Greensand Surgery - Ampthill

Quality Report

The Health Centre, Oliver Street, Ampthill
Bedfordshire, MK45 2SB
Tel: 01525631390
Website: www.greensandsurgery.co.uk

Date of inspection visit: 17 November 2015
Date of publication: 21/01/2016

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 carried out an announced comprehensive inspection at Greensand Surgery Ampthill on 17 November 2015. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events. However, records were not always kept up to date and completed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had the skills, knowledge and experience to deliver effective care and treatment.
- 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.
- Access to the service was monitored to ensure it met patients' needs. Patients said 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.
- 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.
- The provider was aware of and complied with the requirements of the Duty of Candour.

However there were areas where the provider should make improvements.

- Ensure that risk assessments of staff to determine their suitability for DBS checks are formalised and documented.
- Risk assess stocks of emergency medicines kept to ensure they are suitable and that up to date protocols for their use are maintained to enable the practice to respond appropriately to a medical emergency.

Professor Steve Field CBE FRCP FFPH FRCGPChief 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. There was a system in place for reporting and recording significant events. Systems were in place to identify and respond to concerns about the safeguarding of adults and children, although two members of staff were still due to complete update training. One member of staff did not have the required background checks needed to be carrying out chaperoning duties. Risks associated with non clinical staff carrying out chaperoning duties had been assessed and mitigated, although the risk assessment for one member of staff was informal. The practice adhered to infection control guidance to ensure people were protected from the risks of infection. The medical equipment at the practice was fit for purpose and maintained correctly. Medicines were stored correctly and emergency medicines were in date. The protocol for use in case of anaphylaxis was not kept with the emergency medicines and was out of date. However we received evidence from the practice that staff had recently had relevant training in this area and were already aware of the required updated dosages. The practice immediately updated their protocol but should ensure that these protocols are regularly reviewed. The practice did not have one recommended item in the emergency medicines kit and this was ordered immediately following our inspection.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff assessed needs and delivered care in line with current evidence based guidance. This included assessing capacity and promoting good health. Staff received training appropriate to their roles and records were kept. There was evidence of appraisals for all staff. Staff worked with multidisciplinary teams to understand and meet the range and complexity of people's needs.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients were positive about the care they received from the practice. They commented that they were treated with dignity and respect and that staff were caring, helpful and supportive. Information for patients about the services available was easy to understand and accessible. Patients felt involved in planning and making decisions about their care and treatment. We saw that staff treated patients with kindness and maintained their privacy.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. For example providing an enhanced service for patients at risk of unplanned hospital admissions. The practice had closed its branch service and in response to the concerns raised by affected patients, was renting a room from a local pharmacy where it provided blood pressure checks and phlebotomy services from every week. Patients said 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. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff at regular meetings.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. The practice had a number of policies and procedures to govern activity. Systems were in place to monitor and improve quality and identify and address risks. The practice was aware of future challenges and was proactive in discussing and preparing for these. The practice sought feedback from patients and staff which it acted upon. The patient participation group was active.

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 was knowledgeable about the number of older patients using the service and their health needs, offering them proactive and personalised care. Nationally reported data showed that outcomes for patients were good in conditions commonly found in older people. They kept up to date registers of patients' health conditions and used this information to plan reviews of health care and to offer services such as vaccinations for flu and a Doppler service for patients who needed stockings for prevention and management of wound care. (A Doppler ultrasound is a non-invasive test used for estimating blood flow through blood vessels) .The practice worked with other agencies and providers to provide support and access to specialist help when needed. It was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The practice held information about the prevalence of specific long term conditions within its patient population such as diabetes and chronic obstructive pulmonary disease (COPD). This information was reflected in the services it provided, for example, reviews of conditions and treatment, vaccinations programmes and screening programmes. A diabetic retinal screening van was hosted by the practice once a year at the practice. These patients had a named GP and a structured annual review. Interim six monthly reviews were available to patients with enhanced needs. Patients who were housebound were visited at home. The practice had multi-disciplinary meetings to discuss the needs of palliative care patients and patients with complex needs. These patients were sent invitation letters offering them vaccinations they are entitled to such as flu and shingles vaccines.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, the safeguarding lead GP liaised and met regularly with the health visitor to discuss any concerns about a child and how they could be supported. The practice computer system clearly identified and alerted staff to those children subject to a child protection plan, living in looked after conditions or who had been

identified as at risk. Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies, with a specific children's area in the waiting room. There were no set immunisation clinics for babies and children. The practice had recognised the risk of errors occurring with the complexity of the current immunisation programme and a specific clinic will operate from January 2016. We saw evidence of joint working with midwives, health visitors and school nurses. Contraceptive and sexual health advice was provided.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. The practice was registered with the electronic prescribing service (EPS) and had plans to extend the online services available to patients via its website. There were no set times for clinics ensuring that patients could receive the reviews and treatment they needed at times that were suitable for them. Patients were able to book appointments with GPs and nurses online.

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 those with a learning disability. Patients electronic records alerted staff to patients requiring additional assistance .The practice worked with local drug and alcohol services to provide tailored care for patients who were drug or alcohol dependent. One of the GPs made monthly visits to a local facility providing care for individuals with severe physical and learning disabilities, to enable them to receive continuity of care in an environment they recognised. Staff we spoke with had appropriate knowledge about safeguarding vulnerable adults and they had access to the practice's policy and procedures and had received training in this.

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

maintained a register of patients receiving support with their mental health. Of the 47 people on the dementia register 87% had had their care reviewed in a face to face meeting in the last 12 months. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice's flexible appointment system benefitted these patients who could arrange appointments according to their individual needs. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. The practice monitored prescriptions for patients with poor mental health, for example providing weekly prescriptions for patients at risk of an overdose.

Summary of findings

What people who use the service say

Results from the national GP patient survey July 2015 (from 112 responses which is equivalent to 1.65% of the patient list) demonstrated the practice was performing above local and national averages.

- 95.4% found it easy to get through to this surgery by phone compared to a CCG average of 78.8% and a national average of 73.3%.
- 94.1% found the receptionists at this surgery helpful (CCG average 88.3%, national average 86.8%).
- 96.3% were able to get an appointment to see or speak to someone the last time they tried (CCG average 86%, national average 85.2%).
- 94.9% described their experience of making an appointment as good (CCG average 76.1%, national average 73.3%).
- 84.6% were satisfied with the surgery's opening hours (CCG average 77.1%, national average 74.9%).

The practice was only marginally below average in two of the areas which were:

- 63.9% usually waited 15 minutes or less after their appointment time to be seen compared to a CCG average of 64.9% and a national average of 64.8%
- 72.9% found the GP surgery was open at times that were convenient (CCG average 73.4%, national average 73.8%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 41 comment cards which were all positive about the standard of care received. We spoke with three patients and two representatives of the PPG who were equally as positive in their description of the service they received. (The PPG is a group of patients who work with the practice to discuss and develop the services provided). The doctors, nurses and support staff were all praised for their proactive and caring approach. Patients told us they were treated with dignity and respect and involved in their care and treatment planning. In particular, patients repeatedly commented on the ease with which they were able to book and arrange appointments. They told us that they were always given adequate time during their appointments and never felt rushed by GPs or nurses even when on occasion clinics were running late.

Greensand Surgery - Ampthill

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Greensand Surgery - Ampthill

Greensand Surgery Ampthill provides a range of primary medical services from semi-rural premises at The Health Centre, Oliver Street, Ampthill, Bedfordshire, MK45 2SB. It shares these premises with another practice and Trust community staff. The practice has 7414 patients with an above average population of those aged from 40 to 59. There are lower than average populations of males aged from 20 to 34 years and females aged from 25 to 39 years. The population is largely white British with a minority ethnic community. National data indicates the area served is less deprived in comparison to England as a whole.

The clinical staff team consists of one male and two female GP partners, one female salaried GP, five nurses (two of whom are nurse practitioners), two health care assistants and a phlebotomist. The team is supported by a practice manager, finance administrator and team of administrative support staff. The practice holds a PMS contract for providing services.

The practice is open from 8am to 6.50pm Monday to Friday. Appointments are available with a GP from 8.30am to 12pm and 3pm to 6pm daily. Nurse appointments are available from 8.10am to 1pm and 2pm to 6.50pm daily. A duty doctor is available for same day urgent appointments from 8am to 6.30pm Monday to Friday. When the practice is closed out-of-hours services are provided by Care UK.

Why we carried out this inspection

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

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The 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 inspecting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 17 November 2015. During our inspection we spoke with a range of staff including two GP partners, a salaried GP, two nurses, a health care assistant, the practice manager and members of the reception team. We spoke with three patients and two representatives of the patient participation group (the PPG is a group of patients who work with the practice to discuss and develop the services

Detailed findings

provided). We observed how staff interacted with patients. We reviewed the practice's own patient survey and 41comment cards where patients 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)

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.

Good

Are services safe?

Our findings

Safe track record and learning

There was an open and transparent approach to reporting, recording and monitoring significant events, incidents and accidents. Significant event forms were available on the practice computer system. We saw records were completed and action was taken as a result. Where learning had occurred it was shared. For example, an incident occurred where a patient did not receive a cancer referral within the recommended two week period following a change to the practice's procedures. We saw evidence that this was reported, reviewed and actioned. Staff were informed of the incident and told to revert to a previous system for managing these referrals which the practice felt was more efficient.

We reviewed records of significant events that had occurred during the last 12 months and saw that this system was followed appropriately on almost all occasions. There was one occasion where the recording of the outcome of a significant event had not been completed. However, staff we spoke with regarding the event were able to confirm discussions that had occurred and learning that had been actioned as a result. We saw that significant events were a standing item on the partners and clinical practice meeting agendas and that relevant significant events were also raised at multi – disciplinary team, staff and nurse meetings. Staff told us they would inform the practice manager of any incidents and that they knew how to raise an issue for consideration at the meetings and felt confident to do so. The senior staff understood their roles in discussing, analysing and reviewing reported incidents and events.

Where patients had been affected by something that had gone wrong they were given an apology and informed of actions taken to prevent the same thing happening again. There was an incident where a child had incorrectly been given a booster vaccination that was not needed. The practice immediately informed the parent and apologised and assured the parent that there was no risk to the child. As a result of the incident it was recognised that there was more complexity to the new childhood immunisations programme and that a specific baby immunisation clinic would be needed to reduce the risk of errors when administering children's vaccinations, encompassing longer appointment times.

Safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance. This enabled staff to understand risks and gave a clear, accurate and current picture of safety. Safety alerts were received by the practice and distributed appropriately.

Overview of safety systems and processes

The practice had processes and practices in place to keep people safe. Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. A GP partner was the lead for safeguarding. There were quarterly safeguarding meetings with the health visitor. Staff demonstrated they understood their responsibilities, although two members of staff had not received recent training to update their knowledge we saw this was booked and scheduled for completion. There was an alert system used on patients' notes to inform staff of concerns. We reviewed records of safeguarding concerns that had arisen and saw how new concerns were discussed in meetings and relayed to the practice team.

There was a chaperone policy. All staff who acted as chaperones were trained for the role and all but one had received a disclosure and barring check (DBS). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). Although there was no formal risk assessment in place, we were informed that this staff member was never left alone with patients. Immediately following our inspection we were sent evidence that a DBS check had been submitted for the outstanding member of staff and informed they would not chaperone until this was returned.

Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy. The practice nurse was the infection control lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control folder and all staff had received appropriate up to date training. Staff we spoke with were knowledgeable in their

understanding of infection control practices. We looked at infection control audits and we saw evidence that action was either taken or planned to address any improvements identified as a result.

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely. There was a policy for ensuring medicines were stored at the correct temperature and records showed fridge temperature checks were carried out ensuring medicines were stored at the correct temperature. Medicines were checked regularly to ensure they were in date and were rotated. The nurses and health care assistants (HCAs) used Patient Group Directions (PGDs) and Patient Specific Directions (PSDs) to administer vaccines and prescribe medicines that had been produced in line with legal requirements and national guidance. The practice met quarterly with the CCG prescribing lead to ensure prescribing was in line with best practice guidelines for safe prescribing. The practice held a cylinder of liquid nitrogen for the removal of warts and we saw that this was securely stored and that personal protective equipment was available for use.

Both blank prescription forms for use in printers and those for hand written prescriptions were securely stored and there were systems in place to monitor their use. No controlled drugs were kept at the practice. There was a clear system in place to monitor repeat prescriptions. Repeat prescriptions that needed to be authorized by a GP, for example for high risk medications, were highlighted on the practice computer system and there was a reliable process for managing these.

Recruitment checks were carried out and the five files we reviewed showed that appropriate checks had been undertaken prior to employment. For example, proof of identification, qualifications and registration with the appropriate professional body. Staff received regular annual appraisals.

Monitoring risks to patients

There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the staff room. The practice building was managed by NHS property services and another tenant in the building, South Essex Primary Trust, (SEPT) had been allocated responsibility for storing building maintenance records, risk assessments and checks. The practice had up to date fire risk assessments and regular fire drills were carried out by SEPT. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. SEPT were able to provide evidence of a Legionella risk assessment (Legionella is a bacteria that may cause Legionnaire's disease). Identified risks in these assessments had been rectified or were being monitored by NHS property services. The practice manager carried out regular visual checks of the practice environment and shared identified risks with NHS property services to ensure they were actioned.

Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The practice were struggling to recruit a new GP partner and staff told us this had put the practice under pressure. The practice had invested in additional training for its nursing staff to ensure patient care was not compromised. For example, a nurse had recently qualified as a minor illness nurse with the support of the practice. Locum staff were also being employed and the practice had successfully recruited a long term locum able to cover the same day each week. There was a rota system in place to ensure enough staff were on duty and we were told that the administrative staff were multi skilled to enable them to cover additional roles if needed. The staff members we spoke with told us they worked well as a team and felt competent to fulfil their responsibilities.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents. There were panic buttons installed which alerted staff of an emergency. All staff had received training in basic life support and those we spoke with said they felt confident in their knowledge of what to do in an emergency situation.

The practice had a defibrillator on the premises with adult pads available and oxygen with adult and children's masks. There was also a first aid kit and accident book available.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All medicines we checked were in date and fit for use. However, the protocol for anaphylaxis was not in accordance with latest guidelines for dosages. (Anaphylaxis is a sudden allergic reaction that can result in rapid collapse and death if not treated). We received evidence

Good

Are services safe?

from the practice that staff had recently had relevant training in this area and were already aware of the required updated dosages. The practice immediately placed an updated protocol in the emergency medicines kit and circulated updated guidance within the practice. The practice provided enhanced services for coil fitting and minor surgery. It is recommended that practices providing these services should have atropine in their emergency drugs kit. (Atropine is a medicine used to maintain proper heart function in some emergency situations). The emergency medicines kit at the practice did not have atropine on the day of inspection, and the practice had not assessed the risk of not having this medicine available. Following our inspection the practice provided evidence that they had ordered stock of atropine.

The practice had a business continuity plan in place for major incidents such as power failure or building damage. There was a cascade system in place for alerting staff. In the event of a closure the practice would share premises with one of the two practices within close proximity (one in the same premises and the other across the road). These practices operated from the same computer software so staff would be able to access the required patient information using their smart cards.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met peoples' needs.

Staff demonstrated how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They were able to explain how care was planned and how patients identified as having enhanced needs, such as those with diabetes or Chronic Obstructive Pulmonary Disease (COPD) were reviewed at regularly required intervals. (COPD is the name for a collection of lung diseases, including chronic bronchitis and emphysema. Typical symptoms are increasing shortness of breath, persistent cough and frequent chest infections).

Management, monitoring and improving outcomes for people

The practice participated in the Quality Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The most recent results (at the time of inspection) were 95.1% of the total number of points available, with 3.7% exception reporting. (QOF includes the concept of exception reporting to ensure that practices are not penalised where, for example, patients do not attend for review, or where medication cannot be prescribed due to a contraindication). This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2013-14 showed;

- Performance for diabetes related indicators was similar to the national average. For example the percentage of patients on the diabetes register, with a record of having had a foot examination and that had been risk classified within the preceding 12 months was 87.8% where the national average was 88.4%.
- The percentage of patients with hypertension having regular blood pressure tests was similar to the national average at 85.8% where the national average was 83.1%.
- Performance for mental health related indicators was comparable to the national average. For example, the percentage of patients with diagnosed psychoses who have a comprehensive agreed care plan was 81.8% where the national average is 86%.Psychosis is a mental health problem that causes people to perceive or interpret things differently from those around them. This might involve hallucinations or delusions.

The practice participated in applicable local audits, national benchmarking, accreditation, peer review and research. Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes. Examples of full-cycle clinical audits included those on the appropriate use of drugs used to slow down or prevent bone damage and another on the use of a type of oral contraceptive. Both audits compared the practice against current best practice guidance. Following these audits the practice had changed the way they reviewed patients taking the drug used to slow down or prevent bone damage. They had also recognised the need to not prescribe a particular oral contraceptive to patients with a BMI within a particular range.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. All staff interviewed spoke highly of their working environment and the support they received from the practice manager and GP partners.

The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. Staff received training that included safeguarding, complaints, basic life support and equality and diversity training. Protected learning sessions were held once a month for eight months of the year. During these sessions practice staff had access to e-learning training modules, in-house and external training. The practice manager held records of staff training.

We saw learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate

Good

Are services effective?

(for example, treatment is effective)

training to meet these learning needs and to cover the scope of their work. This included ongoing support during sessions, one-to-one meetings, appraisals, clinical supervision and facilitation and support for the revalidation of doctors. All staff except one new member of staff had had an appraisal within the last 12 months.

The practice were in the process of recruiting a new GP partner. They had recognised the difficulties they were having in filling the position and had shared them with patients. They had made efforts to employ long term locums where possible and to encourage the same locums to return while they were undergoing their recruitment drive. The practice had a box for locums which contained practice forms including those used for referrals. They also had an information sheet that they went through with all locums to ensure they were familiar with the practice arrangements at the beginning of the day.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's electronic patient record system and their computer system. This included care and risk assessments, care plans, medical records and test results. All relevant information was shared with other services in a timely way, for example when people were referred to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan on-going care and treatment. This included when people moved between services, such as referral to or discharge from hospital. Unplanned hospital admissions and readmissions were reviewed by a nurse and then allocated to the relevant GP for follow up, review and discussion at multi-disciplinary team meetings as necessary. The practice held a register of patients at risk of unplanned hospital admission or readmission. This register was discussed at weekly meetings alongside any new unplanned admissions. The patients on the register were updated following these weekly meetings. We saw evidence that care plans were routinely reviewed and updated.

The practice held meetings that made use of the gold standards framework (for palliative care) to discuss all patients on the palliative care register and to update their records accordingly to formalise care agreements. A list of the practices palliative care patients was also shared with the out of hours service to ensure patients' needs were recognised.

Staff we spoke with were able to demonstrate a clear understanding of their responsibilities to protect patient confidentiality and ensure that records were stored securely. For example, by ensuring they removed their smart cards from computers and by refraining from disclosing personal identifiable information about patients they were discussing in public areas of the practice. The smart cards for non-clinical staff were locked in a safe at the end of the day.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance. GPs we interviewed were aware and demonstrated a good understanding of the gillick competency test (a process to assess whether children under 16 years old are able to consent to their medical treatment, without the need for parental permission or knowledge). Consent forms for minor surgical procedures were used and scanned into the patient's medical records.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice, including those in the last 12 months of their lives, those with long term conditions (or at risk of developing long term conditions) and carers. Smoking cessation advice was available from the health care assistant and practice nurses.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 87.7%, which was comparable to the national average of 81.9%. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Good

Are services effective?

(for example, treatment is effective)

Childhood immunisation rates for the vaccinations given were comparable to CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 95.7% to 98.9% and five year olds from 96.8% to 98.9%. Flu vaccination rates for the over 65s were 79.3%, and at risk groups 56%. These were also comparable to national averages.

The practice offered patients appropriate health assessments and checks. All new patients were offered a health check which included a review of patients' weight, blood pressure and smoking and alcohol consumption. NHS health checks were also available for people aged 40 – 74. At the time of our inspection, for the period September 2011 to September 2015 the practice had completed 1284 of 2498 eligible health checks for the 40-74 year olds. Appropriate follow ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

During our inspection we saw that members of staff were courteous and helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect. Curtains were provided in consulting rooms to maintain patients' privacy and dignity 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. The reception area had been redesigned to allow patients more discretion when talking to staff, who spoke quietly with patients to protect their confidentiality in public areas as much as possible.

All of the 41 patient CQC comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Staff told us that the practice had an all-encompassing culture and approach to providing services to its patients. They told us of steps they had taken to ensure a patient with no fixed residence was still able to register with the practice and receive treatment.

We also spoke with three patients and two members of the patient participation group (PPG). They all spoke positively about staff behaviours and the excellent clinical care they felt was provided by the practice and said their dignity and privacy was respected. Comment cards highlighted staff responded compassionately to patients when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with doctors and nurses. For example:

- 92.4% said the GP was good at listening to them compared to the CCG average of 87.3% and national average of 88.6%.
- 92.4% said the GP gave them enough time (CCG average 85.9%, national average 86.6%).
- 97.3% said they had confidence and trust in the last GP they saw (CCG average 94.9%, national average 95.2%)
- 92.9% said the last GP they spoke to was good at treating them with care and concern (CCG average 83.7%, national average 85.1%).
- 98.9% said the last nurse they spoke to was good at treating them with care and concern (CCG average 91.6%, national average 90.4%).
- 94.1% said they found the receptionists at the practice helpful (CCG average 88.3%, national average 86.8%)

Care planning and involvement in decisions about care and treatment

The practice had made suitable arrangements to ensure patients were involved in decisions about their care. Patients told us that 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 available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

Data from the national GP patient survey published in July 2015 showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were above local and national averages. For example:

- 96.8% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 84.4% and national average of 86.0%.
- 92.8% said the last GP they saw was good at involving them in decisions about their care (CCG average 79.2%, national average 81.4%)

Staff told us that translation services were available for patients who did not have English as a first language and the practice used an online translate service. There was a hearing loop in reception and one of the nursing staff was able to use British sign language.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations. For example, smoking cessation and carers support. A practice newsletter was updated regularly and provided patients with useful information about services offered by the practice, such as return to work certificates.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 1.2% of the

Good

Are services caring?

practice list as carers and had taken steps to support them. For example, by inviting them independently for flu vaccines and providing home visits for carers who could not leave their dependents unaided. Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them to offer support and a sympathy card was sent from the practice. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. The recently deceased were also discussed at monthly multi-disciplinary meetings.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example, the practice offered a range of enhanced services, such as avoiding unplanned hospital admissions and dementia assessments. Staff told us the practice computer system alerted them of patients at risk of unplanned hospital admission. If these patients were admitted to hospital they would be contacted by their named GP and their care plan would be amended accordingly. At the time of our inspection 130 patients (1.9% of the practice's population) were receiving such care. The practice held multi-disciplinary meetings to discuss the needs of palliative care patients, patients with complex needs and patients who were at risk of unplanned hospital admissions.

We saw that patients with diabetes received an annual health review at the practice, with an interim basic check at six months. A diabetic retinal screening van was hosted by the practice on site once a year. The practice offered flexible appointments for reviews rather than set times and clinics to facilitate patient's preferences and needs.

There were registers for patients with dementia and those with a learning disability. These patients were also invited for an annual review. The practice had completed 100% of the annual reviews for patients on the learning disability register. At the time of our inspection there were 58 patients on the dementia register (four of which had been added less than a year ago) of those eligible, 47 had received a review in the last year.

The practice had a patient participation group (PPG) and a virtual PPG (vPPG) who met with the practice staff, carried out surveys and made suggestions for improvements. We met representatives from the PPG, who told us improvements had been made as a result of their involvement, for example, the practice will be initiating an online system for patients to view their test results online following recommendation from the PPG. They told us that they felt listened to and that their opinions mattered.

Access to the service

The practice was open from 8am to 6.50pm Monday to Friday. Appointments were available with a GP from 8.30am to 12pm and 3pm to 6pm daily. Nurse appointments were available from 8.10am to 1pm and 2pm to 6.50pm daily. A duty doctor was available for same day urgent appointments from 8am to 8.30 am and from 6pm to 6.30pm Monday to Friday. These opening times provided some additional access to the practice for patients who found it difficult to attend during normal working hours.

The practice operated a book on the day appointment system, although there was allocation each day for pre-bookable appointments that could be booked up to six weeks in advance. Additional appointments were made available a day or two in advance. A duty doctor provided additional urgent appointments daily for people that needed them. On the day of our inspection we found that there were 19 appointments available the following morning and 14 available the same afternoon. The first routine pre-bookable appointment was in two days. Minor illness clinics were run daily by the nurse practitioners and practice nurses. We found the appointment system was structured to allow GPs time to make home visits when needed and ensure that all urgent cases were seen on the same day.

Information was available to patients about appointments on the practice website, including the option to book appointments online. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. Information on the out of hours (OOH) service was available on the practice website and was provided by Care UK which could be accessed via the NHS 111 service.

The practice provided care to residents in a local care facility who had severe physical and learning disabilities. The practice had identified that access to the surgery for these patients was difficult due to the larger than average size of the wheelchairs used by these patients. There were no further changes that could be made to the building to accommodate them and therefore monthly visits were made to the facility by the same GP, ensuring these patients received continuity of care and had access to a local GP service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Results from the national GP patient survey showed that patients' satisfaction with how they could access care and treatment was above or comparable to local and national averages.

- 84.6% of patients were satisfied with the practice's opening hours compared to the CCG average of 77.0% and national average of 74.9%.
- 95.4% of patients said they could get through easily to the surgery by phone (CCG average 78.8%, national average 73.3%).
- 94.9% of patients described their experience of making an appointment as good (CCG average 76.1%, national average 73.3%.
- 58.2% of patients said they did not normally have to wait too long to be seen (CCG average 57.6%, national average 57.7%).

The practice's own patient survey in 2013 had identified that 26% of its patients found it hard to get through to the practice on the telephones on Monday mornings. As a result the practice had increased the number of staff answering the phones on Monday mornings from two to three. People told us on the day that they were able to get appointments when they needed them.

Listening and learning from concerns and complaints

The practice had an effective 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. There was a designated responsible person who handled all complaints in the practice.

Information about how to make a complaint was displayed in the reception area and on the practice website. There were details of when, how and who to complain to. The complaints policy clearly outlines a time framework of when the complaint would be acknowledged and responded to. In addition the policy advised patients on whom to contact if they were unhappy with the outcome of a complaint.

The practice kept a complaints log for written complaints. We looked at complaints received in the last 12 months and found none significantly clinical. Lessons were learnt from concerns and complaints and action to improve the quality of care was taken as a result. For example, following an error that was made when reissuing a prescription, staff were reminded of the correct procedure and the patient was issued with an apology.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver excellent clinical care that was available, accessible and efficient. This was displayed on the practice website and staff we spoke with knew and understood the values of the practice.

Governance arrangements

The practice had decision making processes in place. Staff at the practice were clear on the governance structure. They understood that the GP partners were the overall decision makers strongly supported by the practice manager and financial administrator. Clinical staff met to review complex patient needs, review significant events, discuss new protocols and keep up to date with best practice. We saw evidence of meetings for reception and administrative staff, where discussion and learning occurred. Partners and the practice manager met regularly, along with the financial administrator, to look at the overall operation of the service.

There was a leadership structure in place and clear lines of accountability visually displayed in the practice's management wheel which we saw available on display to the practice staff. We spoke with clinical and non- clinical members of staff who demonstrated a clear understanding of their roles and responsibilities. There were GP leads for safeguarding, personnel and clinical governance and a nurse practitioner was the infection control lead.

The practice used the Quality and Outcomes Framework (QOF) and other performance indicators to measure their performance. The GPs and senior management staff spoken with told us that QOF data was regularly discussed and action plans were produced to maintain or improve outcomes for patients. For example, lower performance in smoking cessation had led to additional training for staff to improve the service offered by the practice.

The practice had completed clinical audits to evaluate the operation of the service and the care and the treatment given. A discussion with the GPs and evidence provided showed improvements had been made to the operation of the service as a result of audits undertaken.

The practice had a number of policies and procedures in place to govern activity and these were available to staff electronically as well as in a policy folder kept in the office.

We looked at a sample of policies and procedures and found them to be available and up to date. The practice engaged in clinical governance meetings with the local CCG once every three months.

The practice had a system in place for identifying, recording and managing risks. We looked at examples of significant incident reporting and actions taken as a consequence. Staff were able to describe how changes had been made or were planned to be implemented in the practice as result of reviews of significant events.

Leadership, openness and transparency

The partners in the practice have the experience, capacity and capability to run the practice and ensure high quality care. They prioritise safe, high quality and compassionate care. The partners were visible in the practice and staff told us that they were approachable and always take the time to listen to all members of staff.

Staff told us there was an open culture within the practice and they had the opportunity to raise issues at meetings or as they occurred with the practice manager or a GP partner. Staff told us they felt well supported by the practice and that it was well managed. Meetings took place regularly to share information, look at what was working well and where any improvements needed to be made. The practice closed one afternoon a month for eight months of the year allowing for protected learning time.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service. It had gathered feedback from patients through the patient participation group (PPG), through surveys and complaints received. Patients could leave comments and suggestions about the service via the website or a comments box in the waiting room. The practice also sought patient feedback by utilising the Friends and Family test. The NHS friends and family test (FFT) is an opportunity for patients to provide feedback on the services that provide their care and treatment. Results from June to August 2015 showed that 93% of patients who had responded were either 'extremely likely' or 'likely' to recommend the practice.

Are services well-led?

Good

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

The practice had also gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and that they felt involved in improving how the practice operated.

Continuous improvement

The practice team was forward thinking and part of local schemes to improve outcomes for patients in the area. For example, the practice had a teenage health initiative where patients received an information leaflet on their fourteenth birthday advising them of the services available and inviting them to discuss any concerns with the clinical staff available.

The practice was aware of future challenges, for example a local housing development planned for the area would increase the number of new patients joining the practice in the future and they had begun planning how they would cope with these additional demands. They had recognised the problems their patients and patients of their neighbouring two surgeries faced with very limited parking facilities and had initiated a local campaign raising their concerns with their local MP.

The practice had previously held a branch surgery in a local remote village. The branch surgery had been closed but the practice had listened to the concerns of the patients affected by this and had worked with a local businessman to rent a room in a pharmacy where they could provide phlebotomy and blood pressure checks once a week.