Station Street Surgery

Quality Report

45 Station Street
Atherstone
Warwickshire
CV9 1DB
Tel: 01827718631
Website: www.stationstreet.warwickshire.nhs.uk

Date of inspection visit: 24 February 2015
Date of publication: 02/07/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected this service on 24 February 2015 as part of our new comprehensive inspection programme.

The overall rating for this service is good. We found the practice to be rated as good in providing safe, effective, caring, responsive and well-led services. We found the practice provided good care to older people, people with long term conditions, families, children and young people, the working age population and those recently retired, people whose circumstances may make them vulnerable and people experiencing poor mental health.

Our key findings were as follows:

- Patients were kept safe because there were arrangements in place for staff to report and learn from incidents that occurred. The practice had a system for reporting, recording and monitoring significant events over time.
- There were systems in place to keep patients safe from the risk and spread of infection.
- Evidence we reviewed demonstrated that patients were satisfied with how they were treated and that this was with compassion, dignity and respect. It also demonstrated that the GPs were caring, good at listening to patients and gave them enough time.
- The practice had an open culture that was effective and encouraged staff to share their views through staff meetings and significant event meetings.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Lessons were learned and communicated widely to support improvement although these had not always been formally recorded. Risks to patients were assessed and well managed.

There were robust safeguarding measures in place to help protect children and vulnerable adults. Reliable systems had been arranged for safe storage and use of medicines and vaccines within the practice. There was a designated lead to oversee the hygiene standards within the practice to prevent infections. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Clinicians worked to the National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. NICE is the organisation responsible for promoting clinical excellence and cost-effectiveness and producing and issuing clinical guidelines to ensure that every NHS patient gets fair access to quality treatment.

Patients' needs were assessed and care planned and delivered in line with current legislation. Clinicians had carried out clinical audits and made changes where necessary to promote effective treatments for patients. Systems were in place for regular reviews of patients who had long term conditions, those identified as at risk and housebound patients. Staff had received training appropriate to their roles and any further training needs had been identified and planned. The practice could show that appraisals and the personal development plans had been completed for all staff. Staff worked well with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. Staff treated patients with kindness and respect and maintained confidentiality.

Summary of findings

We observed staff interacting with patients in a caring and supportive way. Accessible information was provided to help patients understand the care that was available to them.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Patients told us they could get an appointment with a named GP or a GP of choice, with continuity of care and urgent appointments available the same day.

The practice had good facilities and was well equipped to assess and treat patients in meeting their needs. There was an accessible complaints system with evidence demonstrating that the practice responded appropriately and in a timely way.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice saw the provision of quality and caring services as its top priority. All practice staff worked together to achieve this. Staff had received regular performance reviews and attended staff meetings and events. An induction procedure was in place for implementation when new staff were employed to work at the practice.

Patients told us that the practice was always supportive and provided excellent care to meet the healthcare needs of patients. The practice had responded to feedback from staff about the services offered and how improvements could be made to benefit the practice and its patients.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. The practice offered proactive, personalised care to meet the needs of its population. Practice staff were responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs.

Many of the patients had been with the practice for many years and were known to the GPs. As a small practice relationships had been established over time which gave patients the confidence that the GP knew their medical history and were able to respond to their health needs accordingly.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Practice staff held a register of patients who had long term conditions and carried out regular reviews. There was a recall system in place when patients failed to attend for their reviews.

For patients with the most complex needs GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care. Emergency processes were in place and referrals were made for patients who had a sudden deterioration in health. The practice specifically reviewed all hospital admissions so that lessons could be learnt.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Practice staff liaised with local health visitors to offer a full health surveillance programme for children. Checks were also made to ensure maximum uptake of childhood immunisations. The practice nurse offered immunisations to children in line with the national immunisation programme. Alerts and protection plans were in place to identify and protect vulnerable children.

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. The practice offered patients in this group open access or specific appointment times which were accessible, flexible and offered continuity of care.

Summary of findings

The practice was proactive in offering a full range of health promotion and screening that reflected the needs of this age group. This included health checks for patients aged 40 - 70 years of age.

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 those with a learning disability. It had carried out annual health checks for patients with a learning disability and most of these patients had received a follow-up. It offered longer appointments for these patients.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. GPs carried out regular home visits to patients who were housebound and to other patients on the day they had been requested.

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). The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. They carried out screening for patients identified at risk of dementia and advance care planning for patients diagnosed with dementia.

Patients who presented with anxiety and depression were assessed and managed within with the National Institute for Health and Care Excellence (NICE) guidelines. Annual health checks were offered to patients who had serious mental illnesses.

GPs had the necessary skills and information to treat or refer patients with poor mental health. Practice staff worked in conjunction with the local mental health team to ensure patients had the support they needed. The practice participated in the local enhanced scheme for patients with dementia to ensure regular reviews were carried out and care plans were developed.

Summary of findings

What people who use the service say

We reviewed the 28 patient comments cards from our Care Quality Commission (CQC) comments box that we had asked to be placed in the practice prior to our inspection. Patients who had completed these comment cards had written extremely positive comments. These included that the staff were lovely and caring and that the GPs listened to them. Patients said they were happy with the appointment system at the practice and knew that they could always get an appointment when they needed one. We spoke with two patients during the inspection and they confirmed that they were treated well, with dignity and respect by all staff at the practice. They confirmed they were happy to wait to see a GP, knowing that if they arrived by 10am they would be seen that morning.

At the time of the inspection the practice no longer had an active Patient Participation Group (PPG). PPGs are an effective way for patients and practice staff to work together to improve services and promote quality care. The practice website and the practice newsletter requested patients to join a PPG and the practice confirmed they were making efforts to establish another group.

The results from the National Patient Survey 2014 showed that 93% of patients felt that their overall experience of the practice was good and 84% of patients would recommend the practice to someone new to the area.

Station Street Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP specialist advisor.

Background to Station Street Surgery

Station Street Surgery is located in Atherstone and provides primary medical services to patients in and around the Atherstone area.

The practice ownership changed at the end of 2014, when the now senior partner took over the practice and registered in January 2015 with the Care Quality Commission (CQC). Following the new ownership of the practice changes have been made, with further plans for development to the management of the practice and to the structure of the practice building.

Station Street is a small practice in an area with a higher number of older patients on their register, together with younger patients with varied health needs, such as drug or alcohol problems. The practice told us they also have a temporary migrant population.

The practice has two GP partners (male) and one salaried GP (female). A locum GP works at the practice on a regular basis. There is a practice manager, one practice nurse, administrative and reception staff. There were 2830 patients registered with the practice at the time of the inspection. The main practice is open from 8.30am to 5.30pm Mondays, Wednesdays and Fridays; from 8.30am to 5pm on Tuesdays; and 8.30am to 4.30pm on Thursdays. Home visits are available for patients who are too ill to attend the practice for appointments. The practice has a branch surgery at Baddesley Ensor Health Centre. The branch surgery is open for appointments only, for an hour each day on Mondays, Tuesdays and Wednesdays and for half an hour on Thursdays and Fridays. We did not inspect the branch as part of this inspection.

The practice treats patients of all ages and provides a range of medical services. The practice provides a number of clinics such as chronic disease management which includes asthma, diabetes, heart disease and stroke, obesity and dietary clinics and smoking cessation clinics. It offers child and travel immunisations. The practice does not provide an out-of-hours service to patients but has alternative arrangements in place for patients to be seen when the practice is closed. For example, the practice telephone answer machine and the website advises patients with severe chest pain, loss of blood, suspected stroke or suspected broken bones to call 999 and ask for an ambulance. Patients are advised to contact NHS 111 in the event they need urgent advice. Alternatively, patients can visit the walk in centre at nearby Camp Hill, which is a GP led heath centre open from 8am to 10pm, seven days per week.

Station Street Surgery has a General Medical Services(GMS) contract.

Why we carried out this inspection

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

Detailed findings

legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

Before our inspection of Station Street Surgery we reviewed a range of information we held about this practice and asked other organisations to share what they knew. We contacted Warwickshire North Clinical Commissioning Group (CCG) and the NHS England Area team to consider any information they held about the practice. We also supplied the practice with comment cards for patients to share their views and experiences of the practice.

We carried out an announced inspection on 24 February 2015. During our inspection we spoke with a range of staff that included the senior partner GP, the practice manager, the practice nurse and reception staff. We also looked at procedures and systems used by the practice.

We observed how staff interacted with patients who visited the practice. We reviewed 28 comment cards where patients and members of the public shared their views and experiences of the practice.

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?

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

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People whose circumstances may make them vulnerable
- People experiencing poor mental health

Good

Are services safe?

Our findings

Safe track record

The practice was able to demonstrate it had a good track record for safety. Practice staff used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts, as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. The practice manager showed us there were effective arrangements in line with national and statutory guidance for reporting safety incidents.

The GPs and practice manager held regular meetings which included a review of the practice's safety record. From the minutes we saw we found that minutes had not been kept for all meetings. The practice manager confirmed this was an area they had identified where improvements had been needed and minutes were to be kept for all future meetings.

We reviewed safety records and incident reports and saw how the practice manager recorded incidents and ensured they were investigated. We saw that where action had been required systems had been put in place to address them.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these.

We saw that three significant events had occurred in the time following the change of practice ownership in 2014. We saw that each of these events had been individual occurrences and had not identified any themes or trends. For example, one event had involved violence and aggression towards staff and another had recorded that a medicine prescribed by the practice had been incorrectly supplied by the pharmacy. In all events, the key issues had been identified, action taken and discussions held with relevant staff to prevent any recurrences.

Although staff confirmed that significant events were a standing item on the practice meeting agenda both the senior GP and the practice manager were aware that they needed to formalise the meetings and ensure that minutes accurately reflected the discussions and learning that took place. They told us arrangements had been made to address this for all future meetings.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Training records made available to us showed that all staff had received relevant role specific training on safeguarding. This was confirmed when we spoke with staff. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours and those details were easily accessible.

The senior GP was appointed as the lead for safeguarding vulnerable adults and children. The GP had been trained to an appropriate level and demonstrated they had gained the necessary knowledge from this training to enable them to fulfil this role. Staff confirmed they knew who the safeguarding lead was and that they were able to access policies and procedures we saw available in the practice. Staff explained to us the processes they would follow in the event they became concerned that a patient may be at risk of harm. The lead safeguarding GP was aware of vulnerable children and adults registered with the practice. There was a system to highlight vulnerable patients on the practice's electronic records. This included information so that staff were aware of any relevant issues when patients attended appointments.

A chaperone policy was in place and information about the service was visible on the waiting room noticeboard and in consultation rooms although this information was not included on the practice's website. 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. The policy included details about who was able to act as a chaperone, confidentiality and the procedure to follow including recording information in patients notes post examination. Staff told us that they always asked patients whether they required a chaperone when they received any intimate treatment. The practice nurse and GPs carried out chaperone duties when required.

Good

Are services safe?

Medicines management

We saw that the practice had policies and procedures in place for the management of medicines dated September 2014. This included safe stock control, dispensing medicines to patient, disposal and safe storage of vaccines. Staff told us they were aware of these policies and procedures and confirmed they were able to access these as required.

We saw that there was a protocol for repeat prescribing which was in line with national guidance. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff confirmed they followed the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. Cleaning schedules were in place and cleaning records were kept. Patients commented that they always found the practice clean and tidy, and had no concerns about infection control.

The practice manager was the lead for infection control. All staff received induction training about infection control specific to their role. We saw evidence that infection control audits had been carried out. We looked at the audit completed for 14 July 2014. This audit had a plan in place which identified actions that needed to be completed, such as wall mounted paper towel holders to be installed in toilets, consulting and treatment rooms throughout the practice building. Following the completion of an extension to the practice building a follow up audit had been completed on 13 February 2015. This showed that all actions from the July 2014 audit and been completed. Staff and the practice manager told us that where actions following infection control checks had been identified, information had been shared with them.

Staff records showed where staff had completed infection control training with further training arranged during protected learning time at the end of February 2015. Staff we spoke with confirmed this.

We saw that staff had access to the infection control policy and posters were displayed in consultation rooms. 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.

We saw that personal protective equipment including disposable gloves, aprons and coverings for examination couches were available for staff to use. Staff described to us how they would use these to comply with the practice's infection control policy.

There were arrangements in place for the safe disposal of clinical waste and sharp instruments, such as needles and blades. We saw evidence that their disposal was arranged through a suitable company. There were guidelines informing staff what to do in the event of a needle stick injury. Staff confirmed to us that they knew what action to take in the event they or a colleague sustained such an injury. We saw clear guidelines displayed in the treatment rooms to guide staff.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). Records showed that the practice was carrying out regular checks in line with this policy, to reduce the risk of infection to staff and patients. For example, we saw that a legionella check had been carried out in January 2015. The practice manager told us that an updated risk assessment would be done now that the extension work to the practice building had been completed to ensure all areas were included in the risk assessment.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All

portable electrical equipment was routinely tested and stickers indicating the last testing date were displayed. For example, equipment checks had been done 24 February 2014. We saw that a schedule of testing was in place.

We saw maintenance records which showed equipment at the practice was being serviced. Calibration stickers were seen on relevant equipment including weighing scales and blood pressure machines. This ensured they were fit for use. For example, we saw that annual calibration (testing for accuracy) of relevant equipment such as weighing scales, nebulisers and blood pressure monitoring machines had been carried out on 23 February 2015.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Many of the staff who worked at the practice had been employed for many years with the previous owner. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment for the most recently recruited member of staff. For example, proof of identity, references, qualifications, registration with the appropriate professional body and criminal records checks as required through the Disclosure and Barring Service (DBS). The practice manager showed us the risk assessment form that would be completed for those staff employed where a DBS check was not required, such as reception staff that had no direct patient contact.

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 to ensure that there were enough staff on duty. Staff told us they worked additional hours to cover sickness and annual leave within the practice. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

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, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

The GPs and practice manager informed us there were sufficient appointments available for high risk patients, such as patients with long term conditions, older patients, and babies and young children. Patients were able see a GP through open access appointments each morning or they were offered appointments that suited them, for example same day, next day or pre-bookable appointments with their choice of GP. There was a system in place that ensured patients with long term conditions were invited for regular health and medicine reviews and followed up if they failed to attend.

The practice had identified and monitored patients with long term conditions who were at high risk of an unplanned hospital admission. The practice completed care plans with patients and ensured these were followed up and reviewed every month.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage medical emergencies. We saw records that showed all staff had received training in basic life support and staff confirmed they knew how to respond to a medical emergency should one occur. Emergency equipment was available that included a resuscitation kit with disposable airways to support patients should they stop breathing, access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). We found that although the oxygen cylinder had been available and regularly checked to ensure that it was fully operational the cylinder had not been serviced according to the manufactures guidance. We discussed this with the practice manager and immediate action was taken to address this during the inspection. They now had a system in place for checking the medicines in the GP home visit bag which provided us with assurance that this issue was now addressed. Staff we spoke with knew the location of this equipment and records we saw confirmed these were checked regularly.

We saw that a kit was available for the emergency treatment of allergic reactions that may occur at the practice. However, this kit had limited supplies of the type of medicines that could be used. We saw that no risk

Good

Are services safe?

assessment had been completed by the practice to show their rationale for the limited stock of emergency medicines held. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. However, when we checked the medicines stocked in the GP home visit bag we found that three of the four medicines in the bag were out of date. The practice addressed this following the inspection and sent us details of the completed risk assessment and confirmed that all medicines were now stocked, as recommended by professional bodies such as the British Medical Association (BMA).

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. The risk assessment had been updated 10 January 2015 following the extensions to the property. Records showed that staff were up to date with fire training.

There were systems in place to respond to emergencies and major incidents within the practice. Risks identified included power failure, loss of main surgery building, loss of medical records, staff shortage and access to the building. The business continuity plan provided action plans and important contact numbers for staff to refer to which ensured the service would be maintained during any emergency or major incident. For example, contact details of an electrical company to contact in the event of failure of the electricity supply and utility services such as heating and water suppliers. We saw that the plan was scheduled for review in December 2016. The practice manager confirmed that copies of this plan were held off site with designated management staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. They also described the processes they followed to ensure that informed consent was obtained from patients whenever necessary, and demonstrated awareness of the requirements of the Mental Capacity Act (MCA) 2005 used for adults who lacked ability to make informed decisions.

The practice nurse we spoke with told us they carried out regular health checks of patients with range of long term conditions. They confirmed that meetings were held with the palliative care teams to ensure co-ordinated care was provided to patients that matched their needs and wishes. The practice manager told us that minutes of these meetings had not been kept but confirmed that minutes would be kept for all future meetings.

The GPs attended educational meetings facilitated by the Clinical Commissioning Group (CCG), and engaged in annual appraisal and other educational support. The annual appraisal process required GPs to demonstrate that they had kept up to date with current practice, evaluated the quality of their work and gained feedback from their peers. GPs told us they ensured best practice was implemented through regular training, networking with other clinical staff and regular discussions with the clinical staff at the practice. We were told that GPs were very approachable and that staff felt able to ask for support or advice if they felt they needed it.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with the senior partner GP, the practice manager and the practice nurse showed that the culture in the practice was that patients were referred on need and that age, sex and ethnicity was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Staff throughout the practice had key roles in monitoring and improving outcomes for patients. These roles included infection control, scheduling clinical reviews, managing medicine alerts and medicines management. There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They 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. The computer system flagged up relevant medicines alerts when the GP prescribed specific medicines.

There was a system in place for carrying out clinical audits. Clinical audits are quality improvement processes that seek to improve patient care and outcomes through systematic review of care and the implementation of change. It includes an assessment of clinical practice against best practice such as clinical guidance to measure whether agreed standards are being achieved. The process requires that recommendations and actions are taken where it is found that standards are not being met. GPs were supported by a pharmacist who visited the practice each week. This resulted in a number of clinical audits regarding prescribed medicines. We found that these audits were still in the early stages of completion and GPs told us further audit cycles would be completed over a period of time, and for some audits reviews would be on-going.

Clinical staff actively participated in recognised clinical quality and effectiveness schemes such as the national Quality Outcomes Framework (QOF) and the local Clinical Commissioning Group (CCG) enhanced service schemes. QOF is a national performance measurement tool. We were shown the latest QOF achievements that told us that practice staff were meeting the national standards.

The senior GP partner showed us data from the local CCG of the practice's performance for antibiotic prescribing dated 19 August 2014. The data showed that the prescribing rate for a medicine used to treat high cholesterol by the practice was 4%, which was higher than the national average of 2.67%. We discussed this with the practice manager and the senior GP who told us that an audit had confirmed the prescribing rate had been reduced to 2.87% at the time of the inspection.

We saw details of a report on the prescribing of antibiotic medicines and saw that rates had increased from 5% in

Good

Are services effective?

(for example, treatment is effective)

May 2013 to 9.06% in September 2014. The senior GP told us audits of prescribing had been carried out. We saw copies of monthly reports that showed a steady prescribing decrease with the latest rate of 7.37% being achieved.

Practice meetings were held weekly on Friday afternoons to discuss clinical matters, significant events and any complaints received. This included GP partners and the practice manager. The senior GP and the practice manager told us that records of these meetings had not always been kept and that they had identified this as an area for improvement within the practice. We were assured that minutes would be taken at all future meetings at the practice to ensure evidence of discussion, learning and sharing of information had taken place.

The practice had a palliative care register and had regular contact with multidisciplinary teams and attended relevant meetings to discuss the care and support needs of patients and their families.

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 training courses such as annual basic life support. All GPs had completed their yearly continuing professional development requirements and all had either been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. 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).

All staff undertook annual appraisals that identified learning needs from which action plans had been documented. We saw that the practice nurse's appraisals were carried out by the senior GP partner. Staff confirmed that the practice was proactive in providing training and funding for relevant courses. For example, staff told us they were able to access on line training courses as well as vocational courses as these became available.

The practice nurse was expected to perform defined duties and was able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, ear syringing, smoking cessation programme and lifestyle advice.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. It received blood test results, x-ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The GP who saw these documents and results was responsible for the action required. Patients were invited to contact the practice to receive their test results. However, if a test result was abnormal, patients would be contacted and informed by the GP either face to face or by telephone consultation.

All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice participated in multidisciplinary team meetings as required to discuss the needs of complex patients, for example those with end of life care needs or children who were considered to be at risk of harm. These meetings included health visitors and palliative care nurses. Decisions about care planning were documented in each patient's record. Staff felt this system worked well.

Information sharing

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

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals. The practice made referrals directly and 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 GP and practice nurse we spoke with told us they had good working relationships with community services, such

Good

Are services effective?

(for example, treatment is effective)

as district nurses. There was good evidence of joint working relationships and their ability to make contact with each other at short notice when a patient's condition changed to enable provision of appropriate care. Although health visitors did not attend meetings at the practice, staff told us they were accessible and they had a good working relationship with them.

Consent to care and treatment

Patients told us they had been involved with decisions about their healthcare and treatments. They had been provided with sufficient information that enabled them to make choices and felt they had been able to ask questions when they had been unsure about anything.

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. The clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice, in relation to consent to treatment.

The GP we spoke with knew how to assess the competency of children and young people as to their capability to make decisions about their own treatments. They understood the key parts of legislation of the Children and Families Act 2014 and were able to describe how they implemented it in their practice. The GP demonstrated a clear understanding of the Gillick test. The Gillick test helps clinicians to identify children under 16 years of age who have the legal capacity to consent to medical examination and treatment.

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

The practice had not needed to use restraint in the last three years, but staff we spoke with were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

It was practice policy to offer all new patients registering with the practice a health check with the GPs or practice nurse. The GP was informed of all health concerns detected and these were followed up in a timely manner. We noted a culture amongst the GPs and the practice nurse to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by carrying out opportunistic medicine reviews, offering lifestyle advice, or to review the patient's long term condition.

The practice also offered NHS Health Checks to all its patients aged 40-75 years of age. The NHS Health Check programme was designed to identify patients at risk of developing diseases including heart and kidney disease, stroke and diabetes over the next 10 years. GPs and clinical staff showed us how patients were followed up within two weeks if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The practice also kept a register of all patients with learning disabilities and these patients were offered annual physical health checks. The practice manager confirmed that of the five patients with a learning disability, four reviews had been completed with one review declined. We were told that the patient's record had been amended to show that the healthcare review offered had been declined. Similar mechanisms were in place to identify patients at risk such as those who were likely to be admitted to hospital and or patients receiving end of life care. These patient groups were offered further support in line with their needs.

The practice offered a full range of immunisations for children and flu vaccinations in line with current national guidance. The practice offered flu vaccinations to patients over the age of 65 and to patients with chronic diseases such as asthma, diabetes, heart disease, and kidney disease.

Patients were encouraged to take an interest in their health and to take action to improve and maintain it. We saw that a range of health promotion leaflets were available in the reception area, waiting room, treatment rooms and on the practice's website. Clinical staff we spoke with confirmed that health promotion information was available for all patients. They told us that they discussed health issues such as smoking, drinking and diet with patients when they carried out routine checks with patients. Staff confirmed that patients were given information to access other services as was needed.

Good

Are services effective?

(for example, treatment is effective)

The practice was also designated as a Place of Safety for vulnerable people and staff had been trained accordingly. A place of safety is a community place where people could go to get help if they felt unsafe, at risk or vulnerable when they were out in the community.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction from the national GP Patient Survey dated July 2014. The evidence showed that patients were satisfied and felt they were treated with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated above average for its satisfaction scores on consultations with GPs and the practice nurse. Data showed that 79% were satisfied with appointment times which was comparable with the national average of 80%; 92% described their experience of making an appointment as good compared with a national average of 75%; and 84% of patients would recommend this practice to someone new to the area which compared with a national average of 79%.

Patients were invited to complete CQC comment cards to provide us with feedback on the practice. We received 28 completed cards and all gave positive feedback about the service they experienced. Patients commented that they thought the practice was very good, efficient and very caring. Other patients commented they had been registered with the practice for many years and had always been treated with respect and courtesy, and that treatment had always been first class. We spoke with two patients during the inspection who told us they were happy with the appointments system and confirmed that they could always see a GP when they needed.

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

Staff told us they offered a chaperone service if patients preferred. Staff we spoke with told us they had received chaperone training. We saw records to confirm that training had been completed 25 September 2014. Staff told us that information was made available to patients to inform them that a chaperone option was available to them. We saw information displayed in the reception area that confirmed this.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us they would investigate these and any learning and changes to practise identified would be shared with staff.

Care planning and involvement in decisions about care and treatment

Patients told us on the comment cards and in person that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also commented that they felt supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.

GPs and staff demonstrated knowledge regarding best interest decisions for patients who lacked capacity. They told us that patients were always encouraged to be involved in the decision making process. They told us that they always spoke with the patient and obtained their agreement for any treatment or intervention even if a patient had attended with a carer or relative.

The practice was able to evidence joint working arrangements with other appropriate agencies and professionals. For example, palliative care was carried out in an integrated way. This was done using a Multidisciplinary Team (MDT) approach with district nurses, palliative care nurses and hospitals.

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 patients that this service was available.

Patient/carer support to cope emotionally with care and treatment

Comment cards completed by patients were positive about the emotional support provided by the practice. For example, comments confirmed that staff responded compassionately when they needed help and provided support when required. Patients said that the staff had always been supportive of them and their family, and were very friendly and caring.

Good

Are services caring?

Notices and leaflets in the patient waiting room and the practice website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

We saw that regular multi-agency meetings were held and recorded. End of life care and bereavement information was available to patients and their relatives or carers in the waiting rooms on the practice noticeboard. The practice manager informed us the respective GP contacted bereaved families and went out to visit them. The practice also offered the opportunity to speak with the GP or a nurse whenever they wanted to.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged with them to discuss local needs and service improvements that needed to be prioritised. The senior GP told us that the practice was preparing to become more involved in medical research in order to develop the service provided to patients.

The practice delivered core services to meet the needs of the main patient population they treated. For example, screening services were in place to detect and monitor the symptoms of long term conditions such as asthma and diabetes. Clinical staff told us they carried out regular and routine blood tests for patients with diabetes. They explained they also used these sessions to give dietary advice and support for patients on how to manage their conditions. Longer appointments were available for patients who needed them such as patients with mental health concerns, learning disabilities and long term conditions.

The practice had register of patients who had mental health concerns and we saw that annual health checks had been carried out. The practice had a palliative care register and regular multidisciplinary meetings were held to discuss patient and their families care and support needs.

Tackling inequity and promoting equality

The practice proactively removed any barriers that some people faced in accessing or using the service. A female GP worked at the practice and was able to support patients who preferred to have a female doctor. This also reduced any barriers to care and supported the equality and diversity needs of the patients.

There were arrangements in place to ensure that care and treatment was provided to patients with regard to their disability. For example, the practice was on one level and there were no steps to negotiate. Doors were wide enough for patients in wheelchairs to gain access. 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.

The practice had recognised the needs of different groups in the planning of its services such as carers and vulnerable patients who were at risk of harm. The computer system used by the practice alerted GPs if patients had a learning disability, or if a patient was also a carer so that additional appointment time could be made available. For example, where patients were also identified as carers we saw that information was provided to ensure they understood the support that was available to them should they need it. Staff told us that translation services were available for patients who did not have English as a first language. This service could be arranged to take place either by telephone or in person.

The practice had a policy in place and provided equality and diversity training through e-learning. Clinical staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months. We saw training records that confirmed this training had been completed or was planned.

Access to the service

The practice operated open access sessions for patients to see GPs on weekday mornings, with appointments available weekday afternoons. The main practice was open from 8.30am to 5.30pm Mondays, Wednesdays and Fridays; from 8.30am to 5pm on Tuesdays; and 8.30am to 4.30pm on Thursdays. Home visits were available for patients who were too ill to attend the practice for appointments. The practice had a branch surgery at Baddesley Ensor Health Centre. The branch surgery was open for appointments only, for an hour each day on Mondays, Tuesdays and Wednesdays and for half an hour on Thursdays and Fridays.

Information was available to patients about appointments on the practice leaflet and through their website. This included details on how to arrange home visits. The practice did not provide an out-of-hours service to patients but had alternative arrangements in place for patients to be seen when the practice was closed. For example, the practice telephone answer machine and the website advised patients with severe chest pain, loss of blood, suspected stroke or suspected broken bones to call 999 and ask for an ambulance. Patients were advised to

Good

Are services responsive to people's needs?

(for example, to feedback?)

contact NHS 111 in the event they needed urgent advice. Alternatively, patients could visit the walk in centre at nearby Camp Hill, which was a GP led heath centre open from 8am to 10pm, seven days per week.

Patients confirmed on the comment cards that they were always able to see a GP on the same day if they needed to and they could see another GP if there was a wait to see the GP of their choice. Patients commented that they had always been able to see a GP when they were in urgent need of treatment on the same day of contacting the practice.

Patients we spoke with told us they were happy with the availability of appointments and told us they knew that they would be seen by the GP at open access times provided they arrived by 10am. Patients who completed comment cards confirmed they were happy with the appointment system.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. The practice notice board had information available to patients about how to make a complaint if they needed to.

Practice staff had a system in place for handling concerns and complaints. The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. The summary of the five complaints received demonstrated that all complaints had been investigated, responded to and there were instances where changes had been made to prevent recurrences. Practice staff told us that the outcome and any lessons learnt following a complaint were shared with relevant staff and discussed during meetings.

We saw that complaints had been received by letter and by email. The method of complaints received by the practice had indicated patients knew how to complain. Patients we spoke with and patients recorded on comment cards that they were aware of the process to follow should they wish to make a complaint. None of these patients had ever needed to make a complaint about the practice.

The practice kept a record of all compliments received, such as one from a patient's family who was grateful for all the help and support they had received through a particularly difficult time.

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

Station Street Surgery is a small practice within the town of Atherstone. GPs told us their aim for the practice was to deliver high quality care and promote good outcomes for patients. The practice considered that to be able to deliver this service they needed to be knowledgeable, caring, competent and compassionate at all times. The practice aimed to ensure patients had easy access to the services they required and that they understood the care and treatment they were offered. We spoke with four members of staff and they all demonstrated that they understood the vision and values for the practice. They knew what their responsibilities were in relation to these. They told us they felt all staff worked as a team and were encouraged to make suggestions that led to improved systems and patient care.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff in hard copies and on the computer within the practice. We looked at six of these policies and procedures. We saw plans were in place to ensure these were reviewed annually or sooner if required.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. QOF is a national performance measurement tool. We were told by the senior partner GP and the practice manager that QOF data was regularly discussed at their practice meetings. These meetings had previously been held informally. Minutes had not been recorded or specific action plans produced to demonstrate what action had been agreed to be taken to maintain or improve outcomes for patients. The practice had recognised this as an area for improvement and we saw that plans were in place to address this for all future meetings.

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

Leadership, openness and transparency

There was a clear and visible leadership and management structure in place. Staff told us that there was a positive culture and focus on quality at the practice. We saw examples where staff had been supported and encouraged to develop their skills through individual appraisals. We spoke with four staff who confirmed that there was an open and transparent culture of leadership, encouragement of team working and concern for staff well-being.

Staff told us that the practice was well led. We saw that there was strong leadership within the practice and the senior management team were visible and accessible. The practice manager told us that they met with the GPs each week and information from those meetings was shared with staff. Staff told us that the GPs and the practice manager were very supportive.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, an induction policy and a recruitment and equal opportunities policy which were in place to support staff. Staff we spoke with knew where to find these policies if required.

The feedback we received from patients was positive about the staff at the practice. They said that staff had a professional and respectful approach.

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

The practice had previously had an active patient participation group (PPG). PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The purpose of the PPG was to discuss the services offered and discuss how improvements could be made to benefit the practice and its patients. We saw reports from the previous two years where the group had met and had discussed a range of topics. This included the results of the patient surveys that had been completed during the years 2012 and 2013.

The practice manager told us that they aimed to restart the PPG and would be actively recruiting to achieve this in the near future. We spoke with two previous members of the PPG who told us about their time with the group. Their overall experience was positive and they told us they had developed positive relationships with the previous practice owner and staff in working towards improved outcomes for patients.

Are services well-led?

Good

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

Staff told us that staff meetings usually took place every month. They confirmed that practice discussions and information sharing took place during these meetings. Staff told us that they felt able to make contributions and suggestions at all times and their views were actively sought and acted upon. They told us they could also meet with the practice manager whenever they wished. This supported staff to be able to discuss issues and raise any concerns they may have.

Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. For example, staff had identified that open surgery days were busiest on Mondays and Fridays. Staff told us they had suggested that two GPs worked on those days instead of one and this had been agreed by the practice and implemented at the end of 2014. They told us this had improved access and outcomes for patients.

Management lead through learning and improvement

The practice held regular meetings that ensured continued learning and improvements for all staff, although minutes of these had not always been recorded. All staff we spoke with confirmed that meetings had taken place on a range of topics. This included significant events, complaints and palliative care for patients, with discussions on actions to be completed where appropriate.

Staff told us that senior staff supported them to maintain their clinical professional development through training and mentoring. We looked at some staff files and saw that regular appraisals had taken place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had protected learning time where guest speakers and trainers attended.

GPs held regular meetings to discuss each patient who had been admitted to hospital to monitor their progress and to determine if there were any lessons to be learnt.