

Wheal Northey 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?		Good	
Are services effective?		Good	
Are services caring?		Good	
Are services responsive to people's needs?		Good	
Are services well-led?		Good	

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Wheal Northey Surgery on 8 January 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for all the population groups.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said, although sometimes difficult to get through by telephone they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

The provider should:

Summary of findings

- Carry out a full infection control audit within the practice to the cleanliness of the environment, and the re-usable equipment for patient use or at point of care.

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?

The practice is rated as good for providing safe services.

Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. Medicines were stored and managed in line with national guidance. There were safeguards in place to identify children and adults in vulnerable circumstances. There was enough staff to keep people safe. Recruitment procedures and checks were completed as required to ensure that staff were suitable and competent. The practice was clean, tidy and hygienic. We found that suitable arrangements were in place that ensured the cleanliness of the practice was maintained to a high standard.

Good



Are services effective?

The practice is rated as good for providing effective services.

Supporting data obtained both prior to and during the inspection showed the practice had systems in place to make sure the practice was effectively run. The practice had a clinical audit system in place and audits had been completed. Care and treatment was delivered in line with national best practice guidance. The practice worked closely with other services to achieve the best outcome for patients who used the practice. Staff employed at the practice had received appropriate support, training and appraisal. GP appraisals and revalidation of professional qualifications had been completed. The practice had extensive health promotion material available within the practice and on the practice website.

Good



Are services caring?

The practice is rated as good for providing caring services.

Patients said they were treated with compassion, dignity and respect, they were involved in care and treatment decisions and were given sufficient time to speak with the GP or nurse.

Accessible information was provided with leaflets and information on the practice website to help patients understand the care available to them. Patients were referred appropriately to other

Good



Summary of findings

support and treatment services either within the practice or the nearest hospital. We were told by patients and we observed that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

The practice reviewed and understood the needs of their local population. The practice identified and took action to make improvements. Patients reported that they could access the practice when they needed. Patients reported that their care was good. The practice was well equipped to treat patients and meet their needs.

There was an accessible complaints system with evidence demonstrating that the practice responded appropriately and in a timely way to issues raised. There was evidence that learning from complaints was shared with staff.

Good



Are services well-led?

The practice is rated as good for being well-led.

The practice had a clear vision and strategy to deliver quality care and treatment and they were looking for ways to improve. Staff reported an open culture and said they could communicate with senior staff. The practice had a number of policies and procedures to govern activity and regular governance meetings took place. There were systems in place to monitor and improve quality and identify risks. There were systems to manage the safety and maintenance of the premises and to review the quality of patient care.

The practice had an active patient participation group (PPG) which was involved in the core decision making processes of the practice.

Good



Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as good for providing care to older people.

All patients over 75 years had a named GP. Health checks and promotion were offered to this group of patients. There were safeguards in place to identify adults in vulnerable circumstances. The practice worked well with external professionals in delivering care to older patients, including end of life care. Pneumococcal vaccination and shingles vaccinations were provided at the practice for older people on set days as well as during routine appointments.

Good



People with long term conditions

The practice is rated as good for providing care to people with long term conditions.

The practice managed the care and treatment for patients with long term conditions in line with best practice and national guidance. Health promotion and health checks were offered in line with national guidelines for specific conditions such as diabetes and asthma. Longer appointments were available for patients if required, such as those with long term conditions. The practice had a carers' register and all carers were offered an appointment for a carers' check with nursing staff. Patients were screened for depression if appropriate. All patients suffering with asthma or chronic obstructive pulmonary disease had a care plan.

Good



Families, children and young people

The practice is rated as good for families, children and young people.

Staff worked well with the midwife to provide prenatal and postnatal care. Postnatal health checks were provided by a GP. The practice provided baby and child immunisation programmes to ensure babies and children could access a full range of vaccinations and health screening. Information relevant to young patients was displayed and health checks and advice on sexual health for men, women and young people included a full range of contraception services and sexual health screening including chlamydia testing and cervical screening. The GPs training in safeguarding children from abuse was at the required level.

Good



Working age people (including those recently retired and students)

The practice is rated as good for providing care to working age people.

Good



Summary of findings

The practice provided appointments on the same day. Emergency appointments were available. The practice operated extended early opening hours four mornings and one late evening during the week. Appointments and prescriptions could be managed through the practice website. Smoking cessation appointments were available. The practice website invited all patients aged between 40 years to 75 years to arrange to have a health check with a nurse if they wanted. A cervical screening service was available.

People whose circumstances may make them vulnerable

The practice is rated as good for people whose circumstances may make them vulnerable.

The practice had a vulnerable patient register to identify these patients. Vulnerable patients were reviewed at team meetings. Referral to a counselling service was available. The practice did not provide primary care services for patients who were homeless as none were known, however, staff said they would not turn away a patient if they needed primary care. Patients with interpretation requirements were known to the practice and staff knew how to access these services. Reception staff were able to identify vulnerable patients and offer longer appointment times where needed.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as good for people experiencing poor mental health, including people with dementia.

The practice was aware of their aging population group. Staff were aware of the safeguarding principles and GPs and nurses had access to safeguarding policies. The nurses had received training in the Mental Capacity Act (MCA) 2005 and were aware of the principles and used them when gaining consent. There was signposting and information available to patients. The practice referred patients who needed mental health services and community psychiatric nurses visited the practice. Patients suffering poor mental health were offered annual health checks as recommended by national guidelines.

Good



Summary of findings

What people who use the service say

We looked at patient experience feedback from the national GP survey from 2013/2014. The patient's survey showed 95% of the 117 patients that responded found that GPs gave them the time they needed. 85% said that GPs were good at explaining treatment and tests to them. 85% of patients said that the nursing staff were very helpful and explained their treatment well and 96% of the patients found the reception staff helpful.

We spoke with three patients during the inspection and collected 15 completed comment cards which had been left in the reception area for patients to fill in before we visited. Of the comment cards, 13 gave positive feedback. The remaining two stated that they found making an appointment with a GP difficult as they could not get through on the telephone. Patients told us the staff were

friendly, they were treated with respect, their care was very good, and they were always able to get an appointment. The comment cards also told us how they felt listened to by the staff and how supportive staff were.

Patients were satisfied with the facilities at the practice. Patients commented on the building being clean and tidy. Patients told us staff used gloves and aprons where needed and washed their hands before treatment was provided.

Patients found it easy to get repeat prescriptions from the practice.

The practice had an active patient participation group (PPG). We met with a member of this group who told us how they are working with the practice to maintain and improve services for patients.

Areas for improvement

Action the service **SHOULD** take to improve

- Carry out a full infection control audit within the practice to the cleanliness of the environment, and the re-usable equipment for patient use or at point of care.

Wheal Northey Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector, a second CQC inspector, a GP specialist advisor and a practice manager specialist advisor.

Background to Wheal Northey Surgery

The Wheal Northey Surgery provides primary medical services to people living in St Austell and the surrounding areas.

The Wheal Northey Surgery is part of the consortium known as the St Austell Healthcare Group Ltd and they have in place an agreement to help manage and lead Polkyth Surgery for which they have overall responsibility for managing.

This was a comprehensive inspection.

At the time of our inspection there were approximately 8,900 patients registered at the service. There had been a vast increase of patient numbers in the past six months due to patients moving from the Polkyth Surgery. The practice had a team of three male and one female GP partners and one female salaried GP. The partners held managerial and financial responsibility for running the business. There were three nurses, a midwife and three healthcare assistants at the practice. In addition there was a practice manager, and additional administrative and reception staff.

Patients who use the practice have access to community staff including district nurses, health visitors, physiotherapists, and mental health counsellors.

The Wheal Northey Surgery is open from 8am until 6pm on Monday and 7:30am to 6pm on Tuesday through to Friday for regular appointments. During evenings and weekends, when the practice is closed, patients are directed to an Out of Hours service delivered by another provider.

The practice was a GP training practice and was able to take registrars, (doctors training to be GPs). They also had medical students from the Peninsular Medical School.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting the practice, we reviewed a range of information we held about the service and asked other organisations, such as the local clinical commissioning group, local Health watch and NHS England to share what they knew about the practice. We carried out an announced visit on 8 January 2015.

During our visit we spoke with staff and patients who used the service. We observed how people were being cared for and talked with carers and/or family members and

Detailed findings

reviewed the personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

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

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 these were discussed. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred and we were able to review these. Significant events were a standing item on the practice meeting agenda. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

National patient safety alerts were disseminated by the practice manager. Non medicine alerts were e mailed to all practice staff. Medicines alerts were e mailed to the GPs and if action was required this was documented and recorded. All alerts were discussed at practice meetings.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities

and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained to level three and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines management

The GPs were responsible for prescribing medicines at the practice. The control of repeat prescriptions was managed well. If a medication review was due then this was flagged up on the computer to alert the GP. The GP would then review the clinical records and take any appropriate action. Patients were not issued any medicines until the prescription had been authorised by a GP. Patients were satisfied with the repeat prescription processes. They were notified of health checks needed before medicines were issued. Patients explained they could use the prescription drop-off box at the practice, or use the on-line request facility for repeat prescriptions. Patients could also request that their prescriptions were sent to the chemist of their choice this resulted in them not having to make an unnecessary trip to the practice.

Safe management of medicines were in place. The practice nurse was responsible for the management of medicines within the practice and there were up-to-date medicines management policies. Staff were able to show us where medicines were stored and explain their

Are services safe?

responsibilities. Medicines were kept securely in a locked cupboard. Controlled drugs were stored in a locked cupboard. Expiry date checks were undertaken regularly and recorded.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. We saw up to date evidence that nurses had received appropriate training to administer vaccines. Fridge temperatures were also checked daily to ensure medicines were stored at the correct temperatures.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead nurse responsible for infection control. All staff had received induction training which included infection control measures specific to their role and had received annual updates. A full audit had not been carried out but we saw evidence that mini audits had been undertaken. And the findings discussed with the practice manager to implement improvements. For example following a training session in a hand washing an audit was undertaken to check the usage of liquid soap in dispensers. The results were favourable.

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, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. 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.

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 displayed stickers indicating the last testing date was. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer had been tested in September 2014.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

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.

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.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager had shared the recent findings from an infection control audit with the team.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received

Are services safe?

training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

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, and anaphylaxis.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as minor surgery and family planning. The practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice manager showed us seven clinical audits that had been undertaken in the last two years. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The

scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of pain relieving and blood thinning medicines. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

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 mandatory courses such as annual basic life support. 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).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. The lead nurse received appraisal from the practice manager and a GP and then appraised remaining nursing staff. The practice manager appraised all the administrative staff. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example, a healthcare assistant (HCA) told us that they had been a receptionist and the practice had supported her to train to be a HCA.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, administration of vaccines.

Are services effective?

(for example, treatment is effective)

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

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of

patients with complex needs. 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 practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place 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 the policy for reading and responding to hospital communications was working well in this respect. The practice undertook a yearly audit of follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed.

The practice held multidisciplinary team meetings monthly to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals through the Choose and Book system. (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). The practice had recognised the importance of timely referrals and employed a staff member for this specific role.

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 commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff had received training in and were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and was able to describe how they implemented it in their practice.

There was a practice policy for documenting consent for specific interventions. For example, the nurses obtained signed consent for ear syringing. The consent form listed any complications that may occur during the procedure as well as listing when the procedure should not be carried out allowing the patient to make informed consent.

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. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant or practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their

Are services effective?

(for example, treatment is effective)

contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice's performance for cervical smear uptake was 79.46%. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG, and again there was a clear policy for following up non-attenders by the named practice nurse.

The practice was accredited with Level 2 EEFO status. EEFO is a word that has been created by young people, to be owned by young people. EEFO works with other

community services to make sure they were young people friendly. Once a service had been EEFO approved it meant that service had met the quality standards. For example, confidentiality and consent, easy to access services, welcoming environment and staff trained on the issues young people face.

A travel consultation service was available. This included a full risk assessment based on the area of travel and used the 'Fit for travel' website. Vaccinations were given where appropriate or patients were referred on to private travel clinics for further information and support if needed.

There was information on various health conditions and self-care available in the reception area of the practice. The practice website contained information on health advice and other services which could assist patients. The website also provided information on self-care.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients told us they felt well cared for at the practice. Patients we spoke with on the day of the inspection told us they were communicated with in a caring and respectful manner by all staff. Patients spoke highly of the staff and GPs. We did not receive any negative comments about the care patients received or about the staff.

We reviewed the most recent data available for the practice on patient satisfaction. This included a national survey performed in 2014. Evidence from 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 patient survey showed the practice was rated high for all outcomes including consideration, reassurance, and confidence in ability and respect. Patients reported on consultations with doctors and nurses with 94% of practice respondents saying the GP was good at listening to them and 95% saying the GP gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 15 completed cards and the Of the comment cards, 13 gave positive feedback. The remaining two stated that they found making an appointment with a GP difficult as they could not get through on the telephone. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located in a separate room away from the reception desk. We observed this in operation during our inspection and noted that it enabled confidentiality to be maintained.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 92% of 117 practice respondents said the GP involved them in care decisions and 85% felt the GP was good at explaining treatment and results.

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

Translation services were available for patients who did not have English as a first language.

Notices in the reception areas informed patients this service was available. A hearing loop was available for patients that were hard of hearing. Information leaflets were also available in audio or large print.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and patient website also told patients how to access a number of support groups and organisations. The practice's computer system

Are services caring?

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.

Staff told us that if families had suffered bereavement, their usual GP sent a letter of condolence with leaflets giving

advice on how to find a support service. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

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 practice welcomed feedback from patients and external bodies and used significant events, complaints and near misses to improve the services provided. To obtain additional feedback from patients, a patient participation group (PPG) consisting of 42 members was in place to undertake surveys. These surveys covered topics such as opening times, making routine and urgent appointments, telephone access, environment and the overall opinion of the practice.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the PPG. For example, the practice was experiencing increased usage of the telephone system resulting in longer waits for patients. As a result of this feedback the practice recruited additional staff and increased the number of telephone lines into the practice which has improved the service.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Staff said no patient would be turned away. The practice staff knew how to access language translation

services if information was not understood by the patient, to enable them to make an informed decision or to give consent to treatment.

The practice had level access for patients using wheelchairs and patients with pushchairs. The front door and corridors were wide. The consultation and treatment rooms were on two floors, there were stairs and a lift to the first allowing easy access for patients with pushchairs and wheelchair users. Toys were available for younger children. 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.

The practice had the medical equipment it required to provide the services it offered. Clinical treatment rooms had the equipment required for minor surgery and other procedures which took place.

Access to the service

Opening times and out of hours arrangements were displayed on the front door of the practice and in all practice leaflets and on relevant posters, the practice website, and on the NHS Choices website. Appointments were available from 8am to 1pm and then from 2pm until 6pm. There were extended hours on four mornings a week and one evening a week to accommodate patients that had difficulty accessing the practice during the day.

Patients were able to telephone to pre-book an appointment with a GPs nurses and healthcare assistants. Patients could also book an appointment up to two weeks in advance on-line via the practice website using 'The Waiting Room', which was available twenty four hours a day. Patients were able to telephone the practice to make an appointment on the day with a GP, nurse or health care assistant following a triage system for patients wanting to be seen on the same day.

Comprehensive information was available to patients about appointments on the practice website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed.

If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to local care homes by a GP for those patients who needed one.

Patients were generally satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to. They also said they could see another GP if there was a wait to see the GP of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

Listening and learning from concerns and complaints

Are services responsive to people's needs? (for example, to feedback?)

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. The procedure was displayed as well as information about advocacy services. Complaints forms were

readily available on the reception desk. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and observed that themes had been identified, for example, difficulty in making an appointment in the morning. The practice had acted on this information and reviewed their telephone systems.

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

Staff were able to describe the vision, values, strategic and operational aims of the practice. Staff said one of the main strengths of the practice was the morale and team atmosphere. There were clear lines of accountability and areas of responsibility. Staff knew what their responsibilities were in relation to these.

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. We looked at these policies and procedures and most staff had completed a cover sheet to confirm that they had read the policy and when.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead for infection control and a partner was the lead for safeguarding. We spoke with 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.

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. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had an on going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example the practice were auditing medicines being prescribed in the practice.

The practice held monthly governance meetings. We looked at minutes from the last two meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team

meetings. The practice also held informal staff meetings every morning for staff to meet over coffee to discuss any issues or share learning. The staff said that this protected time was very important for them.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example disciplinary procedures, induction policy, and management of sickness which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through patient surveys and complaints received. We looked at the results of the annual patient survey and patients were making reference to the difficulty of getting through to the practice on the telephone. The practice had responded by increasing the number of telephone lines into the practice and employing additional staff to take the telephone calls.

The practice had a patient participation group (PPG). These members were regularly asked to comment on areas where they believed the practice could improve upon the services they deliver. The results and actions agreed from these surveys are available on the practice website.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us 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 in the staff handbook and electronically on any computer 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 staff files and training records and saw that regular appraisals took place which included a personal development plan.

Are services well-led?

Good 

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

The practice was a GP training practice and was able to take registrars, (Doctors training to be GPs). The practice also had medical students from the Peninsular Medical School.

The practice had completed reviews of significant events and other incidents and formally shared action and learning from these events with the staff group to ensure the practice improved outcomes for patients.

This section is primarily information for the provider

Compliance 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.

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.