD) and patients' response to treatment. Examples of other clinical audits undertaken included the review of patients receiving blood thinning medicines and an audit review of patients referred for physiotherapy treatment.

The practice had considered some of the risks of delivering services to patients and staff and had implemented some systems to reduce risks. The practice had employed the services of an external advisor to conduct a health and safety risk assessment and provide advice and appropriate tools to ensure the ongoing assessment and monitoring of risks within the practice. We reviewed the risk assessments in place. These included assessment of risks associated with fire safety arrangements and staff work stations.

Leadership, openness and transparency

GPs and staff told us about the clear leadership structure and which members of staff held lead roles. For example, there was a lead nurse for infection control and one GP partner was the lead for safeguarding. We spoke with 11 members of staff and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

We saw evidence that the practice held regular clinical team meetings, staff meetings and partners meetings. We saw that information was shared between the different meetings to ensure that all staff were fully updated. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. Administration and reception staff told us that they also met within their teams. All of the staff we spoke with reported that communication was good in the practice and they were always made aware of new developments and changes.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies to support and guide staff. These were reviewed regularly and up to date. Staff we spoke with knew where to find these policies if required.

Are services well-led?

Good

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

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

The practice had gathered feedback from patients via a patient survey which had last been conducted in March 2014 and via comments and complaints received. The practice had a small patient participation group (PPG) which met regularly. The PPG had distributed the survey questionnaires to patients within the practice over a 2 week period. The survey had also been available to patients on the practice website and to students at the university health centre.

The practice had responded to patient feedback and had reviewed ways in which it shared information with patients about the appointments system. A review of the distribution and availability of appointments had been carried out and the practice had introduced a newsletter to improve communication with patients. The practice also planned to provide extended hours telephone consultations for patients from January 2015.

The practice gathered feedback from staff through informal discussions and via team meetings. Staff told us they felt able to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged within the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff. Staff we spoke with were aware of the policy and how they could whistleblow internally and externally to other organisations.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We spoke with 11 staff and they confirmed they participated in regular appraisals which identified their training and personal development needs. Staff told us that the practice was very supportive of training and education.

Nursing staff reported that training was available in order for them to maintain and update their skills and they were well supported to attend training events. The practice had appointed a lead nurse who provided developmental support to the nurse team.

The practice had completed reviews of significant events and other incidents. These were shared with staff via meetings to ensure the practice improved outcomes for patients. For example, one complaint had resulted from an error in medicine administration. The practice had sought advice from a specialist centre and shared the learning with the patient's family and the staff team. Nurses were supported in accessing additional training as a result of the incident.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that the registered provider did not ensure that effective systems were in place to assess the risk of, and to ensure that patients and staff were protected against the risk of, infection from legionella bacteria which is found in some water systems. This was in breach of regulation 12 (1) (a) (b) (c) (2) (a) (c) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (1) (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing We found that the registered provider did not ensure that persons employed for the purposes of carrying out the regulated activity received appropriate training. This was in breach of regulation 23 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

We found that the registered provider did not ensure that service users were protected against the risks of unsafe or inappropriate care and treatment due to a lack of records and policies relating to the management of the regulated activity.

This was in breach of regulation 20 (1) (b) (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 (2) (d) (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed We found that the registered provider did not ensure that information specified in Schedule 3 was available in respect of a person employed for the purposes of carrying out the regulated activity, and such other information as appropriate. This was in breach of regulation 21 (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 (3) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.