Crondall New Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Crondall New Surgery on 15 October 2014.

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

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

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- 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.
- Information about services and how to complain was available and easy to understand.
- 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.

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

Importantly the provider SHOULD:

- Review the level of detail recorded in the Controlled Drugs register of who collected the Controlled Drugs.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. 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 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. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services.

Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated 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.

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. 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. The practice had good facilities and was well equipped to treat patients and meet their

Summary of findings

needs. 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 with staff and other stakeholders.

Are services well-led?

Good

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

It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.

Nursing staff and GPs had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

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

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. We saw good examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students).

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. 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.

Summary of findings

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 had an open door policy for those patients they had identified a vulnerable. It carried out annual health checks for people with a learning disability and 100% of these patients had received a follow-up. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable 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 practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Summary of findings

What people who use the service say

Patients said that their privacy and dignity was respected and staff were polite when speaking with them. Patients were involved with making decisions about their care and treatment. Results from the national patient survey showed that 94.8% would recommend the practice and 93.2% said their experience of using the practice was very good or good.

Patients said that they were able to make appointments easily and could usually see the same GP if they wanted to.

Areas for improvement

Action the service SHOULD take to improve

The practice should review the level of detail recorded in the Controlled Drugs register of who collected the Controlled Drugs.

Crondall New Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Lead Inspector**.** The team included a GP specialist advisor and a practice manager specialist advisor.

Background to Crondall New Surgery

Crondall New Surgery is a well-established village surgery which moved to its current premises in 2004. The premises are owned by the GP partners. The patient participation group has ben actively involved, over the years, in raising funds for some of the furnishings and equipment for the surgery.

There are about 4550 patients currently registered with the practice. The practice has three GP partners, one nurse practitioner and three practice nurses. The practice is supported by a practice manager, receptionists, a dispensary team and an administrative team. Three of the non-clinical staff are trained in phlebotomy. Attached staff includes a midwife, health visitor, community matron, community nursing team and palliative care nurse. There is also a named mental health nurse linked to the surgery.

The practice has a dispensary catering for patients who live further than one mile from a pharmacy. The practice is open from 8am to 6:30pm Monday to Friday and has extended hours clinic from 6.30-7.30pm on Tuesdays. The practice is rated at 268 out of 7929 GP practices in the national patient satisfaction survey and scores highest in the clinical commission group area. The practice has out of hours arrangements with North Hampshire Urgent Care.

We carried out our inspection at the practice's only location which is situated at;

Crondall New Surgery

Redlands Lane

Crondall

Farnham

Surrey

GU10 5RF

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 15th October 2014. During our visit we spoke with a range of staff including GPs, nurses, Administration and management staff and spoke with patients who used the service. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

- Is it safe?

Detailed findings

- 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)

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. This included reported incidents and national patient safety alerts as well as comments and complaints received from patients. The practice was able to demonstrate the process for recording incidents with the practice manager and the GPs. All serious events were discussed at meetings. This provided staff with the opportunity to discuss the incident and to record any learning points. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term. Records we viewed confirmed this. A GP said that there was an open/no blame culture at the practice to enable staff to report any significant incidents or events.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. There was a specific proforma for staff to complete when a significant event occurred. Any action needed was put into place and recorded; there was on going monitoring of significant events to ensure actions taken were effective. An example given of a significant event was when there was a power failure to one of the medicine refrigerators. The practice's protocols were followed and some vaccines had to be destroyed. As a result of this incident a new thermometer was purchased. During the investigation into this event, the practice noted that the other medicine refrigerator was consistently operating out of range and they therefore purchased a new one.

A GP said that significant events presented at meetings had input from other health professional when needed, for example practice nurses, other GPs or health visitors. They showed us examples of forms that had been completed and reviewed. We found these forms were fully completed and included actions taken and learning points. Action plans for the eight significant events, apart from one had been completed; this one was on going at the time of our inspection.

Meetings were held for staff to discuss concerns, complaints and significant events and review action taken when needed. Staff we spoke with confirmed this and minutes of meetings held showed that the process was in place and effective.

Reliable safety systems and processes including safeguarding

The practice had systems and processes to help staff identify and respond appropriately to any safeguarding concerns. There was a named safeguarding lead who had completed level three safeguarding vulnerable adults and children courses. We saw evidence that all of the staff who worked at the practice had also received training in safeguarding. We examined the training records and saw that all clinical staff, including GPs and practice nurses, had completed safeguarding up to level three and administration staff had completed training to level two. All of the staff we spoke with knew who the safeguarding lead was. They were also aware of how to report any safeguarding concerns.

There were systems in place to identify vulnerable adults and children. For example, any reports or letters relating to children failing to attend hospital appointments were passed to the lead GP. These were then discussed with health visitors or at child protection meetings.

The practice had a chaperone policy that had been updated and reviewed in March 2013. A chaperone is a person who accompanies another person to protect them from inappropriate interactions. Information about how to request a chaperone was made available to patients through the patient information leaflet and was also displayed in reception and in each consultation room. All the staff we spoke with were aware of the chaperone procedures and only clinical members of staff acted as chaperones.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system, which collated all communications about the patient including scanned copies of communications from hospitals. We saw evidence audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Medicines management

Medicines recalls were received via the pharmaceutical wholesaler as a web alert and acted on by dispensary staff. We checked medicines stored in the dispensary and medicine refrigerators and found they were stored securely

and were only accessible to authorised staff. Practice staff monitored the refrigerator storage temperatures and appropriate actions were taken when the temperatures were outside the recommended ranges.

Processes were in place to check medicines were within their expiry date and suitable for use. We saw records of practice reviews and the actions taken in response to these reviews. For example, patterns of anti-coagulant, contraceptive, chronic obstructive pulmonary disease (a breathing condition) and poly-pharmacy prescribing within the practice.

Vaccines were administered by nurses using Patient Group Directions that had been produced in line with national guidance and we saw up to date copies. There were also appropriate arrangements in place for the nurses administer medicines that had been dispensed for patients.

Staff explained how the repeat prescribing system was operated. For example, how staff generated prescriptions and monitored for over and under use and how changes to patients' repeat medicines were managed. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary. All prescriptions except for repeat prescriptions for dispensing patients were reviewed and signed by a GP before they were given to the patient. Blank hand written prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. For those prescriptions not signed before they were dispensed we were told by the dispensary staff how these were within the review date or number of permitted repeats. However, they also told us that their computer access allowed them to override the system.

There was a system in place for the management of high risk medicines which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). For example, controlled drugs were stored in controlled drugs safes, access to them was restricted and the keys including the spare keys held securely. Whilst records were kept of who had collected the controlled drugs some of these records were not person identifiable. There were arrangements in place for the destruction of controlled drugs. For returned patients own controlled drugs these records were only kept from the point of destruction.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. The practice had a daily and weekly checklist for cleaning procedures and records showed the toilets were checked twice a day.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff had received training about infection prevention and control specific to their roles. We saw evidence the lead had carried out audits for each of the last three years and that any improvements identified for action were completed on time. Practice meeting minutes showed the findings of the audits were discussed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement infection control measures. 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 in order to comply with the practice's infection control policy. One example we were given was the use of gloves when examining patients. There was also a policy for dealing with needle stick injuries.

Hand hygiene information and techniques was displayed around the practice and in staff and patient toilets. Hand washing sinks with liquid hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of Legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy in order to reduce the risk of infection to staff and patients.

Clinical waste was stored and disposed in line with current waste regulations. We saw that waste consignment notes were also kept in accordance with the regulations.

Good

Are services safe?

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. We saw evidence of calibration of relevant equipment that included refrigerator thermometers.

All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date of November 2013.

Staffing and recruitment

The practice had a 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 of staff had been undertaken prior to their employment. These checks included proof of identification, qualifications, registration with appropriate professional bodies and criminal records checks via the Disclosure and Barring Service.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure there was enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

The practice had a system of employing locums when needed. We saw evidence that showed locums were up to date with their qualifications and revalidation and were familiar with the specific workings of the practice. This is because the practice tried to use the same locums wherever possible.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was a lead health and safety representative.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency medicines, including access to oxygen, were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were in place to check and record that 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. Emergencies 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. For example, contact details of a heating company to contact in the event of failure of the heating system.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice used a software system that had assessment and treatment templates based on best practice guidance. 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 and from local commissioners. Information was discussed at practice meetings and current guidance was disseminated to staff. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

Patients who were diagnosed with long term conditions, such as, asthma and chronic obstructive pulmonary disease which is a condition which causes breathing difficulties. These patients had care plans in place detailing the care and support they needed. Care plans for patients who were vulnerable, such as those with dementia were also in place and the practice had liaised with other health professionals when needed. The practice undertook regular visits to local care homes and each care home had a named GP.

We were shown examples of care plans, such as one for a patient with multiple sclerosis and dementia. There were key action points and details of physical signs to be aware of and what action was needed. The GP, who shared the care plans with us, said that quite often these were completed at the patient's home during a home visit. This allowed sufficient time to ensure details were correct and involve the patient fully.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management.

The practice had a system in place for completing clinical audit cycles. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool.

We looked at examples of audits with the full cycle of standard-setting, first cycle audit, a discussion with peers, agreeing changes, implementing them and then re-auditing to see whether it has made a difference or not. There was evidence of reflection at the end of the full cycle, regardless of whether the desired change was achieved not. An example seen was audits of diclofenac used. Diclofenac is a pain killer that can have significant side effects, such as stomach ulcers, when used inappropriately. This audit was undertaken as a result of an alert received by the Medicines and Healthcare Products Regulatory Agency. Learning points were put into place and there were protocols for on going monitoring of prescribing of this particular medicine.

Nurses who worked in the practice had responsibility for treating patients with long term conditions and held regular clinics. For example, for chronic obstructive pulmonary disease (COPD), a condition which causes breathing difficulties. The practice referred patients with COPD to a singing group in the community; singing assists patients to breathe correctly and deeply.

The practice held a register of patients with a learning disability. All of these patients had received their annual review.

Effective staffing

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines. Those with extended roles for example seeing patients with asthma and diabetes were also able to demonstrate that they had appropriate training to fulfil these roles.

A practice nurse had completed training to be a nurse prescriber and was responsible for diabetes management. As part of their role in managing diabetes they liaised with other nurses who were community based to provide support and treatment for patients.

Training had been provided to staff on areas such as fire safety, moving and handling and infection control. GPs were up to date with their yearly continuing professional development requirements and all either had been

Good

Are services effective?

(for example, treatment is effective)

revalidated or had a date for revalidation. Every GP was appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council. Other staff who worked in the practice received an annual appraisal; learning needs were identified and planned for. Staff said they found this process was useful and they considered that their training needs were met.

The practice had an appraisal system in place. Staff who had received appraisals in the past year said they were able to discuss their training needs and were able to access relevant training.

Working with colleagues and other services

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system and said they were able to use it easily and there was scope for adding addition information when needed. Paper communications, such as those received from hospitals, were scanned and saved into the system on the individual patient record.

We found referrals to secondary care (hospitals) were made following a protocol. This consisted of faxing urgent referrals on the same day and those for suspected cancer. A GP said they were able to contact consultants in the hospital for advice either by telephone or by writing a formal letter.

Patients were able to use the choose and book system, this is an online system which allows patients the choice of hospital and appointment.

Information sharing

The practice had a range of meetings to discuss care and treatment provided by them. These included meetings of the GPs and practice manager; meetings to discuss finances and forward planning; and nurse meetings once a month. All these were minuted and learning and actions were shared with relevant staff groups.

The practice held care meetings for those patients with complex needs and Gold Standard framework meetings for end of life care once a month. Patients with these conditions were discussed and if needed other relevant health professionals attended the meeting, such as the community matron. Care plans were shared with the out of hour's service.

Administration staff had quarterly meetings to discuss issues specific to their work.

Consent to care and treatment

The practice had a policy on use of the Mental Capacity Act 2005, which was accessible for staff to refer to. We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. Nurses and GPs gave examples of when they had to use this. One related to a patient who was writing cheques to third parties and the family had concerns. A GP was asked to assess this patient and subsequently made a referral for a formal assessment of capacity by trained assessors. We were also given an example of a patient with learning disabilities who had a best interest meeting which involved the patient and other health professional such as their care coordinator.

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance.

GPs said there were various support services in the area which they were able to refer patients to, or patients were able to self-refer. For example, an alcohol and substance misuse advisory service for patients with alcohol or substance misuse. Smoking cessation sessions were offered at the practice. They also used appointments opportunistically to offer advice on lifestyle choices which might have a detrimental effect on health.

The practice website and waiting areas had information on health promotion and self-management of conditions. Such as, sexual health, heart disease signs and symptoms

Good

Are services effective?

(for example, treatment is effective)

and advice on coughs and colds. Voluntary sector talks were arranged by the patient participation group on keeping well and the practice produced a newsletter with health advice and articles for the parish magazine.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Staff were able to demonstrate how they respected patients' privacy and dignity. For example, by ensuring the door was closed during a consultation and using privacy curtains and blankets when a patient had an examination, Patients said that their privacy and dignity was respected and staff were polite when speaking with them. Results from the national patient survey showed that 94.8% would recommend the practice and 93.2% said their experience of using the practice was very good or good.

Care planning and involvement in decisions about care and treatment

A GP highlighted the importance of involving patients in decisions and said they would always listen to what the patient had to say first, before discussing any treatment options. Staff said they would inform patients of different treatment options and any risks related to each option, before a final decision was made on how to proceed. A GP said they signposted patients to relevant information to assist them in making a decision.

Patient/carer support to cope emotionally with care and treatment

The practice had a system in place for coding patients who were carers. When these patients attended for consultations they would be asked about how they were coping and if they had sufficient support, as well as discussing their medical need. The practice prided itself on continuity of care and tried to arrange whenever possible for the same GP to see a patient, so they could establish a positive relationship. A GP said that on occasion they would suggest to patients to bring a relative or friend for support.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, if a patient was a carer or care for an alert was placed on their medical record in order that GPs and nurses were aware of their social situation. The practice had three care homes in their area and undertook regular visits at specific times. There were military families living in the area and the nurses and GPs said they were aware of these patients and offered support when needed. For example, if a relative of a patient was killed or injured in action. Students who lived in the area during term time were able to register as temporary patients with the practice.

Tackling inequity and promoting equality

The practice had ramps and electronic doors at the entrance to the premises and accessible toilet facilities. There was a limited supply of equipment, such as crutches which could be loaned to patients on a short term basis. There were also wheelchairs for use on site.

The practice website had a video on how to book appointments on line and the website was able to be translated into alternative languages. The practice could access a telephone interpreting service if needed.

Staff told us they had received training on equality and diversity and there was a policy they were able to refer to when needed. Where patients required help with administering their medicines a monitored dosage system was offered, for example, medicines dispensed in blister packs or specialist boxes with days and times on them. GPs said that on occasion they would help patients with a learning disability to complete forms for social services.

Access to the service

There were a range of appointments that patients could access. The system used by the practice was based on a traffic light system. Red appointments were for urgent same day appointments; amber for conditions needed attention in the following few days; and green for routine appointments which could be seen in two or three weeks. Patients were asked minimal questions by reception staff to enable them to book the most appropriate appointment. Information on the types of conditions was available on the practice website and in the practice. For example, red conditions included a high fever with a rash; amber included throat infections; and green included medicine reviews. We found that patients were usually able to get routine appointments within 48 hours and same day appointments were always available. Children under five years of age would automatically be seen by a GP on the same day. Patients told us that they were always able to get an appointment at a suitable time and were always seen on the same day if needed.

The practice had an electronic message system in place to alert nurses and GPs if a patient needed to be seen on the same day and reception staff said they would also telephone GPs and nurses if needed.

Older patients and those with complex needs, or a learning disability were able to booked longer appointments. A GP said that this worked well for older patients, as they usually wished to discuss more than one condition. Another GP said that the practice was flexible and would add extra appointments onto the end of lists if needed. Home visits were available for those who required them.

The most recent results from a national patient survey showed that 93.8% of respondents were satisfied with their experience of making an appointment. The results also showed that 98.5% of patients reported that it was easy to get through to the practice on the telephone and 88.6% were satisfied with the opening hours. These results were in line with or above the national average when compared with other GP practices.

Listening and learning from concerns and complaints

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

During the past year the practice had received a total of three complaints. We found that each concerns had been investigated and a response provided to the complainant. Information on how to make a complaint or comment was available in the practice and on its website.

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 gave a presentation at the start of our inspection and stated that their values and vision were serving the local community and providing traditional family medicine with an emphasis on continuity of care. They were actively encouraging patients to register with them. These values were communicated to all staff via meetings. Staff we spoke with confirmed this and we found they demonstrated the values in their everyday work.

Governance arrangements

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line or above national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

Administration staff had a handover meetings daily to ensure important information and work which needed to be achieved were communicated effectively and completed.

The practice had a Caldicott guardian lead, who was responsible for ensuring patients information, was kept security and only shared when relevant and necessary. The practice had systems in place to ensure this occurred, such as password protected access to computer systems, a policy outlining and stressing the importance of confidentiality. GPs, nurse and others staff were able to demonstrate how they ensure patients' information was handled and maintained securely. There were suitable systems in place to manage risks associated with health and safety. For example, a fire risk assessment and risk assessments for moving and handling. These were reviewed and changes made when needed to minimise risk.

Leadership, openness and transparency

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

We saw from minutes that team meetings were held at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We also noted that social events were held in the summer and at Christmas time. GPs said that the leadership culture was one of including staff in decision making and engaging them in the organisation of the practice.

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

We met with members of the patient participation group (PPG). They told us that they met every two months and assisted the practice with fund raising for equipment and patient surveys. One item of equipment that had been purchased through their fund raising was a blood pressure monitor. As a result of the patient survey carried out in 2013/14 the practice had reorganised the seating in the reception area to minimise the risk of patients being overheard when speaking to reception staff.

Quarterly practice meetings were held for all staff to attend and this provided them with an opportunity to discuss concerns or give feedback on how the practice was performing. The reception team considered that they would appreciate being more involved in meetings, but did not have any concerns about approaching the GPs with ideas or suggestions.

The practice had a whistleblowing policy in place which staff were aware of and knew how to use it if needed.

Management lead through learning and improvement

The practice undertook and participated in a number of regular audits. We saw that incidents were reported promptly and analysed. We noted examples of learning from incidents and audits, and noted that where applicable practices and protocols had been amended accordingly. Findings were shared with relevant staff. AN example given of team working related to care of patients with a high blood pressure. A nurse identified patients with this and carried out a health review and referred patients onto the a GP for a medical review who completed a care plan,

Each staff member had an annual appraisal to monitor performance and identify further learning needs. Staff said their learning needs were discussed and plans were in place for the staff member to achieve their learning goals.

Are services well-led?

Good

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

The GPs met regularly monthly to discuss clinical care and on occasion health visitors and other health professionals attended, to share learning and best practice. The practice also had links with the clinical commissioning group and used these to inform best practice and learning. GPs said that when clinical learning needed were identified they would invite specialists to give a talk, for example on allergy advice for mothers with children who had food intolerance.