Spinney Surgery

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	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 at Spinney Surgery on 20 April 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services for the older people, people with long-term conditions, families children and young people, working age people (including those recently retired) people whose circumstances make them vulnerable and people experiencing poor mental health (including people with dementia). It required improvement for providing safe services.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of some medicines related risks.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Most staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Most patients said they found it easy to make an appointment when they needed one, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw one area of outstanding practice:

- The practice had a very pro-active approach to identify and support carers. They had an appointed 'Carers Champion', strong links with the Carers Trust and good information resources. They also held carer's surgeries to meet with carers on an individual basis, refer them to the local carers trust scheme or a multidisciplinary worker to help them access other voluntary support organisations. The practice also offered flexible appointment times to fit in with caring responsibilities. The practice had received very positive comments from patients who used this support service.

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

Importantly the provider must;

- Ensure that all medicine errors or near miss events are recorded so that learning can be actioned. All medicines checks must be recorded and improvements made to the storage of prescription pads. All staff involved in the dispensing of medicines must have attained suitable qualifications.

The provider should also;

- Ensure that learning from incidents, near miss events or complaints is communicated more widely to the staff team.
- Review the whistleblowing policy to include external agencies who can offer staff support.
- Complete a risk assessment for the safety of the cupboard used for storing cleaning equipment.
- Ensure that outstanding actions from the legionella risk assessment are completed.
- Ensure the systems for reporting faulty equipment is robust.
- Consider the need for staff to receive update training about the principles of Gillick competence.

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 as there are areas of medicines management where it should make improvements. We found that staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. However, we found that medicine errors and safety incidents were not always being recorded in the central log so that learning could be shared. Lessons were learned from other concerns and incidents and action was taken to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. However, some medicines checks were not being recorded and prescription pads were not always stored securely. There were enough staff to keep patients safe although the qualifications and training of staff involved in dispensing medicines must be reviewed.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above the national average. Staff referred to guidance from the National Institute for Health and Care Excellence and could demonstrate this was used routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing their capacity to make decisions and using opportunities to promote good health. The majority of staff had received training appropriate to their roles and any further training needs had been identified and planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked closely with multidisciplinary teams to ensure that patient's received effective care, treatment and support.

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 compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients know about the services available was easy to understand. The practice had an established process to identify carers and a proactive approach to ensure they were provided with relevant support. We also saw that staff treated patients with kindness, dignity and respect and maintained confidentiality.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients told us they were generally satisfied with the appointments system and were able to access their preferred GP most of the time. They also told us the practice could usually accommodate their urgent GP appointment requests on the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to any concerns that were raised and learnt from them. Learning was shared with external colleagues and other appropriate health and care service providers.

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 and open leadership structure and staff felt supported by the management team. The practice had a number of policies and procedures to govern activity and held regular meetings where governance issues were discussed at length. Although we found learning from incidents and complaints needed to be communicated more widely to the staff team. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with complex needs. The practice operated a system of a named GP for patients over 75 and patients we spoke with confirmed this was the case.

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 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 or who may be at risk (e.g. children and young people who frequently attended A&E). Immunisation rates were equal to or above national averages for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with health visitors and school nurses.

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. For example early opening hours and late evening appointments were available for routine screening appointments

with the practice nurse as well as GP appointments. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

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 people, travellers and those with a learning disability. Annual health checks had been offered to people with a learning disability although few had responded to the offer during the last year.

The practice regularly worked with multi-disciplinary teams by reviewing the case management of vulnerable patients. A dedicated multidisciplinary co-ordinator worked with the practice to assist them to support vulnerable patients who have had unplanned admission to hospital to help prevent similar occurrences. Information to signpost vulnerable patients to access support groups and voluntary organisations was readily available. Staff knew how to recognise signs of abuse in vulnerable adults and were aware of their responsibilities to share information with external agencies.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Annual physical health checks were offered to patients with long term mental health needs although uptake had been low in the last year. The practice regularly worked with multi-disciplinary teams to support people experiencing poor mental health, including those with dementia. A dedicated co-ordinator had been appointed to reduce avoidable hospital admissions by ensuring that appropriate help was available to support patients in their homes. The practice carried out advance care planning for patients with dementia.

The practice shared information with patients experiencing poor mental health on how to access support groups and voluntary organisations such as MIND. Patients could access counselling or support from advisory services through the practice either privately or on the NHS. Staff had received training on caring for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with eight patients as part of the inspection process and we received 19 CQC comment cards. All of the comment cards gave very positive feedback about the support patients had received and complemented the practice team on the high standard of care and support they provided. Four comment cards contained less positive comments about the length of time to see their preferred GP and the length of time they spent in the waiting room when appointments ran behind time.

Patients told us the practice offered an excellent service, staff were efficient, helpful and caring. They said they could get an appointment at a time to suit them, staff treated them with dignity and respect, always listened and explained information to them clearly.

Areas for improvement

Action the service MUST take to improve

Ensure that all medicine errors or near miss events are recorded so that learning can be actioned. All medicines checks must be recorded and improvements made to the storage of prescription pads. All staff involved in the dispensing of medicines must have attained suitable qualifications.

Action the service SHOULD take to improve

- Ensure that learning from incidents, near miss events or complaints is communicated more widely to the staff team.
- Review the whistleblowing policy to include external agencies who can offer staff support.
- Complete a risk assessment for the safety of the cupboard used for storing cleaning equipment.
- Provide additional training for the lead member of staff with responsibility for infection prevention and control.
- Ensure that outstanding actions from the legionella risk assessment are completed.
- Ensure the systems for reporting faulty equipment is robust.
- Consider the need for staff to receive update training about the principles of Gillick competence.

Outstanding practice

The practice had a very pro-active approach to identify and support carers. They had an appointed 'Carers Champion', strong links with the Carers Trust and good information resources. They also held carer's surgeries to meet with carers on an individual basis

Spinney Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a specialist GP advisor, a specialist practice management advisor, a CQC medicines management advisor and a second CQC inspector.

Background to Spinney Surgery

The Spinney Surgery provides services to approximately 10,300 registered patients in the market town of St Ives and surrounding villages. The service has four GP partners and a practice manager who is also a partner. The practice offers an extensive range of services to the local community including support to two care homes. It opens 8.00am until 6.00pm and offers extended hours appointments on four mornings and one evening per week.

The practice employs five salaried GPs, five practice nurses, three health care assistants, two secretaries and six reception staff. The practice also has its own dispensary and employs two staff. It is a training practice and supports two trainee GPs. The practice is contracted to provide primary medical services.

The practice has opted out of providing out-of-hours services to their own patients. This service is provided by Urgent Care Cambridgeshire.

Why we carried out this inspection

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

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

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

- Is it safe?
- 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:

Detailed findings

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 20 April 2015.

During our visit we spoke with a range of staff including GPs, nurses, a health care assistant, reception staff, the managing partner and dispensary staff. We spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members.

We also collected the views of other patients through the completion of CQC comments cards, placed at the practice two weeks prior to our visit.

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 with 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 safety issues were discussed. These showed the practice had managed these consistently over time and could evidence 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.

There were regular practice meetings where the management team discussed significant events. For example staff had identified that a piece of sterile equipment, used for a minor procedure was out of date. This had resulted in a policy review and the implementation of regular sterile equipment checks. An audit three months later showed sterile instruments were safe for use.

We found that incidents related to medicines were included in the regular practice meetings. However, when we looked at records of dispensing errors we noted they had not been raised as significant events at the meetings so that they could be discussed and where appropriate, necessary actions taken. By talking to staff we established that near-miss dispensing errors had not been recorded which meant that trends could not be identified and monitored.

Reliable safety systems and processes including safeguarding

The practice had designated two GPs to lead on the safeguarding of vulnerable adults and children. The GPs advised and supported staff within the practice as well as linking with external agencies and the safeguarding team for the local authority. Information on seeking urgent advice or making a referral to the local authority was accessible to staff if required in the absence of the safeguarding leads.

There were systems in place to ensure that safeguarding information was recorded in the electronic records system and that appropriate staff had access to it. The practice had recently had a safeguarding audit completed. This identified that some staff needed to complete a higher level of training in safeguarding appropriate to their role. The practice told us they would action this as soon as possible.

The practice had a whistleblowing policy that had been reviewed in January 2015. It did not include any external organisations that staff could contact to raise concerns about a colleague's practice such as the Public Concern at Work agency. A member of staff we asked was unaware of this policy or how to find it.

The practice had a chaperone policy in place. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. We saw that posters were displayed in the waiting room and in consultation rooms advising patients that chaperones were available to them. Staff we spoke with had received training and understood their role and responsibility of acting as a chaperone.

Following a recent audit of safeguarding procedures, the practice had decided to ensure that all administration staff who met patients would have a criminal record check with the Disclosure and Barring Service. This included checks for reception staff before undertaking the role of a chaperone to patients.

Medicines management

The practice must make some improvements to the way they manage medicines.

We noted the arrangements in place for patients to order repeat prescriptions. The practice had monitored and assessed some aspects of the quality of its dispensing service. Patients received their repeat prescriptions promptly and did not experience delays in the supply of their medicines. Prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were tracked through the practice in accordance with national guidance. We looked at the

arrangements for the storage and security of prescription forms and medicines at the practice and advised on security improvements needed to ensure they could only be accessed by authorised members of staff.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. There were arrangements in place for the destruction of controlled drugs. We checked a sample of controlled drugs and found we could account for them in line with registered records. We were told that staff undertook regular audits of controlled drugs but there were no recent records about this.

Processes were in place to check medicines in the dispensary were within their expiry date and suitable for use, however, records about this were not available. Medicines for use in an emergency in the practice and in doctor's bags were monitored for expiry and checked regularly for their availability. Records demonstrated that vaccines and medicines requiring refrigeration had been stored within the correct temperature range. Staff described appropriate arrangements for maintaining the cold-chain for vaccines following their delivery.

The practice had signed up to the Dispensing Services Quality Scheme (DSQS), which rewards practices for providing high quality services to patients of their dispensary. Dispensary staffing levels were overall in line with DSQS guidance. However, we were told that at times, a single-handed dispenser routinely supplied medicines to patients with checks by other staff who had not attained suitable qualifications. One dispenser who at times worked alone was undergoing training, but at the time of our inspection had not completed the training to attain a suitable qualification. Therefore, we could not be assured that safe procedures for medicine supply were always being followed and patients were provided their medicines by staff with appropriate dispensing qualifications.

Cleanliness and infection control

We found that the practice was visibly clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. The practice had employed the current cleaning company since September 2014. They stored cleaning materials in a cupboard on the first floor of the building. We found the cupboard was not locked although it was located near staff offices and not consultation rooms. The managing partner agreed to complete a risk assessment to review the safe storage of cleaning materials. We saw there were cleaning schedules in place and records of daily, weekly and quarterly cleans were kept. Three cleaning audits had taken place since the new company had taken on the cleaning contract which demonstrated improved cleaning standards. The most recent audit in April had scored 97%.

Responsibility for cleaning and infection control was shared between the managing partner and a nurse. We spoke with the practice nurse and found they had not completed any additional training in infection control. However, they told us this had been identified during a recent appraisal and training was being sourced.

All staff received induction training about infection control specific to their role and received annual updates. The health care assistants had responsibility for cleaning any clinical equipment and this was recorded.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, hand hygiene, personal protective equipment (e.g. gloves, aprons) and clinical waste management. We observed that staff complied with the policies and were able to describe an appropriate level of knowledge for their role. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

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

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can contaminate water systems in buildings). A legionella risk assessment had been completed in February 2012. Most recommendations had been implemented, however the practice's water tank still required testing to meet with water supply regulations. In addition, the person who completed legionella water checks had not received appropriate training.

Equipment

Requires improvement

Are services safe?

The practice had an equipment register although they were in the process of improving this further. Staff were expected to complete visual checks of the equipment they used and report any faults to the managing partner who took action. We found there was no record to demonstrate this process or to ensure another member of staff followed it up in the absence of the managing partner.

All electrical items in the practice had received a safety test within the last year. A register of any hazardous substances such as cleaning products was also in place.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to the employment of staff. For example, proof of identification, references, qualifications, previous experience and registration with the appropriate professional body. Criminal records checks were made through the Disclosure and Barring Service (DBS) for all clinical staff. Non-clinical staff had not received DBS checks although the practice had decided to review this. This was because some reception staff occasionally acted as a chaperone to a patient during their examination with a nurse or GP. These staff were not acting as chaperones until their DBS checks were completed.

The practice had an appropriate recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. The policy would be updated by the managing partner following the practice's recent decision to complete DBS checks for administrative staff. This meant they could meet the increased demand for staff to act as a chaperone.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. 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. A process was in place to manage staff absences.

Staff told us there were usually enough staff to maintain the smooth running of the practice and to keep patients safe. They provided cover for each other during annual leave or sick leave. Many staff worked part-time hours and this meant they were more able to be flexible in their working hours when required. The practice used a regular locum GP providing availability for patients when required.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, information management, waste management, staffing, dealing with emergencies. The practice also had a health and safety policy. Health and safety information was displayed for staff to see although an information poster displayed required updating.

The practice had considered safe access to the building by completing an audit. Recommendations such as putting up extra rails outside, marking the kerb edges to make them more visible and painting the hand rail had been implemented.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, there were emergency processes in place for identifying acutely ill children and young people.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records we reviewed showed that all staff had received training in basic life support and clinical staff in responding to anaphylaxis. This is a sudden allergic reaction that can result in rapid collapse and death if not treated.

Emergency equipment was available including access to oxygen and an automated external defibrillator (a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). Members of staff we spoke with all knew the location of this equipment. Records confirmed that it was checked regularly to ensure it remained fit for use.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. A protocol was in place for staff to take

Requires improvement

Are services safe?

immediate action in the event of an emergency and dial 999 to call an ambulance. 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 guide staff in dealing with a range of emergencies that may impact on the daily operation of the practice. It was reviewed on a regular basis. The document included contact details for staff to refer to. For example, contact details of a heating company in the event of a failure.

The practice had carried out a fire risk assessment to maintain fire safety. Records showed that staff were up to date with fire training and that they had recently practised a fire drills. Two members of staff had received training as fire marshals to ensure the safe evacuation of the building in an emergency.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We spoke with GPs and nursing staff who were familiar with best practice guidelines and could describe their approach to clinical care and support confidently. They were able to demonstrate that they accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners to ensure patients were receiving care in line with guidance. We saw records of practice meetings that showed new guidelines were disseminated and any impact for patients were discussed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that patient's received support to achieve the best health outcome for them. We found that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

Specialist clinical areas of responsibility were shared amongst the GPs. For example, diabetes, dermatology and women's health. The practice nurses were skilled in providing clinics for patients with long-term conditions such as diabetes, leg ulcer management and respiratory conditions such as asthma and chronic obstructive pulmonary disease. Clinical staff we spoke with said they worked in an open culture where they were comfortable in providing colleagues with advice and support. The senior staff told us this supported all staff to continually review and share knowledge of best practice guidelines. The records of clinical meetings confirmed this.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. Staff we spoke with and records we reviewed showed that patient referrals for specialist assessments (for example for patients with suspected cancers) were reviewed by clinical staff on a daily basis. This helped to ensure that any improvements to practice were shared with staff.

Interviews with GPs and nursing staff showed that the culture in the practice was that patients were cared for and treated based on need. The practice took account of patient's age, gender, race and culture as appropriate to ensure patient's needs were being met.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. However they had recognised that the annual audit plan required improvement so that more audits were completed to help inform and improve their practice. Examples of clinical audits included high risk category medicines such as those used to treat patients with rheumatoid arthritis or to manage long-term mental health conditions, diabetes and antibiotic prescribing.

The practice showed us four clinical audits that had been undertaken in the last year. Two of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example the practice had completed a diabetes audit as part of the local Clinical Commissioning Group (CCG). This looked at diabetic patients who were not taking insulin to ensure they were receiving treatment and support in line with local and national guidelines. The audit took place in June 2014 and March 2015. The outcomes identified areas for improvement that were actioned. This included additional training for the specialist nurse in initiating medication and more frequent patient reviews.

The practice had completed the first cycle of an audit on antibiotic prescribing as part of a review by the CCG. This identified areas for improvement that the practice had started to work on and planned to check again in six month's time.

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. 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 e.g. diabetes and implementing preventative measures. The results are published annually. Data we reviewed with the lead GP for quality showed that the practice had made great improvements to their performance during the last year. These improvements were in areas such as mental health, diabetes care and management of high blood pressure.

There was a positive learning culture at the practice where staff shared and reviewed their performance in a variety of ways including through audit, team meetings and clinical supervision. The staff we spoke with told us they also reflected on the outcomes being achieved and how they could improve on an informal basis for example through one to one discussion or during breaks.

Good

Are services effective?

(for example, treatment is effective)

There was a protocol for repeat prescribing which was in line with national guidance. Patients who received repeat prescriptions were reviewed by the GP on a regular basis. Staff also checked that all routine health checks were completed for patients with long-term conditions such as diabetes and that the latest prescribing guidance was being used. GPs received medicine alerts through the IT system when prescribing medicines. This meant they were prompted to consider the use of the medicine and whether it was still relevant for individual patients. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice was using the gold standards framework for end of life care and a designated GP led on palliative care issues. A register for palliative care was in place so that staff were able to monitor on-going care and support needs for these patients and their families. Palliative care meetings took place monthly although patients with more immediate needs were reviewed as and when necessary. The practice had good working relationships with the Macmillan nurse and community nurses. They had also links with the palliative care doctors who had led educational sessions for staff.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending annual training courses such as basic life support, infection control and confidentiality.

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Staff undertook annual appraisals that identified their learning needs from which action plans were documented. We found that the nursing team were up to date with their appraisals and administrative staff were in the process of having these at the time of the visit. A plan for undertaking formal appraisals more regularly had been agreed. Staff we spoke with confirmed that the practice was proactive in providing training and funding for relevant courses, for example a practice nurse had attended a course to enable her to treat patients with leg ulcers. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support.

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

However, in the dispensary we found that one member of staff who worked unsupervised at times, had not fully completed their training. In addition other staff were used to support dispensary work by completing medicine checks but they had not attained suitable qualifications to do so. Patients therefore received medicines from staff who were not fully trained in safe procedures for the supply of medicines.

Working with colleagues and other services

The practice worked with other health care services to meet patient's needs. There were systems in place to receive information such as blood test results, Xray results, and letters from hospital either by post or electronically. There were further systems to ensure information was exchanged with the out-of-hours GP services and the 111 service so that patients who had received support from those services continued to receive care from the practice in accordance with their needs. The relevant GP for the patient reviewed the information and took responsibility for taking any action required. During times the GP was unavailable, another GP covered for them to ensure that results were checked and action was taken in a timely way. Staff told us this system worked well.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that effective systems were in place to communicate with hospital staff so that the enhanced services worked well.

The practice held multidisciplinary team meetings each month. These focused on patients with complex needs, for

Good

Are services effective?

(for example, treatment is effective)

example those with end of life care needs or vulnerable patients who have had unplanned admission to hospital. The meetings were often attended by community nurses, Macmillan nurse, physiotherapists, occupational therapists and voluntary groups such as Age UK and the Richmond Fellowship. The practice also had a multidisciplinary team co-ordinator allocated to them by the CCG to support staff in their work to prevent vulnerable patients being admitted to hospital un-necessarily.

We spoke with key staff in two care homes supported by the practice. They told us they had a good relationship with staff at the practice and they listened to their views to help meet the needs of people who lived in the homes.

Information sharing

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, and the practice made 92.5% of referrals last year through the choose and book system. (Choose and book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

The practice had signed up to using the electronic Summary Care Record. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system and had appropriate access to the information they required. Any paper communications, such as those from hospital could be scanned and saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and understood the key principles of the legislation. They were able to describe how they implemented it in their practice to promote patient's right to make their own decisions whenever possible. There was a consent policy in place to help guide staff in their practice and this included documenting the decision making process or consent gained from a patient in their medical records.

When we spoke with clinical staff they were able to describe examples of when a patient's best interests were taken into account if the patient did not have capacity to make their own decision. We found that some non- clinical staff were not always clear about the principles of Gillick competencies and update training may be beneficial. Gillick competencies are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Health promotion and prevention

The practice had good relationships and links with the CCG and NHS England local area team. They used this to support and share information about the health and social care needs of the local area to help identify health promotion activity. The practice operated a named GP system for patients over the age of 75. Other patients were able to be seen by their preferred GP.

It was practice policy to offer a health check with the health care assistant to all new patients registering with the practice. We found the assessment reviewed issues including weight, smoking status and alcohol consumption. Checks were also made on patient's blood pressure, cholesterol and urine tests. Any concerns were reported to the GP and these were followed up in a timely way. All new patients who took regular medication were reviewed by a GP when newly registered.

The practice developed a weight loss service for their patients. The model they had adapted won the Patient Participation Award from the Royal College of General Practitioners in 2004 and was still being used. The practice had also provided a specific weight loss club to support the needs of Asian women in their community.

The practice also offered NHS Health Checks to its patients aged 40 to 75 years every five years by inviting them to attend. The practice data showed that 611 patients in this age group took up the offer of the health check during the previous year. Patients were followed up within four weeks if they had risk factors for disease identified at the health check and were scheduled for further investigations.

Good

Are services effective?

(for example, treatment is effective)

The practice kept a register of all patients with a learning disability. However, we found that four out of 29 had attended for an annual physical health check in the last year. The practice manager told us they had changed their invite system from making a personal call to sending a letter. This had reduced the number of patients accepting the check and they would be returning to telephone invites this year with an aim to improve the response. The practice offered support and smoking cessation clinics to patients who smoked and told us they took opportunities to promote this service although uptake remained at a low level.

The practice's performance for cervical smear uptake was in line with national averages. Calls and recall appointments were managed externally. The practice offered early morning appointments with a practice nurse in order to provide more convenient appointments to suit working women.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was equal to or above the national average.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP patient survey March 2014 and a survey of 107 patients undertaken by the practice. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national GP patient survey showed the practice was rated as being above the national average for patients who rated the practice as good or very good. The practice had similar satisfaction scores for consultations with doctors and nurses with 92% of practice respondents saying the GP treated them with care and concern.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 19 completed cards and they all complimented the practice team on the high standard of care and support they provided. They said staff treated them with dignity and respect. Four comment cards contained less positive comments about the length of time to see their preferred GP and the length of time they spent in the waiting room when appointments ran behind time. We also spoke with six patients on the day of our inspection and the experience of these patients further supported the feedback in the comments cards.

Consultations and treatments were carried out in the privacy of a consulting room. Privacy curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. Notices in waiting areas and consultation rooms alerted patients that they could request a chaperone during an examination or treatment if they wished to do so. The role of a chaperone is to acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure.

Staff were mindful of the practice's confidentiality policy when discussing patients' confidential information to ensure that it was kept private. Patients' calls were received away from the reception desk which helped keep patient information private. The practice survey in 2014 identified that 19% of patients were concerned about privacy at the reception desk. We found that staff had introduced a system that encouraged one patient at a time to approach the reception desk. This had helped to reduce the risk of other patients overhearing private conversations. Staff could take patients to a more private area if they requested this.

We observed staff interacting with patients in the reception, waiting rooms and on the telephone. All staff showed genuine empathy and respect for people, both on the phone and face to face.

We saw how a more elderly and vulnerable patient was appropriately supported by staff to attend their appointment at the practice.

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 GP patient survey showed the GPs and nurses scored similar to or above national average for being involved in decisions about their care and treatment.

Patients who completed comments cards and those we spoke with during the inspection told us they felt the staff took time to talk with them and answered their questions. For example one patient told us their GP listened and had responded to their request to try different types of medicines. Five patients told us they had been referred for treatment at a hospital and had been involved in the decisions to do so. They all told us that plans had worked well and referrals had gone very smoothly.

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

Patient/carer support to cope emotionally with care and treatment

The practice made a pro-active approach to identifying and supporting carers and this work had been recognised with a national award in 2004. They had an appointed Carers Champion who acted as an information source and advised colleagues at the practice. Carers were offered flexible appointment times to fit in with their caring responsibilities. Staff sign posted patients to local support groups and the local carers trust scheme. The

Good

Are services caring?

practice had a close relationship with the local carers trust who assisted the practice with a carers' information noticeboard in reception and hosting carers' surgeries where one to one meetings were offered. The Carer's Champion was also assisted by a patient champion and were involved with plans to set up a 'carers walk'. The practice had received very positive comments from patients who used this support service.

The practice had implemented a system that enabled reception staff to complete carers' prescription requests and refer them to the carers' trust. These referrals were always authorised by a GP. A member of the patient group also supported this work as an additional carer's champion.

Staff told us that if families had suffered a bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

We saw staff support a patient who had arrived at reception in a distressed state. The receptionist took time to calm the patient and reassure them she would make appropriate arrangements to meet their needs by speaking with their GP that day.

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

The NHS England Area Team and 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. We saw minutes of meetings where this had been discussed by the management team.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example the practice arranged to remove some hedges in the car park to create more space and considered ways to improve privacy in the reception.

The practice worked with the PPG to organise patient education meetings. These were held in a local hall and were open to any patient who wished to attend. Topics covered included; holiday health, getting older, men's health and children's health. They often included interactive stalls and expert speakers and were very well attended.

The practice supported two local care homes for older people. We spoke with representatives from each home who told us the practice staff were very supportive and always responded to their requests to see a patient in a timely and professional way.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example we found the practice had considered the needs of Asian patients and responded to health issues experienced by this group by running a weight loss club for Asian women. Many patients in this group had a vitamin D deficiency and staff supported them to make improvements to their health through the use of diet and supplements. Staff also gave an example of responding with sensitivity to a transgender patient by meeting with them to discuss their needs and how the practice could support them.

The practice had access to translators including a telephone translation service. Some staff spoke other languages although the practice preferred to use the translation service if this was required. They told us there was little call for the service as most patients were able to speak English.

The practice had provided staff with some equality and diversity training through e-learning. Staff we spoke with confirmed this. The managing partner told us they were planning additional training for the staff team where they would have opportunities to discuss issues and learn from one another.

The practice was situated on two floors of the building. Patients with limited mobility were always seen on the ground floor. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities on both floors of the building.

The practice told us they treated patients from a small group of travellers who stayed in the local area on a regular basis. They treated adults and children whenever they needed to access health checks or attend for a consultation. A service was provided to vulnerable patients such as the homeless by registering them care of the practice's address. They also supported patients who misused drugs or alcohol by working with other specialist services when relevant.

Access to the service

The practice opened 8am to 6pm and offered appointments between 8.30am to 5.30pm on weekdays. They closed for an hour on Tuesdays and Thursday lunchtimes to allow for staff meetings and training. Extended opening hours were available four mornings from 7.10am and one evening until 7.45pm to patients of working age by appointment. This included GP appointments in person or by telephone and nurse appointments for example for cervical smear tests and phlebotomy (taking blood samples).

Good

Are services responsive to people's needs?

(for example, to feedback?)

Detailed information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits. Patients were able to book appointments through the website if they had registered with the practice to do so. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances.

Standard appointments were for 10 minutes although longer appointments were available for patients who needed them such as patients with complex conditions. This included appointments with a named GP or nurse.

Patients told us they were generally satisfied with the appointments system and were able to access their preferred GP most of the time. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients and our observations showed that patients in urgent need of treatment were able to make appointments on the same day they had contacted the practice.

Listening and learning from concerns and complaints

The practice has a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England. The managing partner dealt with any complaints raised about the service and had an open door policy to encourage staff and patients to raise concerns. The practice leaflet included information for patients on raising concerns and the website enabled patients to give feedback by email.

When we spoke with patients, they told us they knew how to raise any concerns or complaints. Comments cards and patients we spoke with identified that some patients were concerned about the length of time to see their preferred GP and that appointments often ran behind time. The practice was already aware of these themes and was working with staff on possible improvements.

Complaints were given a high priority and used to improve the service wherever possible. A record of the concerns and complaints showed that 23 were received between April 2014 and March 2015. These were accepted in written or verbal format, considered by the managing partner and appropriate action taken to notify the patient of any outcomes and apologise. Actions included feeding back concerns at staff meetings such as patient dissatisfaction about appointments running behind time and adding additional baby change facilities.

An overview of the complaints received allowed the practice to identify any trends being raised. There were no outstanding complaints at the time of the inspection.

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 business and succession plan in place that focused on ensuring the delivery of high quality care and promoting good outcomes for patients. We found the practice was refining their vision for the service in discussion with all staff groups. This was to ensure they could continue to provide a service that used resources wisely and responded to the needs of the local population. We spoke with 12 members of staff who knew what their responsibilities were in relation to supporting practice values and were aware of the challenges faced by the practice in terms of delivering a responsive service.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. The policies and procedures had been reviewed regularly and were up to date. Staff we spoke with told us they referred to their protocols in everyday practice and they were particularly helpful to support new staff that were learning their role.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a reception team manager, a lead nurse for infection control and a GP lead for safeguarding. We spoke with 12 members of staff and they were all clear about their own roles and responsibilities. They told us they felt valued and supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards with some areas scoring above average (learning disabilities register and management of palliative care patients). The QOF performance data was discussed at team meetings with staff so that improvements could be made or maintained where possible.

The practice had conducted several reviews of activities or services they provided such as the diabetes service and antibiotic prescribing but had identified prior to the inspection, that they needed to use the clinical audit cycle in a more pro-active way to review key issues that were relevant to the health needs of their registered patients. They had developed a more detailed on-going programme of clinical audits to ensure that audits were followed up to complete the audit cycle and maximise opportunities for shared learning.

The practice had arrangements for identifying, recording and managing risks and were able to show us examples of risk management they had in place for example fire safety.

Leadership, openness and transparency

Staff told us that there was an open door culture within the practice and they felt comfortable in approaching members of the management team to ask questions or raise any issues. Members of staff told us they enjoyed their jobs and felt they worked in a supportive environment.

The practice had a clear meeting structure in place and held management meetings with the partners every two weeks where quality/governance issues were raised. All GPs met together every two weeks and the managing partner met weekly with the nursing team. A separate meeting was held between the managing partner and the health care assistants every three months. The managing partner also called meetings for relevant staff to discuss current issues on an as required basis. For example issues with the patient appointment system so that any changes could be identified and addressed in a timely way.

We found that the process to share learning from any significant events, incidents or complaints required improvement to ensure that such learning was always shared with the staff team in a timely way.

The managing partner was responsible for human resource policies and procedures. The policies we reviewed demonstrated these were fit for purpose and readily available for staff when required.

One GP also worked part time for NHS England on a local basis to lead on issues in General Practice across the area.

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

The practice had established methods for gathering feedback from patients. This included a patient survey last completed in 2014. The practice decided to run this particular survey through their website and received 107 responses. The results of the survey were reviewed and shared with the staff team. An action plan was agreed in

Are services well-led?

Good

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

discussion with the patient participation group (PPG) and patient feedback was provided in the practice's spring newsletter. A PPG is a group of patients registered with a practice who work with them to improve services and the quality of care. One of the issues raised was the difficulties patients experienced in booking appointments online. The practice responded by increasing the number of appointment slots that were available to meet the demand for online booking.

For several months the practice have been using the NHS Friends and Family Test (FFT) as another method of seeking feedback from patients. A link to the form is also provided on the practice website. The feedback is monitored and responses are given where appropriate by the practice manager. For example further improvements have been made to the to baby change facilities.

The practice had an active patient participation group (PPG) that had been established for 19 years. We spoke with a representative who had been a member throughout this time. We found they had a positive relationship with the practice team and felt able to challenge and support improvements to the service. The PPG committee meetings were held every three months. The managing partner was a member of the committee. Patient education evenings were held twice a year with a variety of topics, including updates about local and national changes in the NHS and how this impacts on local services.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Conversations with staff showed they felt involved and engaged in the practice to improve outcomes for both staff and patients. The practice had a whistleblowing policy which was available to all staff within the practice.

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 looked at five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they also had monthly education meetings where guest speakers attended. One session for example, was led by a consultant in palliative care on supporting patients and families to make decisions about their care at the end of life. We saw evidence that induction programmes were in place for clinical and non-clinical staff. The practice was a GP training practice and took up to two GP trainees at a time and some medical students.

The practice completed reviews of significant events and complaints and shared these with staff at meetings to ensure the practice improved outcomes for patients.

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 **Patients were not always protected against the risks associated with the management of medicines because the provider did not have appropriate arrangements in place for the safe keeping and dispensing of medicines.** Regulation 12 (2) (g)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.