Dr Nixon and Partners

Quality Report

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

Summary of findings

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Summary of findings

Overall summary

Shipston Medical Centre provides primary care services for patients in Shipston-on-Stour and the surrounding area. It also provides GP cover to the nearby Ellen Badger Hospital.

All the patients we spoke with were highly complimentary about the service they received. We saw the results of a patient survey that showed patients were consistently pleased with the service they received.

Appropriate systems were in place to ensure patients were kept safe.

The provider regularly met with the local clinical commissioning group (CCG) to discuss service performance and improvement issues. The provider worked in partnership with the CCG and other local health teams and was proactive in responding to people's needs.

The leadership team were highly visible to all staff and had an 'open door' policy. Staff found them very approachable. The practice had appropriate governance and risk management measures in place.

We inspected the following regulated activities; treatment of disease, disorder and injury; surgical procedures; maternity and midwifery services; family planning and diagnostic and screening procedures.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The service was safe. The provider had appropriate safeguarding procedures in place. Staff were familiar with the procedures and knew who the safeguarding lead was. For child protection the practice used the Inter Agency Child Protection Procedures produced and monitored by Warwickshire County Council. All staff were checked through the Disclosure and Barring Service (DBS) before being allowed to work on their own with patients. Patients could be confident that the practice took their safety seriously. We saw evidence the provider learnt from incidents and medical emergencies. Appropriate risk assessments were in place.

Are services effective?

The service was effective. Care and treatment was being delivered in line with current published best practice. Treatment plans were based on guidance issued by the National Institute for Care and Health Excellence (NICE). Patients' needs were consistently met in a timely manner. The provider had appropriate systems in place to assess the performance of its doctors and administrative staff. Patients received care that would meet their individual needs and the provider was engaged with health promotion activities within the local community.

Are services caring?

The service was caring. All the patients we spoke with during our inspection were highly complementary about the service. The provider's own patient surveys produced consistently positive results. The provider's induction and training programmes emphasised the need for a patient centred approach to care. This was evident throughout our inspection. Patients could expect to be treated with compassion and respect. Patients who were bereaved were signposted to appropriate services if they required support.

Are services responsive to people's needs?

The service was responsive to people's needs. There was a culture of openness throughout the organisation and a clear complaints policy. The provider acted on patients' suggestions for improving the service. The provider had an active Patient Participation Group (PPG) which was involved with decision making. The provider participated actively in discussions with the Clinical Commissioning Group (CCG) about how to improve services for patients in the area.

Summary of findings

The provider was aware of patients' individual needs and of the needs of the wider community they were situated in. All the patients we spoke with were happy with the access to appointments and had not experienced delays.	
Are services well-led? The service was well led. There was a strong and highly visible leadership team with a clear vision and purpose. Governance structures were robust and there were appropriate systems in place for managing risks. This gave a firm foundation to all aspects of the practice's work.	

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
The provider tailored each patient's care to their individual needs and circumstances. The provider regularly reviewed the care provided and included family members and carers when appropriate. Planned and unplanned hospital admissions were reviewed and actions taken when necessary. The GPs covered the nearby Ellen Badger Hospital and provided care for people living in a nearby care home. We saw compliments received from the care home regarding the quality of the service provided.

People with long-term conditions
The provider regularly reviewed patients with long term conditions. The provider's care plans had a multi-disciplinary approach and retained oversight of the care provided. Unplanned hospital admissions for older people were reviewed and actions taken when necessary. The provider ran community focus groups for people with a range of long term health conditions, for example, asthma and diabetes.

Mothers, babies, children and young people
The provider used the community midwife service and worked with local health visitors to offer a full health surveillance programme for children aged under five. The practice made checks to ensure the maximum uptake of childhood immunisations. Health awareness sessions were carried out with a health visitor at a local children's centre.

The working-age population and those recently retired
The provider ran a weekly 'commuter clinic' for patients who were at work during the day. Patients could also make appointments for telephone consultations.

People in vulnerable circumstances who may have poor access to primary care
The practice participated in the Warwickshire County Council 'Safe Places' scheme to help keep vulnerable patients safe. Practice staff had made arrangements to enable travellers or other people of no fixed abode to register at the practice. This meant those people were then able to access all NHS services.

Summary of findings

People experiencing poor mental health
The provider worked with community psychiatric nurses and a local psychological therapy service to help ensure that people received the necessary mental health care and support.

Summary of findings

What people who use the service say

All the patients we spoke with during the inspection were highly complementary about the service they received. They told us they were respected and well cared for. People described the staff and doctors as excellent. We also looked at the results of an annual survey that collected the views of patients who used the service. Patients were positive about all aspects of the service they received.

More than 300 patients completed a short questionnaire, issued by the provider, between October and December 2013. This focussed on communication with patients. Of those patients who responded, 96% said the practice was very easy or fairly easy to contact by telephone. This sample represented 3.4% of the patient list.

Good practice

Our inspection team highlighted the following areas of good practice:

- The provider's dispensary had been nominated for a national pharmaceutical industry award for good practice and had been told it will finish within the top three nationally.
- There was a highly visible vision statement which staff fully understood – 'providing personal and continuing care for all'.
- The provider was very active with fundraising in the local community and produced an annual Patient and Community Involvement report to highlight the work within the local community.

Dr Nixon and Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Keith Briant

Background to Dr Nixon and Partners

Dr Nixon and partners provides primary care services for patients in Shipston-on-Stour and the surrounding area at Shipston Medical Centre. The service is responsible for providing primary care for 11,300 patients. The provider is a dispensing practice and also provides medical cover for the ward and minor injuries unit in the nearby Ellen Badger Hospital.

Why we carried out this inspection

We inspected this out-of-hours service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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

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

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problem.

Before visiting, we reviewed a range of information we had received from the out-of-hours service and asked other organisations to share their information about the service.

We carried out an announced visit on 21 May 2014.

During our visit we spoke with a range of staff, including clinical and administrative staff.

We also spoke with patients who used the service. We observed how people were being cared for and reviewed personal care or treatment records of patients.

Are services safe?

Summary of findings

The service was safe. The provider had appropriate safeguarding procedures in place. Staff were very familiar with the procedures and knew who the safeguarding lead was. Child protection policy used the Inter Agency Child Protection Procedures produced and monitored by Warwickshire County Council. All staff were checked through the Disclosure and Barring Service (DBS) before being allowed to work on their own with patients.

Our findings

Safe patient care

The provider had clear incident reporting procedures in place with clearly defined lines of responsibility. We were shown incident reporting forms which showed all incidents were recorded and investigated. Findings were analysed and discussed with the staff concerned and then at clinical and staff meetings as appropriate. Discussions were recorded in the staff meeting minutes. This ensured that there was on-going learning about how the service could improve. We saw the provider made changes as a result of these discussions. Staff were aware of their responsibilities with patient safety and were confident they would be fairly treated if they were to report anything. We were shown records that demonstrated information gained from clinical audits and health and safety audits was assessed with patient safety in mind. Clear procedures were in place to deal with allegations of patient abuse.

Learning from incidents

The provider held a weekly meeting for clinical staff at which all complaints and incidents were discussed.

Key learning points from the analysis of incidents were identified and shared with staff. We were shown minutes of meetings and staff confirmed such discussions took place. We saw evidence that all adverse events were fully recorded before being investigated by the appropriate GP partner.

The provider used a 'serious incident update' form to notify the local Clinical Commissioning Group (CCG) of individual events. The CCG is the NHS body responsible for commissioning local NHS services.

We saw a completed form for a recent event involving a consent issue. The form had been comprehensively filled in with details of the incident, an analysis of events leading up to it and the actions taken by the provider after the event. The local CCG monitored the provider's performance on a monthly basis in relation to the standard and timeliness of significant adverse event reporting.

Safeguarding

The provider had clear safeguarding policies and procedures in place to protect vulnerable patients. They provided guidance and training to all staff during their induction and reviewed this annually. We saw evidence in the training records that such training took place and the

dates refresher training was due to take place. We saw a selection of training certificates which confirmed staff were trained to the appropriate level. Staff we spoke with knew how to recognise different types of abuse and the action they should take if they suspected abuse. Staff were aware who the safeguarding lead was and were familiar with the procedure for referring safeguarding concerns to the local authority. We saw this information was clearly displayed and appropriate action had been taken when needed.

The child protection policy was based on the Inter Agency Child Protection Procedures produced and monitored by Warwickshire County Council. The provider was classified a 'safer place' under the Warwickshire County Council scheme. This was designed to protect vulnerable people and ensure staff had appropriate training. We saw minutes that demonstrated there were regular safeguarding meetings which involved staff from other agencies when appropriate.

Monitoring safety and responding to risk

Staffing levels were continuously monitored to ensure levels of staff present met patient need and minimised risk. We saw evidence of how appointment trends were monitored and staffing levels adjusted to meet changes in demand. This was carried out on a weekly basis. At the time of our visit, the provider had advertised for a permanent salaried GP to replace a partner who was absent long term. This meant delays to patient appointments would be reduced.

Medicines management

The provider had up to date medicines management policies for use within both the dispensary and the practice. Staff we spoke with were familiar with them. Within the dispensary, medicines were kept in a secure store to which only dispensary staff had access. We looked at how controlled drugs were managed. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse. The records showed that the controlled drugs were stored, recorded and checked safely. Chilled medicines were stored at the correct temperature which was monitored daily. We saw evidence that medicines were regularly checked to ensure they were within date.

The provider also had emergency medications for use within the practice which were securely stored and monitored in the same way.

There were standard operating procedures (SOP) for using certain drugs and equipment. We looked at a selection of these and saw each one was in date and clearly marked to ensure that staff knew it was the current version. Clear records were kept whenever any medicines were used. We were shown examples. The records were checked by pharmacy staff who reordered supplies as required. There was a monthly medicines management meeting which discussed and actioned any medicine related issues. We saw minutes of recent meetings.

We noted the pharmacy had been nominated for a national pharmaceutical industry award for good practice and had been told it will finish within the top three nationally.

Cleanliness and infection control

We saw the provider's buildings were clean and organised. Patients we spoke with said they were satisfied with standards of hygiene. There were systems in place to reduce the risk and spread of infection. We observed and staff told us personal protective equipment was readily available and was in date. Patients confirmed staff wore personal protective equipment when needed. Hand sanitation gel was available for staff and patients throughout the practice. We saw staff used this. We saw hand washing posters above each wash hand basin throughout the practice including the patients' toilet.We were shown infection control and decontamination policies. They included the safe use and disposal of sharps; use of personal protective equipment (PPE); spills of blood and bodily fluid amongst others. We were shown evidence that the policies were regularly reviewed and updated when changes were necessary. We were shown the results of the most recent internal infection control audit which had been carried out in February 2014. This did not identify any areas of concern.

We spoke with a practice nurse. They told us they had received infection control training. We saw evidence of this in their staff file. They were also aware of the Department of Health guidance on the prevention and control of infections and knew how to apply it. Staff told us they were aware of the relevant policies and where to find them if they needed to refer to them. This meant that staff had access to guidance for the protection of patients against the risks of infections.There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We saw evidence that their disposal was arranged through a suitable company.

Are services safe?

The provider employed their own cleaners for general cleaning of the practice. We were shown the cleaning schedules and checklists for this and saw there was a regular audit of cleaning undertaken.

Staffing and recruitment

We were shown how the provider ensured there were sufficient numbers of suitably qualified, skilled and experienced staff on duty each day. There was a GP duty rota throughout the week and always a practice nurse on duty. Administrative staff and management had a separate rota. Some job shared, so staff cover was also available if a staff member was unexpectedly absent.

We saw how the provider had monitored their workforce and reviewed their workforce requirements to ensure sufficient staff were available to meet the needs of the population they served. Management confirmed they had sufficient staff on duty throughout the week.

We looked to see what guidance was in place for staff about expected and unexpected changing circumstances in respect of staffing. We saw a selection of policies and procedures in place, for example, staff sickness, and planned absences. We saw how the provider would ensure staff absence was managed in a fair and consistent way to ensure the impact on the practice was minimised.

We saw how if a shortfall of doctors ever occurred, for example, as a result of sickness, locum doctors could be used. We were shown the business continuity plan which had been adopted by the practice which advised what to do should there be 'Incapacity of GPs and practice staff'. This would help to ensure sufficient availability of doctors to continue the primary care service provision to patients.

The provider had a comprehensive and up-to-date recruitment policy in place. The policy detailed all the pre-employment checks to be undertaken on a successful applicant before that person could start work in the service. This included identification, references and a check with the Disclosure and Barring Service (DBS). We looked at a sample of recruitment files for doctors, administrative staff and nurses. They demonstrated that the recruitment procedure had been followed.

Dealing with Emergencies

There was a defibrillator and oxygen available for use in a medical emergency. We saw records which demonstrated the equipment was checked daily to ensure it was in working condition. The staff rota showed the provider ensured there was always a duty doctor or practice nurse available to deal with any medical emergencies. Staff we spoke with, including reception staff knew what to do if an emergency occurred.

Equipment

There were policies in place for the safe use and maintenance of equipment and we were also shown the provider's maintenance schedule. This was fully up to date and the required checks on equipment had been carried out.

Are services effective?

(for example, treatment is effective)

Summary of findings

The service was effective. Care and treatment was being delivered in line with current published best practice. Treatment plans were based on guidance issued by the National Institute for Clinical Excellence (NICE). Patients' needs were consistently met in a timely manner. The provider had appropriate systems in place to assess the performance of its doctors.

Our findings

Promoting best practice

Patients' needs were assessed and care and treatment was planned and delivered in line with their individual wishes. All patients we spoke with were very happy with the care they received and any follow-up needed once they obtained an appointment.

Procedures were in place to obtain patient's consent for treatment. The procedures highlighted care around obtaining consent for children and patients with mental health difficulties. Staff we spoke with had an awareness of the Mental Capacity Act 2005. They understood their responsibility for ensuring patients had capacity to make their own decisions and what to do if they needed support to do this. We saw evidence training had been provided and was regularly updated.

Clinical staff, in conjunction with the practice manager, managed the care and treatment of patients with long term conditions, such as diabetes, asthma and hypertension (high blood pressure). We found there were appropriate systems in place to ensure patients with long term conditions were seen on a regular basis.

Patients who required palliative care (care for the terminally ill and their families) were regularly reviewed. Their details were passed to the out of hours provider each weekend to ensure care would continue when the practice was closed. In addition, families of patients who were on the latter stages of end of life care were given mobile telephone numbers for the GPs responsible so they could be contacted at any time. We saw documentary evidence to confirm this.

Staff showed us how they used the National Institute for Health and Care Excellence (NICE) templates for processes involving diagnosis and treatments of illnesses. NICE guidance supported the surgery to ensure the care they provided is based on latest evidence and was of the best possible quality. Patients received up to date tests and treatments for their disorders. We saw records of meetings that demonstrated revised guidelines were identified and staff trained appropriately.

Management, monitoring and improving outcomes for people

We saw that the provider carried out completed audit cycles. We found the monitoring the provider had carried

Are services effective?

(for example, treatment is effective)

out included chronic conditions and how the practice was organised. We saw evidence staffing levels had occasionally been changed as a result of the latter. Some of this monitoring was carried out as part of the Quality and Outcomes Framework (QOF). This is an annual incentive programme designed to reward doctors for implementing good practice. The provider demonstrated they were meeting the expected targets.

The provider was able to identify and take appropriate action on areas of concern. For example, the provider told us they had a large number of referrals for orthopaedic treatment, but had identified this was due to a large elderly population within the area.

We also saw evidence the provider attended 'buddy group' meetings with other local providers to identify and discuss best practice. We saw learning was shared in an appropriate way and recorded in the meeting minutes.

Staffing

We saw a comprehensive training plan for all staff employed by the provider. We were shown records which demonstrated how continuing professional development training for clinical staff was organised by the GP partners in conjunction with the practice manager and delivered by external experts. Topics were requested by the doctors or linked to learning from previous incidents in the service.

Staff records showed staff had the appropriate qualifications to care for patients to an appropriate standard set by their governing bodies.

Staff had regular individual supervision sessions and an annual appraisal. We saw examples of appraisals in staff files and staff confirmed they found the appraisal system was positive. Training needs were identified and then incorporated into this process. Staff were encouraged and supported to gain additional professional qualifications when appropriate. The provider made effective use of professional clinical audit tools to monitor and assess the performance of its doctors.

Additionally, staff told us they were encouraged to raise concerns at any time and management told us they had an 'open door' policy for management. Staff said the practice manager was always very approachable.

Working with other services

We saw records that confirmed the provider worked closely with the community midwife service and other healthcare professionals, who held clinics within the practice. The provider also referred patients to the health visitor's courses held at the local children's centre.

There were regular multi-disciplinary team meetings. GPs at the provider worked closely with the local Ellen Badger Hospital and provided medical cover for the ward and minor injuries unit. Staff told us there was a good working relationship with the Shipston Link bus service and volunteer drivers to enable less able bodied patients to attend appointments. Information about this service was available in the waiting room.

Details of patients with complex health needs or those who received end of life care were passed to out of hours provider when the surgery closed to ensure continuation of their care.

Health, promotion and prevention

We were shown work the provider had carried out to identify particular health needs within the area. This centred around the large elderly and traveller population. A programme of dementia screening was carried out for elderly patients. Health promotion work was also carried out within the local community, for example at a local sports club.

Are services caring?

Summary of findings

The service was caring. All the patients we spoke with during our inspection were highly complementary about the service. Responses to the provider's own patient surveys showed consistently positive results. The provider's induction and training programmes emphasised the need for a patient centred approach to care. This was evident throughout our inspection.

Our findings

Respect, dignity, compassion and empathy

Staff and patients told us patients' needs were assessed and care and treatment was planned and delivered in line with their individual wishes. All patients we spoke with were very happy with the care they received and any follow-up needed once they obtained an appointment. All patients felt they were consistently treated with dignity and respect by all members of staff. During our inspection we observed, within the reception area, how staff interacted with patients, both in person and over the telephone. Staff were helpful and empathetic, warm and understanding towards patients. Staff we spoke with told us patient care was at the centre of everything they did and their behaviours displayed this at all times.

We saw that patients' privacy and dignity could be respected by staff during examinations. We saw curtains could be drawn around treatment couches in consultation rooms. This would ensure patients' privacy and dignity in the event of anyone else entering the room during treatment.

The provider had made arrangements to ensure that appropriate care and treatment was provided to patients with a disability. We saw that the entrance to the practice was designed so that patients with mobility difficulties could access the practice easily. There were accessible parking places and step free access to the doors. The consultation rooms were situated on the ground floor and the waiting area, corridors and consultation rooms were spacious allowing easy access. To provide more space for the practice, the provider had purchased a neighbouring house and converted some of the rooms into consultation rooms. Some of these rooms were on the first floor. When this building was used, only patients who could access the first floor were booked into consultations there.

We saw there was a chaperoning policy in place for patients who required a sensitive examination by a doctor. There were posters displayed throughout the practice informing patients of their right to be accompanied by a chaperone. Staff we spoke with demonstrated a good knowledge of their chaperoning responsibilities and were able to describe to us what they would do if they had any concerns regarding an examination.

Are services caring?

Patients who required support following bereavement were signposted to relevant services.

Involvement in decisions and consent

We looked at patient choice and involvement. Staff explained how patients were informed before their treatment started and how they determined what support was required for patients' individual needs. Clinical staff told us they discussed any proposed changes to a patient's treatment or medication with them. They described treating patients with consideration and respect and said they kept patients fully informed during their consultations and subsequent investigations. Patients we spoke with confirmed this. Patients had the information and support available to them to enable them to make an informed decision about their care and treatment needs. Staff we spoke with understood the requirements of the Mental Capacity Act.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The service was responsive to people's needs. There was a culture of openness throughout the organisation and a clear complaints policy. Patient suggestions for improving the service were acted upon. The provider had an active Patient Participation Group (PPG) which was fully involved with decision making. The provider participated actively in discussions with the CCG about how to improve services for patients in the area.

Our findings

Responding to and meeting people's needs

The provider understood the different needs of the local population and took appropriate steps to tailor its service to meet these needs. We were shown measures the provider had taken to reach both the elderly population and local traveller community. Patients aged over 75 had been written to with details of their named GP. A focus group also operated which identified their particular needs. This was comprised of representative from the GP and management team, the Patient Participation Group (PPG), patients and other community organisations.

The provider had also undertaken a large amount of work within the local traveller community. Travellers have often found it difficult to access NHS services because of the lack of a permanent address. To resolve this problem, the provider able travellers to register with the NHS using the practice address.

We looked at the measures in place to accommodate patients' equality, diversity and information needs. A wide range of health information was available. We were told patient information could be obtained in a number of languages and there were also language interpretation facilities available to assist patients. These measures showed patients' equality and diversity needs could be supported to enable them to make an informed decision about their care and treatment. We saw evidence staff had been trained to assist patients with sensory impairments and learning difficulties.

Patients we spoke with who had been previously referred to hospital consultants told us referrals had been dealt with quickly and efficiently. Staff showed us how they followed up referrals with the relevant provider if a delay occurred. They showed us how they audited these referrals to ensure patients were given the best possible care. Referrals were made using the NHS 'Choose and Book' system. This ensured patients received a choice of where they wished to be referred to.

The provider planned its services carefully to meet the demand of the local population. We saw minutes of meetings that demonstrated weekly meetings were held to discuss capacity and demand. As a result of this, changes were made to staffing and clinic times when required.

Are services responsive to people's needs?

(for example, to feedback?)

Services were also reviewed in the wider context of the local health economy. Review meetings were held with the CCG and a GP partner was lead GP for this relationship with the CCG. Records confirmed this.

Access to the service

The provider opened from 8.00am to 6.30pm every weekday. For patients unable to attend regular surgery times, a 'commuter clinic' was run every Thursday from 6.30pm to 8.00pm and Saturdays from 8.30am to 9.30am. After 6.30pm and during the weekend, an out of hours service was provided by another provider. Telephone calls were automatically directed to the NHS 111 service. This ensured patients had access to medical advice outside of the provider's opening hours. The dispensary opened throughout surgery hours. This included during the Thursday 'commuter clinic'. Patients we spoke with told us appointment availability was good. They told us they would have to wait a little longer if they wanted to see a specific GP, but patients understood the reason for this and were happy to choose to do so if they wanted to.

For patients who had an urgent medical condition that could not wait until the next routine appointment, the provider operated a triage system. Patient details were taken and the duty doctor would telephone the patient back within an hour. The patient would then be given a same day appointment if necessary. Home visits were available for patients who were unable to go to the practice.

Patients could order repeat prescriptions through an on-line service, or by using a dedicated telephone line. This was open to leave recorded messages 24 hours a day, seven days a week.

Concerns and complaints

Patients' concerns were listened to and acted upon. There was information about how to complain displayed in the waiting area and within the patient information pack. All of the patients we spoke with said they had never had to raise a formal complaint. The complaints procedure identified how complaints would be dealt with. It also identified the timescales for responding to and dealing with complaints. The provider also had a complaints summary which summarised the complaints for each year. Details of the complaints procedure were displayed in the waiting room and within the patient information pack. Patients we spoke with knew how to make a complaint, but had not needed to do so.We looked to see whether the provider adhered to its complaints policy and we reviewed a number of patient complaints in detail. We found that the complaints had been dealt with appropriately and within the timescales set out in the provider's complaints policy. It was also clear that verbal complaints were dealt with in the same way as written complaints. If a patient telephoned the provider to complain, the practice manager would immediately take the call if available.

Are services well-led?

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

Summary of findings

The service was well led. There was a strong and highly visible leadership team with a clear vision and purpose. Governance structures were robust and there were appropriate systems in place for managing risks.

Our findings

Leadership and culture

The provider had a highly visible vision statement – 'providing personal and continuing care for all'. This was stated in its patient information and displayed in the waiting room. The appropriate behaviours were clearly evident from all staff throughout our visit and from comments received from patients. All staff openly spoke with us about how patient care was their priority and we saw patients treated with dignity and respect throughout our visit.

The practice manager (who was also the registered manager) and the GP partners were in day to day control of the service. The practice manager was highly visible, had an open door policy to all staff and actively checked on the well-being of every staff member each day. Staff told us the practice manager was highly supportive and approachable.

The staff performance monitoring system was used as much to recognise and reward good performance as to identify any potential underperformance. All staff we spoke with said they felt valued and respected by the management, GPs and their peers. This was reflected in the length of time most of the staff members had worked for the provider.

We looked at a number of human resources policies, including staff training, staff sickness, and planned absences. These balanced the need to put patient care first, whilst at the time had staff welfare in mind. Staff told us how supportive the provider was, for example, during times of personal difficulty. This also reflected the vision and values held by the provider.

There was a well-established management structure with clear allocations of responsibilities. We were able to talk with several GP partners with lead roles within the practice and each one clearly took an active role in ensuring that a high level of service was provided on a daily basis. The GP partners had an annual 'away day' which was facilitated by the practice manager. We saw records of the discussion which followed the 'away day' held last year. This reflected on the past year and identified challenges and solutions for the year ahead. Staff told us this was disseminated to all staff after the event and used to re-state the vision and values of the provider, along with a clearly defined focus for the year ahead.

Are services well-led?

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

We saw evidence the provider engaged with the local Clinical Commissioning Group (CCG) on a regular basis to discuss current performance issues and how to adapt the service to meet the demands of local people. The CCG is the NHS body responsible for commissioning local NHS services. The provider compiled a monthly report which was submitted to the CCG and one of the GP partners attended relevant CCG meetings. This ensured there was clear communication between the provider and the CCG and ensured the provider was fully aware of local issues within NHS services.

Governance arrangements

The provider had a clear corporate structure designed to provide complete assurance to the management team and local CCG that the service was operating safely and effectively. Within the governance arrangements there were clearly identified lead roles which included medicines management, complaints and incident management, and safeguarding.

Systems to monitor and improve quality and improvement

The provider had an effective system to regularly assess and monitor the quality of service that patients received. We saw the provider carried out regular audits. We found the provider had carried out monitoring which included long term medical conditions, minor surgery, incident reporting, and quality and productivity. All audits were evaluated and action plans to improve quality had been put in place when necessary. Some of this monitoring was carried out as part of the Quality and Outcomes Framework (QOF). This is an annual incentive programme designed to reward good practice. The practice demonstrated they were meeting the targets.

In addition to monitoring and reporting its performance against the national quality requirements, the provider had developed and agreed quality indicators with the local CCG. The indicators were monitored

and performance was reported to the CCG on a monthly basis. This enabled the management team and the CCG to see at a glance if any aspect of performance was below expectation and to put plans in place to improve the situation.

The provider had produced a comprehensive register of potential risks to its business. The risks identified were discussed at staff meetings and risk reduction plans were regularly reviewed and updated. The provider was also part of a 'buddy review group' with other local providers to identify and share best practice.

Patient experience and involvement

The provider asked patients who used the service for their views on their care and treatment and they were acted on. This included the use of surveys to gather views of patients who used the service. We saw there were systems in place for the provider to analyse the results of the survey for information so that any issues identified were addressed and discussed with all staff members. We saw records of discussions within the minutes of staff meetings. All the patients we spoke with on the day of our inspection told us they received a high quality service from the provider. It was clear patients experienced the quality of service that met their needs.

We saw the results of the last annual patient satisfaction survey carried out by the provider. This had focussed on communication and found 96% of the 386 patients surveyed said it was easy or fairly easy to contact the surgery by telephone. A survey of the provider's phlebotomy (blood taking) service had recently been carried out. Of the 111 patients surveyed, 88% rated the service as excellent and the remaining 12% rated it as good.

The provider had an established Patient Participation Group (PPG) in place. This ensured patients' views were included in the design and delivery of the service. The chair of the PPG told us the group played a very active role and a was a key part of the provider's organisation. Regular meetings were held and the PPG was also represented on the CCG's patient forum. This ensured the CCG were aware of and listened to patient views.

We saw how the PPG had been active in identifying and finding a solution to a shortage of car parking space by negotiating space for staff parking at another local premises. This would make additional space for patient parking within the provider's car park. We saw how the provider advertised the PPG on the waiting room display screen and with posters in the waiting room. There was also a patient comment box in the waiting room. Staff told us this was little used, however it was clear staff were highly approachable and patients were happy to discuss any

Are services well-led?

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

concerns face to face. We overheard a patient say they were going to buy flowers for their GP because they were so happy with their treatment and had just been signed as fit for work again after a long time off.

The provider also produced an annual Patient and Community Involvement report. We saw the one produced for 2013-2014 which detailed a Christmas fayre which had raised funds for equipment and for a local bereavement counselling service. Coffee mornings were also held and the practice arranged an annual patient meeting which was open to all patients.

Staff engagement and involvement

All staff were fully involved in the running of the practice. We saw there were documented regular staff meetings. This included meetings for clinical staff and meetings that included all staff. This ensured staff were given opportunities to discuss practice issues with each other. There was a clear culture of openness and 'no blame' in place. This meant staff could raise concerns without fear of reprisals and the provider's whistleblowing procedure supported this.

Staff told us they were actively encouraged to make suggestions and identify ways for the provider's service to improve.

Learning and improvement

We saw evidence that learning from significant events took place and appropriate changes were implemented. We saw that there were systems in place for the practice to audit and review significant events and that action plans were put in place to help to prevent them occurring again.

As part of the annual review process, staff had clearly defined goals for learning and development. Staff were also encouraged to train for further professional qualifications when appropriate. We saw details contained within staff records. This was in addition to the regular training provider to update learning and skills, along with to implement new developments within primary medical services. This ensured staff had up to date knowledge and skills.

Identification and management of risk

The practice had an effective system in place to identify, assess and manage risks to the health, safety and welfare of staff and patients who used the service. We saw risk assessments in place for fire hazards. There was a business continuity plan in place which had assessed the risk to patients in the event of such occurrences as an information technology failure, loss of domestic services or a flood. The latter included flooding within the local area as this was prone to this and had previously caused some difficulty for staff getting to work. Action plans were in place to manage these risks.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Summary of findings

Care was individually tailored to patient's needs and circumstances. The provider regularly reviewed care provided and this included family members and carers when appropriate. Unplanned hospital admissions were reviewed and actions taken when necessary. Care was provided in a local care home and GPs covered the nearby Ellen Badger Hospital.

Our findings

All patients over the age of 75 had a named accountable GP. There was also a focus group for this age category comprised of GPs, management, Patient Participation Group (PPG) members and other patients. This ensured the needs of this age group were identified and met by the provider.

The practice offered flu vaccinations and shingles vaccinations to older people who were most at risk. Planned and unplanned hospital admissions were reviewed and actions taken when necessary.

Care was provided in a local care home for which there was a nominated lead GP. GPs also covered the nearby Ellen Badger Hospital and provided cover for ward rounds and clinical appointments.

For patients at the latter stages of end of life care, the provider gave families and carers mobile phone numbers of individual doctors so they could be contacted at any time. We were shown how consent had been obtained when needed.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Summary of findings

Patients with long term conditions were regularly reviewed. The provider's care plans had a multi-disciplinary approach and retained oversight of the care provided. Planned and unplanned hospital admissions were reviewed and actions taken when necessary.

Our findings

The provider supported patients with long term conditions. Their care was regularly reviewed and patients were followed up if they failed to attend.

The provider's care plans had a multi-disciplinary approach and retained oversight of the care provided. This was managed through meetings held with team members from other organisations. This included community nurses and Macmillan nurses. We were shown records to confirm this.

The provider offered regular nurse led clinics for patients with some long term conditions. This included diabetes, chronic obstructive pulmonary disease (COPD) and coronary heart disease. Patients were identified by the clinical team and received personal invitations to attend. We saw samples of letters sent to patients.

The provider ran community focus groups for people with a range of long term health conditions, for example, asthma and diabetes.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Summary of findings

The provider used the community midwife service and provided a room for their use. They also worked with local health visitors to offer a full health surveillance programme for children aged under five. Checks were also made to ensure the maximum uptake of childhood immunisations. Health awareness sessions were carried out in local sports clubs.

Our findings

The provider referred patients to the health visitor's baby clinic and supported the health visitors in their role. There was a comprehensive range of health care information available in the practice for new and expectant mothers.

We saw procedures that showed children and young people were treated in an age appropriate way and were recognised as individuals, with their preferences considered.

There were effective safeguarding procedures in place to help protect vulnerable children and clinical staff were aware how to assess the competency of children and young people to make decisions about their own treatment. Staff had an understanding of consent issues for children and young people.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Summary of findings

The provider ran a weekly 'commuter clinic' for patients who were at work during the day. Patients could also make appointments for telephone consultations.

Our findings

The provider had aimed to meet needs of patients who worked during the day with a weekly 'commuter clinic' for patients on a Thursday evening. Patients could also make appointments for telephone consultations. The provider produced a leaflet to publicise this and details were also on their website. Both clearly stated these appointments were aimed at patients who might find it difficult to attend the surgery during the working day.

Patients were able to book telephone appointments if they wanted to speak to a doctor without having to attend the practice.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Summary of findings

The practice participated in the Warwickshire County Council 'Safe Places' scheme to help keep vulnerable people safe. Patients who were travellers or within other categories of no fixed abode were able to access all NHS services as they were able to register at the practice.

Our findings

The provider was a designated 'safe place' for people under the Warwickshire County Council scheme. The scheme required staff to have appropriate training and awareness of the needs of potentially vulnerable people. We saw staff had received appropriate training.

The provider had also undertaken a large amount of work within the local traveller community. Travellers have often found it difficult to access NHS services because of the lack of a permanent address. To resolve this problem, the provider allowed travellers to register with the NHS using the practice address.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Summary of findings

The provider worked with community psychiatric nurses and a local psychological therapy service.

Our findings

The provider tailored care plans to the individual needs and circumstances of patients with poor mental health, including their physical health needs. Regular health checks were offered to people with serious mental illnesses when appropriate.

There was access available to a variety of treatments such as listening and advice and cognitive behavioural therapy (CBT). GPs were equipped to recognise and manage referrals of more complex mental health problems to the appropriate specialist services.