Highnam Surgery

Quality Report

Lassington Lane
Highnam Gloucester
Gloucestershire
GL2 8DH
Tel: 01452529699
Website:
www.collegeyard-highnamsurgeries.nhs.uk

Date of inspection visit: 7 January 2015
Date of publication: 30/07/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Highnam Surgery on 7 January 2015. Overall the practice is rated as Good.

We found the practice to be good for providing safe, effective, caring, responsive and well led services for older adults, families and children, patients with long term conditions, vulnerable patients, patients with mental health issues and patients who worked.

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.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about services and how to complain was available and easy to understand.
- Overall patients said they found it easy to make an appointment with a named GP and that there was continuity of care. There were arrangements to enable patients with urgent same day needs to see a GP on the same day. However, patients told us there could be long waits after their appointment time for a same day appointment.
- There was a clear leadership structure and staff felt supported by management.
- The practice met nationally recognised quality standards for improving patient care and maintaining quality.
- The practice met the requirements of the Dispensary service quality scheme to maintain safe medicines management practice.

The provider SHOULD:

Summary of findings

- Ensure the urgent appointments system is reviewed to improve patient waiting times.
- Implement the plan to proactively seek feedback from patients.
- Review governance arrangements to ensure clinical protocols are maintained to clinical governance standards.
- Review the available space in the dispensary to enable the safe storage and dispensing of medicines.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Overall, risks to patients were assessed. There were enough staff to keep patients safe.

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 referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed patients rated the practice higher than other practices in the area for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We saw staff communicated with patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice reviewed the needs of its local population and engaged with the Clinical Commissioning Group (CCG) to secure service improvements where these had been identified. Although patients said they were able to get an urgent consultation with a practice GP on the day of need there could be long waits after their appointment time. Routine appointments could be booked up to four weeks in advance and patients said they were usually able to see a named GP within two weeks. Overall, the practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available in the practice leaflet and easy

Summary of findings

to understand. Evidence showed the practice had responded quickly to the complaints that had been recorded. We did not have evidence on the day of the inspection that patients verbal concerns about the practice were documented.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice was aware of the challenges to the practice and gave examples of how and where improvements could be made. There was a clear leadership structure and staff felt supported by management. There were regular practice meetings which addressed clinical, governance and practice issues. The practice did not have a system to proactively collect patient feedback although, there were plans to start a patient participation group and practice survey. Staff had received inductions, regular performance reviews and attended team meetings.

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 provider was rated as good for all population groups. Care and treatment of older people reflected national guidance. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice provided proactive personalised care to meet the needs of the older people in its population and offered home visits. The practice delivered a range of enhanced services, for example, end of life care and avoiding unplanned admissions to hospital.

People with long term conditions

Good

The provider was rated as good for all population groups. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. Patients were offered a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs including end of life care, the named GP worked with relevant health care professionals to deliver a multidisciplinary package of care based on a person centred care plan.

Families, children and young people

Good

The provider was rated as good for all population groups. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. We were given examples to demonstrate staff understood issues regarding consent and confidentiality when supporting young adults and children with mental capacity. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice offered contraceptive services for women and sexual health self-test screening kits and advice for young people.

Working age people (including those recently retired and students)

Good

The provider was rated as good for all population groups. The needs of the working age population, those recently retired and students had been identified and the practice had adjusted some of the

Summary of findings

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 reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The provider was rated as good for all population groups. The practice held a register of patients with a learning disability and had carried out annual health checks for these patients. There was information on the website and in the practice for patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The provider was rated as good for safe, caring and effective. However, the provider was rated as requires improvement for responsive and well led, which led to these ratings applying to everyone using the practice, including this population group. The GPs regularly worked with health and social care professionals to promote the wellbeing of people experiencing poor mental health,

The practice had information for patients experiencing poor mental health about how to access various support groups and voluntary organisations including recovery orientated alcohol and drugs services. Staff knew their patients and had strategies to support patients with dementia.

Summary of findings

What people who use the service say

On the day of the inspection we spoke with six patients attending the practice. We looked at seven patient comment cards, the GP National Patient Survey 2013/ 2014 and individual GP feedback collected as part of GP appraisal.

Patients we spoke with, patient comments cards and survey feedback we looked at demonstrated patients were overall satisfied with the care and treatment received. Staff were described as caring, understanding and respectful. This was supported by feedback from the GP National Patient Survey 2014 which indicated 93% and 97% of the practice respondents said the last GP and nurse (respectively) they saw treated them with care and concern. 81% of respondents described their experience of the practice as fairly good or very good. 76% of patients saying they would recommend the practice to family and friends.

Patients' feedback told us patients were included in their care decisions, able to ask questions of all staff and had treatment explained so they could make informed choices. Feedback from the GP National Patient Survey 2013/14 indicated 92% of patients said the last GP they saw was good at involving them in decisions and 89% said the last nurse they saw was good at explaining tests and treatments. Patients felt their privacy and dignity were respected.

82% of patients in the GP National Patient Survey (2013/ 2014) said their last appointment was convenient for them. Patients told us there was a wait of up to two weeks to see a GP of choice however, appointments with any GP were usually available in two to three days. Patients told us they appreciated they were able to book appointments up to four weeks in advance which helped with planning work commitments.

All of the patient feedback told us patients were able to see a GP on the day of need if their appointment was urgent. The practice operated an 'open urgent appointment system' with five minute appointments. Feedback from two patients indicated there were long waits after their allocated urgent appointment time. The GP National Patient Survey 2013 data indicated over 40% of respondents waited more than 15 minutes after their appointment time.

Patients we spoke with who used the practice dispensary said the service was prompt and medicines were usually available within 48 hours.

Patients were not aware of the complaint process even though there was information available in the practice. They expressed confidence in the practice to address concerns when they were raised.

Patients told us they were satisfied with the cleanliness of the practice.

Areas for improvement

Action the service SHOULD take to improve

The provider SHOULD:

- Ensure the urgent appointments system is reviewed to improve patient waiting times.
- Implement the plan to proactively seek feedback from patients
- Review governance arrangements to ensure clinical protocols are maintained to clinical governance standards.
- Review the available space in the dispensary to enable the safe storage and dispensing of medicines.

Highnam Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector and GP specialist advisor. Additional inspection team members were a nurse specialist advisor and practice manager specialist advisor.

Background to Highnam Surgery

As part of the inspection we visited Highnam Surgery Lassington Lane, Highnam, Gloucester, GL28DH.

Highnam Surgery is a small dispensing practice which provides primary care services to patients resident in the village of Highnam on the outskirts of the city of Gloucester. The provider has another practice in Gloucester and most staff work across both sites. Although patients are able to access services from either site they are encouraged to utilise appointments at the practice they are registered with.

The practice is purpose built with patient services located on the ground floor of the building. The practice has an expanding patient population of 2,700 of which the highest proportion are young families or of working age.

The practice has three GP partners. One of the partners has been acting in a part-time practice manager role due to a staff vacancy. However, a new appointee started in January 2015. The practice employ four nurses, two dispensary staff, a practice manager and reception/administration staff. Most staff work part-time.

The practice is open five days of the week. Monday to Thursday it is open 8.30am – 7.00pm and Friday 8.30-6.30pm. The practice is closed for lunch every day between 1pm and 2pm. The practice has opted out of the Out of Hours primary care provision. This is provided by another provider South West Ambulance Service NHS Trust.

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

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 patients' needs?
- Is it well-led?

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

- Older patients

Detailed findings

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

Before our inspection, we reviewed a range of information we held about the practice and asked other organisations, such as the Gloucester Clinical Commissioning Group and the local Healthwatch to share what they knew.

We carried out an announced inspection on the 7Jan 2015. During the inspection we spoke with two GPs, three nursing staff, administration and reception staff. We spoke with six patients who used the service. We looked at the GP individual patient survey results and comment cards. We observed how staff talked with patients.

We looked at those practice documents that were available such as policies, meeting minutes and quality assurance data as evidence to support what patients told us.

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

Good

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. The practice utilised a computer software package which identified patients on specific medicines which may have put them at risk if they were not monitored regularly. We saw evidence the GPs reviewed the findings weekly and patients were reviewed if necessary.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Patient safety alerts and safeguarding concerns were a standing item on the monthly/clinical practice meeting attended by all practice staff. In addition patient safety alerts were emailed to staff as they were received by the practice. However, there was not a system to monitor staff had read the alerts.

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 eight records of significant events (for both provider practices) that had occurred during 2014 and we were able to review these. Six of these related to communications from other healthcare providers which had been reported to the appropriate authorities. Significant events were reviewed at the monthly clinical meeting. There was evidence that the practice had learned from these reviews. 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.

Meeting minutes demonstrated the dispensary staff did not meet formally with the GP medicines lead on a regular basis although staff told us the lead GP and other practice GPs were accessible to discuss dispensing issues. Meeting minutes (2013/2014) available demonstrated that dispensing issues, dispensing errors and near misses were discussed. We saw there were no consistent themes from the records of the monthly dispensing errors.

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 dedicated GP leads in safeguarding vulnerable adults and children. They had been trained to an appropriate level. All staff we spoke with were aware who the leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients and their families on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. We were told invitations to health visitors and other relevant agencies to attend safeguarding meetings were made. There were informal arrangements in place to liaise with health visitors when there were concerns about patients and families were at risk. The health visitors held a monthly clinic at the practice and were accessible by telephone.

There were notices in all patient areas advising patients about requesting a chaperone (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 staff undertaking chaperone duties had the appropriate security checks and knowledge of the practice chaperone procedure.

Medicines management

Good

Are services safe?

We checked medicines stored in the treatment rooms and medicine refrigerators. We found the medicines refrigerator, although in a secure treatment room, was not locked. National policy (Health Protection Agency 2014) indicates a validated medicines refrigerator must be kept locked or in a locked room. Staff told us the reason for it not being locked was because it was in use and it was usually locked. Staff addressed the issue while we were in attendance. We observed the treatment room was locked when not in use and therefore unauthorised personnel did not have access.

The practice had processes and systems to ensure medicines risks to patients were minimised and where unavoidable monitored. Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. We noted the dispensary was small. Medicines were stored efficiently in every available space however, we saw from dispensary incident records on two occasions medicines had fallen from a narrow ledge into dispensing bags awaiting completion/collection. The dispensary staff had taken actions to move open dispensing bags from the area.

The nurses administered vaccines using Patient Group Directions (PGDs) that had been produced in line with legal requirements and national guidance. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment). We were told the nurses administering vaccines had received appropriate training.

We saw there was a system in place for the management of high risk medicines such as methotrexate (for treatment of arthritis) and warfarin (used to thin blood), which included regular monitoring in line with national guidance. We looked at one patient record which confirmed the procedure was followed. We looked at prescribing data and saw the practice was in line or slightly below the national prescribing pattern for antibiotic, hypnotic and anti-inflammatory medicines.

The repeat prescribing procedure protected patients from risk. The practice utilised an electronic prescribing system which enabled prescriptions to be sent directly to a pharmacy if patients were not collecting their medicines from the dispensary. All prescriptions were reviewed and signed by a GP before medicines were dispensed to patients. There were systems in place to identify when patients required a medicine or health review before further prescriptions were issued. Drug interactions and drug alerts were clearly identified on the practice electronic system. Newly registered patients taking regular medicines were seen by a GP for a health check.

Blank prescription forms were rarely used however they were handled in accordance with national guidance, tracked through the practice and kept securely at all times.

The practice held a small stock of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs.

Practice staff undertook regular audits of controlled drug prescribing to look for unusual products, quantities, dose, formulations and strength. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area. On the day of the inspection we checked the controlled medicines and found stock records were accurate.

The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary. Records showed that all members of staff involved in the dispensing process had received appropriate training and their competence was checked regularly.

Cleanliness and infection control

The practice had processes to protect patients from the risk of infection. We observed the premises to be visibly 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 for infection control who had completed an infection control audit in 2014. On the day of the inspection the documentation presented did not

include an action plan identifying responsibilities and dates for completion of identified areas for improvement. The practice forwarded the completed action plan within a requested time frame. The information provided demonstrated any identified improvements had been completed or in the process of being addressed.

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. We saw all staff had regular infection control updates for example, hand hygiene in August 2014 and handling specimens in October 2014.

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. Sharps disposal boxes were stored safely.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments.

We noted some equipment such as swabs and dressing packs in the resuscitation oxygen bag had expired. Oral airways in the resuscitation box had been removed from their packaging. In order to keep patients safe staff changed the equipment at the time of the inspection.

Monitoring, testing and maintenance of equipment was not always carried out based on a risk assessment. We saw evidence of equipment being recalibrated and tested. However, records relating to testing were not easy to follow.

Staffing and recruitment

The practice had processes to enable the recruitment of appropriately qualified staff. There was a clear recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

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). Staff explained the interview process which was in line with the practice policy.

Overall, there were enough appropriately qualified staff to maintain the smooth running of the practice. The processes in place to ensure there were enough staff relied on the good team relationships in the practice. There was an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave and at times of sickness.

The practice worked with a long term locum GP to cover GP sessions.

Monitoring safety and responding to risk

Risks to patients who used services were assessed, and overall, the systems and processes to address these risks were implemented to ensure patients were kept safe. There were ongoing checks of the building, the environment, medicines management, staffing and dealing with emergencies.

Identified risks such as the potential risk of flooding had been identified and meeting minutes demonstrated these were discussed with staff.

The practice had a health and safety policy.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed all staff had received relevant 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 it was checked regularly.

Emergency medicines to manage some foreseeable medical emergencies such as collapse due to anaphylaxis (severe allergic reaction) were in a small box labelled 'resuscitation drugs' kept in a secure area of the practice. Other emergency use medicines were kept in the doctors bags. This was in line with the practice policy and based on a risk assessment that nursing staff would only need to use

Good

Are services safe?

medicines to manage an anaphylactic reaction. Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. Records demonstrated the practice had responded appropriately to a flood risk and had applied the lessons learned to improving patient and staff outcomes.

The practice had records to demonstrate there had been a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

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 other research reports.

The use of guidance prompted clinical audit and reviews of clinical guidelines. 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 and looked at three patient electronic records that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. For example, the use of care pathways and care plans for patients with long term conditions such as heart and respiratory disease.

GPs told us they lead in specialist clinical areas such as palliative care, mental health and womens' health and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Each of the practice nurses had a lead role in the management and support for long term conditions such as diabetes and respiratory conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

We looked at data from the local clinical commissioning group (CCG) of the practice's performance for antibiotic prescribing, which was comparable to similar practices. The practice used a risk stratification tool to identify 2% of the most vulnerable patients on the practice list. We were told care plans for patients in care homes had been completed. Personalised care plans were being developed for patients at home to assist patients in their support and treatment to avoid admission to hospital.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of cancer patients. We saw a set of meeting minutes of a peer review meeting that regular reviews of elective and urgent referrals were made.

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, managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to review the services provided.

The practice had completed three audits in 2013/2014 two of which demonstrated where changes to treatment or care may have been needed. For example, a GP reviewed the procedure for obtaining consent and the documentation of pathology results for patients having minor surgical procedures at the practice. The first audit demonstrated consent had been obtained from all patients and there were pathology reports for all specimens sent. The audit was repeated in 2014 following a change in electronic records system. The follow up results also demonstrated 100% compliance. In addition it demonstrated a low complication rate following surgery.

The second audit reviewed the management of patients taking long term steroid (use to treat a range of diseases) medicines. The first audit in 2013 indicated some patients had not had the appropriate monitoring or support treatment in line with best practice guidelines. A repeat audit demonstrated changes in practice. For example, all patients on the steroids had it recorded they had a steroid card (detailing information about the patients treatment). The frequency of the necessary routine blood tests had also improved.

The practice also used the information collected for the Quality Outcomes Framework (QOF is a voluntary incentive scheme for GP practices in the UK). The scheme financially rewards practices for managing some of the most common long-term conditions e.g. diabetes and implementing preventative measures. The results are published annually and the practice used the information collected along with performance against national screening programmes to monitor outcomes for patients. The practice had 100%

Good

Are services effective?

(for example, treatment is effective)

achievement of all of the QOF minimum standards in 2013/14. We reviewed three patient electronic records. The patient records we looked at were comprehensively completed.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

There were clinical protocols on the practice computer desktop as guidance for staff. The quality of the protocols varied. For example, the health promotion protocols such as obesity management, secondary prevention of strokes and blood pressure monitoring were detailed and comprehensive. The protocol for recalling patients requiring regular appointments was robust and was implemented. Although nursing staff we spoke with were confident and knowledgeable about clinical procedures we noted the asthma protocol had not been updated to reflect most recent evidence. Other clinical protocols for guidance for health care assistants such as urine testing were less detailed.

The practice had implemented the Gold Standards Framework for end of life care. It had a palliative care register and worked with other health care professionals to discuss the care and support needs of patients and their families.

Effective staffing

Practice staff included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that overall all staff were up to date and had attended mandatory courses such as annual basic life support. We noted a good skill mix among the doctors with a number having additional training and interests in mental health, palliative care and women's' health. 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).

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, cervical smears and some extended roles such as asthma and diabetes reviews. The specialist practice nurse was a nurse prescriber and had specialist training to insert and remove contraceptive coils. Another practice nurse had completed insulin initiation treatment to support patients with diabetes to move from oral medicines to insulin treatment.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Although we found the appraisal forms were basic our interviews with staff confirmed that the practice was proactive in supporting training for relevant courses.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those 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 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 an enhanced service (enhanced services require an enhanced level of service provision above what is normally required under the core GP contract) to support frail patients to avoid admission to hospital. The GPs had begun to work with the multidisciplinary team to develop and review patient care plans to meet the changing needs of these patients. There was a process in place to follow up patients discharged from hospital. We saw that the procedure for actioning hospital communications worked well. We saw from the significant events records that the practice contacted secondary care providers when discharge information was not accurate or provided in a timely manner.

Palliative care meetings provided an opportunity to discuss the needs of patients with end of life care needs. The

Good

Are services effective?

(for example, treatment is effective)

practice supported patients living in two care homes. Two GPs attended a care home for patients with complex neurological conditions on a daily basis and regularly attended multidisciplinary meetings.

The practice worked with a range of other agencies to support vulnerable patients and those patients experiencing poor mental health. For example, the practice worked in partnership with dementia services in the assessment, monitoring and support of patients with early dementia and their families.

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, for example, 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 implemented the electronic summary care records system in 2014. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record (EMIS) 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 GPs and nurses applied the principles of the Mental Capacity Act 2005 and the Children Acts 1989 and 2004 to their practice area.

Patients with a learning disability and those with dementia were supported to make decisions about their care and treatment. When interviewed, staff gave examples of how to enable patients to make informed decisions. For example, giving more time during appointments and checking patients understood the treatment they were to have by explaining in their own words. Staff understood the principle of acting in a patient's best interest. One member of staff supported a patient's refusal for a specific treatment because they considered the patient had capacity to make the decision and their carer was coercive in their actions. The patient attended with another carer and with the support of staff received the treatment required.

Overall, nursing 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) and a duty of confidentiality to children and young adults.

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

Health promotion and prevention

It was practice policy to offer a health check with a nurse to all new patients registering with the practice. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years.

The practice had number of ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and dementia. All patients with a learning disability were offered a health review with the practice nurse and GP.

The practice had strategies to enable patients to take responsibility for their own health when they were able. There was a range of health promotion information in the practice and on links on the practice website for all patient groups. Free screening kits for chlamydia (a sexually transmitted disease) were available for under 25's. The practice actively offered smoking cessation clinics to patients.

The practice's performance for cervical smear uptake was 77.2%, (National Intelligence Cancer Network 2014) which was similar to others in the CCG area. Performance for breast and bowel cancer screening was similar to the average for the CCG (National Cancer Intelligence Network 2014 81.1% and 69.5 % respectively).

Good

Are services effective?

(for example, treatment is effective)

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

Patients who did not attend for health checks, reviews or follow up appointments were contacted to arrange for another appointment if nurses or GPs were concerned about their wellbeing.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This was data from the GP National Patient Survey (2013/2014) and information from GPs individual appraisals.

Patients completed CQC comment cards to tell us what they thought about the practice. We received seven completed cards and spoke to six patients. Overall patient feedback about staff was positive. They were described as caring, understanding and respectful. This was supported by feedback from the GP National Patient Survey which indicated 93% and 97% of the practice respondents said the last GP and nurse (respectively) they saw treated them with care and concern. 81% of respondents described their experience of the practice as fairly good or very good with 76% of patients saying they would recommend the practice to family and friends. Patients we spoke with felt their privacy and dignity were respected. We observed a number of examples of kind and caring interactions with patients.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. 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 / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. However, we noted in one ground floor disabled patient toilet there was a plain glass window with a net curtain to maintain privacy.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private.

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 GP National Patient Survey (2013/14) showed 92% of practice respondents said the GP involved them in care decisions and 94% felt the GP was good at explaining treatment and results. Both these results were above the CCG average.

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 usually had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.

Staff told us that translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

Information in the patient waiting room, and patient website directed patients to a range of support groups and organisations. Patients experiencing poor mental health could see a mental health nurse who held a monthly clinic at the practice.

The practice's computer system alerted GPs if a patient was also a carer. We saw there was written information available for carers to ensure they understood the various avenues of support available to them. Carers were emailed to invite them for the annual flu injection.

Staff told us that if families had suffered bereavement their GP would contact them. A note was placed on bereaved carers electronic records to inform staff of their bereavement.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice engaged actively with the local Clinical Commissioning Group (CCG) to secure service improvements where these had been identified. For example, one GP was palliative care lead for the CCG. Another practice GP was the CCG Clinical Chairperson.

The practice had a range of services to meet the needs of the practice population. The practice has an expanding patient population of 2,700 of which the highest proportion were of working age and young families. In response to this the practice offered late appointments until 7pm Monday to Thursday each week. In addition the practice had responded to results from a comprehensive evaluation of the contraceptive coil (IUCD) service by allowing extra time for the last practice nursing appointment so the IUCD appointment started promptly. Additional information had been included in the IUCD leaflet to prepare patients for the procedure.

Patients had access to specific treatment and support at the practice rather than having to attend hospital. For example, spirometry (measures breathing capacity) for patients with chronic lung disease, insulin initiation for patients transferring from oral medicines to insulin for diabetes management and blood tests for blood clotting times.

The specialist practice nurse was a nurse prescriber enabling patients' timely access to adjustments in medicines to address changing health requirements. Repeat prescriptions could be requested via a secure online system via the practice website as well as in writing. The dispensary offered a prompt service and most medicines were available within 48hours. Electronic prescriptions were usually sent to participating chemists within 48 hours.

Systems were in place for identifying and following-up children who were at risk. There were informal arrangements in place to liaise with health visitors when there were concerns about patients and families were at risk. The health visitors held a monthly clinic at the practice and were accessible by telephone.

Immunisation rates were relatively equal to or above the Clinical Commissioning Group average for all standard childhood immunisations. Patients told us and we saw evidence children and young people were treated in an age appropriate way and recognised as individuals. The premises were suitable for children and babies. GPs offered chlamydia (a sexually transmitted disease) screening kits for under 25's.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice held a register of patients with learning disabilities and patients with dementia. Longer appointments for patients with learning disabilities could be arranged in recognition of the time needed to involve patients in their care and treatment. Patients over the age of 75 years had a named GP to enable continuity of care.

There were two permanent, well established travellers' sites in the area. We were told patients had access to and used the practice services as other patients did and did not have specific requirements.

Patient services were situated on the ground floor of the building. The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. There was an induction hearing loop for patients with hearing impairment. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

The practice had access to online and telephone translation services for patients where English was not their first language.

Access to the service

The practice was open five days of the week. Monday to Thursday it was open 8.30am – 7.00pm and Friday 8.30-6.30pm. The practice was closed for lunch every day between 1pm and 2pm. Patients were able to book and cancel appointments in person, by telephone and online and GP appointments were confirmed by text with patient permission. Patients could also send and receive secure emails via the practice website once registered with the electronic patient records (Emis) services. For example, to inform them about the progress of their repeat prescriptions.

Patient feedback indicated they were generally satisfied with the routine appointments system. They said they

Good

Are services responsive to people's needs?

(for example, to feedback?)

could see another doctor if there was a wait to see the doctor of their choice which could be a wait of up to two weeks. Appointments were available outside of school hours for children and young people.

The practice told us they offered an 'open system' for patients requesting an on the day need urgent appointment with a GP. Urgent five minute appointments were available after the morning clinics and if patients rang the surgery they were given an appointment time.

Two patients told us there could be a long wait after their appointment time to see a GP for an urgent appointment. Additional data identified 40% of respondents (across both practices) from the GP National Patient Survey 2013/2014 indicated they waited more than 15 minutes after their appointment time. We noted there had been one formal written complaint about urgent appointment waiting times. We were told the practice response to this had been to release more urgent five minute appointments during peak periods.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the 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 in the practice leaflet and website.

Home visits were made to two care homes including a daily visit to one of the homes.

Listening and learning from concerns and complaints

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.

We saw that information was available to help patients understand the complaints system. Although patients we spoke with were not aware of the process to follow if they wished to make a complaint they said they felt able to report concerns and had confidence the practice would manage them appropriately. None of the patients we spoke with on the day of the inspection had needed to make a complaint about the practice.

The practice reviewed complaints at monthly practice and bi-monthly partners meetings. Seven written complaints (across both practices) were recorded in 2014. On the day of the inspection we did not see evidence to demonstrate complaints or concerns dealt with by telephone were documented.

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 understanding about the strengths and challenges to the practice and the patients it supported. They gave examples of how and where improvements could be made such as developing a practice development plan, setting up a patient participation group and reviewing the complaints procedure. The practice statement of purpose emphasised the values of delivering high quality care and the promotion of good outcomes. We saw and read of examples of how these values were reflected in practice.

Governance arrangements GPs

There was a clear leadership structure which had named members of staff in lead roles. For example, there was a nurse with lead responsibilities for infection control and two GPs had lead responsibilities for safeguarding. We were told the GPs met informally on an almost daily basis, with partners meeting scheduled every two months. The practice held monthly practice meetings for all staff. Meeting records demonstrated governance issues included patient safety alerts, significant events and complaints as well as training updates and other practice issues were discussed.

We found practice manager responsibilities which had been covered by one of the GPs whilst a member of staff was appointed required further attention. The practice had policies and procedures in place for staff to govern activity and these were available to staff. On the day of the inspection staff we spoke with were knowledgeable about the procedures. However, there was not a schedule for updating policies and we found the quality of the procedures varied. For example, the health promotion procedures such as obesity management and secondary prevention of strokes, blood pressure monitoring were detailed and comprehensive. Clinical procedures as guidance for health care assistants such guidance for urine testing required further detail to support safe practice.

The practice had schedules to assess and update practice risk assessments. Risks to patients who used services were assessed, and overall, the systems and processes to address these risks were implemented to ensure patients were kept safe.

Significant event and written complaints records were completed. However, on the day of the inspection we did not see evidence to demonstrate complaints dealt with by telephone were documented.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing above national standards.

The practice had completed two audits with full audit cycles to demonstrate the effectiveness of the changes made. For example, the management of patients taking a steroid medicine and minor surgery procedures. In addition there had been an evaluation of the coil fitting service which had resulted in changes to practice.

Leadership, openness and transparency

Staff we spoke with were clear about their own roles and responsibilities. They told us they were well supported and knew who to go to in the practice with any concerns. Staff told us they were well informed of practice issues via practice meetings.

The practice held monthly practice meetings for all staff. The whole practice team met for the first part of the meeting and then divided into administrative team and GP's and nurses. In addition the nursing team met monthly. Evidence we reviewed indicated dispensary staff did not met regularly with the lead GP for medicines management however, we were told they were accessible if staff had concerns.

Staff had access to on-going professional development opportunities and regular appraisal.

We saw evidence of changes to practice resulting from learning from incidents and significant events. For example, the upgrading of the practice IT security systems.

We reviewed a number of human resources (HR) policies, for example, disciplinary procedures, induction policy, management of sickness which were in place to support staff. These were well organised, up to date and reflected current HR procedures.

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

The practice gathered feedback from patients through complaints and individual GP appraisal data. At the time of the inspection the practice did not undertake their own

Are services well-led?

Good

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

patient survey and did not have a patient representative group. However, the practice were responsive to some feedback received for example, changes made to the intrauterine contraceptive device (IUCD) clinic.

We were told the practice had a plan to improve patient involvement and already had a patients' comments box in the practice for some years.

The practice had a whistle blowing policy which was available for all staff to read as guidance.

Management lead through learning and improvement

Evidence gathered throughout our inspection through staff interviews and record and policy reviews indicated overall the management team led through learning and improvement. For example, audit cycles were completed, action plans were reviewed and communication across the whole staff group took place. Learning took place through the review of significant events and other incidents and complaints and meeting records shared with staff.

Staff told us and training records confirmed staff were able to remain updated with mandatory training requirements. We saw continuing professional development opportunities were supported. Staff files demonstrated annual appraisal took place which included a personal development plan.

New staff were supported via an induction programme and specific support to orientate and train them for their role.