Arbury Road Surgery

Quality Report

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Date of inspection visit: 15 April 2015
Date of publication: 11/06/2015

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 visited Arbury Road Surgery on the 15 April 2015 and carried out a comprehensive inspection. The overall rating for this practice is good. We found that the practice provided a safe, effective, caring, and responsive service. Improvements were needed to ensure that robust governance process were in place in relation to policies.

We examined patient care across the following population groups: older people; those with long term medical conditions; mothers, babies, children and young people; working age people and those recently retired; people in vulnerable circumstances who may have poor access to primary care; and people experiencing poor mental health. We found that care was tailored appropriately to the individual circumstances and needs of the patients in these groups. Our key findings were as follows:

- All patients at the practice were registered with a named GP and we saw evidence of continuity of care.
- Patients were satisfied with the opening hours. They reported that it was easy to get through on the telephone to make an appointment and appointments were made at convenient times.
- Patients felt they were treated with dignity, care and respect. They were involved in decisions about their care and treatment.
- The practice addressed patients' needs and worked in partnership with other health and social care services to deliver individualised care.
- The practice had good facilities and was well equipped to treat patient and meet their needs.
- The needs of the practice population were understood and services were offered to meet these. Feedback from the care homes where patients were registered with the practice was positive.
- Staff were clear of their roles and responsibilities and followed available guidance. However improvements were needed to ensure there was a robust process in place for the approval, dissemination and review of policies.

Summary of findings

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

- Identify areas where oxygen is stored and mark them with 'hazardous substance' notices.
- Ensure the process for checking that identified actions had been undertaken following significant events and complaints is completed and documented.
- Ensure all staff attend infection control training.
- Review and update the disaster recovery plan.
- Ensure all staff receive an annual appraisal.
- Provide information on the complaints policy so that it can be easily and independently accessed by patients.
- Ensure there is a robust process for the approval, dissemination and review of practice policies.

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 report incidents and near misses. Lessons were learned from significant events and complaints and communicated to practice staff to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. There was scope to improve the process for checking that identified actions had been undertaken following significant events and complaints. Risks to patients were assessed and well managed. Staff had a good understanding of the types of abuse and their responsibilities in relation to safeguarding. Information was provided to support staff in relation to safeguarding children and adults. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were average for the locality. National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of patients' mental capacity and the promotion of good health. We saw evidence of effective multidisciplinary working. Staff had received training appropriate to their roles and further training needs had been identified and planned for. The majority of staff received an annual appraisal and dates had been arranged for those who had not had an appraisal in the past year.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed patients rated the practice in line with others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.Support was available at the practice and externally for those suffering bereavement or that had caring responsibilities for others.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with NHS England and the Clinical Commissioning Group (CCG) to secure service

Summary of findings

improvements where these were identified. Patients reported good access to the practice with urgent appointments available the same day. The practice had good facilities and were well equipped to treat patients and meet their needs. There was a complaints system with evidence demonstrating that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a vision and staff were aware of their responsibilities in relation to this. There was a clear managerial and clinical leadership structure and the majority of staff we spoke with felt supported in their work. The practice had some policies and procedures to govern its activity. However these had not all been adapted to the practice or dated and not all staff were aware of how to access policies and procedures. Regular governance meetings had taken place. There were systems in place to monitor and improve quality and identify risk. The practice sought feedback from staff and patients and this had been acted upon. Staff had received inductions and attended staff meetings and peer support meetings. The majority of staff had received an appraisal and dates had been planned for those who were due an appraisal.

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. Patients over the age of 75 had a named GP who was responsible for the coordination of their care. 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. GPs regularly visited local care homes to provider support for patients who lived there. The practice was responsive to the needs of older people, including offering home visits, longer appointments and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. There was a broad range of information about a number of long term conditions in the practice's waiting room, which made them easily accessible to patients. When needed, longer appointments and home visits were available. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. All patients were allocated a named GP who had overall responsibility and oversight of their care. Each GP took a lead role for a number of long term conditions and served as a source of expertise for colleagues in the practice.

A weekly diabetic clinic was held by a specialist trained diabetic nurse who was also a nurse prescriber. There were also regular clinics for other long term conditions, for example asthma and chronic obstructive pulmonary disease. All patients with long term conditions had structured reviews, at least annually, to check their health and medication needs were being met. For those people with the most complex needs the GPs and nurses worked with relevant health care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. The practice's downstairs waiting areas were large enough to accommodate patients with prams. Accessible toilet facilities with baby changing facilities were available for all patients attending the practice. Appointments were available outside of school hours. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Summary of findings

The practice offered a full range of immunisations for children and the percentage of children receiving the vaccines was generally in line with or above the average for the local clinical commissioning group. A team of health visitors was based at the practice, allowing good communication between them and other clinicians. Midwives held antenatal clinics twice a week at the practice. Two of the practice's nurses had family planning training and were available to give advice on contraception and provide screening for common sexually transmitted infections.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the 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 offered a range of appointments which included on the day and pre-bookable appointments, as well as telephone consultations. Routine appointments could be booked on-line up to two months in advance. The practice offered extended hours opening until 8 pm on Monday and Tuesday evenings. The practice offered a full range of health promotion and screening which reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. Nationally reported data showed the practice performed above the Clinical Commissioning Group (CCG) and England average for people with a learning disability. The practice held a register of patients with a learning disability and 59% had received an annual health check. There was a process for following up vulnerable patients who did not attend for their appointment, although the practice were in the process of reviewing this to ensure that verbal contact was made with those who had not responded to written correspondence. We were told that longer appointments were given to patients who needed more time to communicate during a consultation, for example people who needed an interpreter. There were arrangements for supporting patients whose first language was not English. The practice did not register patients without a fixed address but referred them to a local service set up specifically to support homeless people's health needs.

The practice held a register of people living in vulnerable circumstances and there was a system to highlight vulnerable

patients on the practice's electronic patient records. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people and held regular meetings to review the needs of those patients who were vulnerable. The practice had sign-posted vulnerable patients to various support groups and third sector 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 and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). Nationally reported data showed the practice scored above the Clinical Commissioning Group (CCG) and England average for people with mental health needs, but below the average for those with dementia. The practice had registers of people with mental health issues and those with dementia. On the day of the inspection, we found that 66% of patients with dementia had received a health check. Patients at risk of dementia were routinely offered cognition and memory testing. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had in place advance care planning for patients with dementia.

Summary of findings

What people who use the service say

We spoke with six patients during our inspection and received many positive comments about the practice and its staff. Patients we spoke with told us the practice offered a good service and they found staff were efficient, helpful and professional. They reported they were satisfied with the opening hours and that it was relatively easy to get through to the practice on the telephone. Patients told us they were able to get an appointment at a time that suited them and with a GP that they knew, and were rarely kept waiting for more than 10 minutes for their appointment once they arrived. All of the patients told us that they had sufficient time with the GP and were not rushed during their consultation. We received a number of positive comments from patients about the cleanliness and standards of hygiene at the practice. Patients also reported a good experience with getting repeat prescriptions. None of the patients we spoke with had any concerns about the practice. Patients felt the practice was accessible because car parking was good and it was near a number of bus stops if needed.

We did not receive any Care Quality Commission comment cards from a box left in the practice two weeks before our inspection. We promoted the completion of these during the inspection but patients chose not to complete them.

We spoke with representatives from four care homes where patients were registered with the practice, all of whom were satisfied with the service provided by the practice. They all gave positive feedback which included the GP listening to patients, involving family members in patients care and treatment where appropriate and having a good working relationship with the staff at the home. They advised that GPs visited on the same day when this was requested and referrals were made in a timely way. We were told that patients with long term conditions were reviewed, annual health checks were undertaken and patients prescribed medicines were reviewed regularly. We spoke with one representative where a GP visits on a regular basis every Monday and Thursday morning.

Areas for improvement

Action the service SHOULD take to improve

- Identify areas where oxygen is stored and mark them with 'hazardous substance' notices.
- Ensure the process for checking that identified actions had been undertaken following significant events and complaints is completed and documented.
- Ensure all staff attend infection control training.
- Review and update the disaster recovery plan.
- Ensure all staff receive an annual appraisal.
- Provide information on the complaints policy so that it can be easily and independently accessed by patients.
- Ensure there is a robust process for the approval, dissemination and review of practice policies.

Arbury Road Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector and a GP specialist advisor. The team also included a nurse specialist advisor and two CQC inspectors who were observing.

Background to Arbury Road Surgery

Arbury Road Surgery is in the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) area. The practice is situated to the north of Cambridgeshire and provides a range of general medical services to approximately 11950 registered patients.

According to Public Health England information, the patient population has a slightly higher than average number of patients aged 0 to 4, a slightly lower than average number of patients aged 5 to 14 and an average number of patients aged between 15 to 18 compared to the practice average across England. It has a significantly lower number of patients aged 65 and over and a slightly lower number of patients aged 75 and over, and aged 85 and over compared to the practice average across England. Income deprivation affecting children is slightly above average and in relation to older people is slightly lower than the practice average across England. A lower percentage of patients had a caring responsibility compared to the practice average across England.

There are seven GP partners who hold financial and managerial responsibility for the practice, one salaried GP and one GP Registrar. (A GP Registrar is a qualified doctor who is training to become a GP.) There are three practice nurses, one nurse practitioner, a number of reception and administration staff a deputy practice manager and a practice manager. The practice is a training practice for medical students and GP Registrars.

The practice provides a range of clinics and services, which are detailed in this report. It operates between the hours of 8am and 8pm, Mondays and Tuesdays and between 8am and 6pm on Wednesdays, Thursdays and Fridays. Outside of practice opening hours a service is provided by another health care provider, Urgent Care Cambridgeshire.

Why we carried out this inspection

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

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

How we carried out this inspection

Before our inspection, we reviewed a range of information we held about the practice and other information that was

Detailed findings

available in the public domain. We also reviewed information we had received from the service and asked other organisations to share what they knew about the service. We talked to the local clinical commissioning group (CCG), the NHS local area team and Healthwatch. The information they provided was used to inform the planning of the inspection.

We carried out an announced visit on 15 April 2015. During our visit we spoke with a range of staff, including GPs, nurses, reception and administration staff, the deputy practice manager and the practice manager. We spoke with one member of the patient participation group (PPG). PPGs are a way for patients and GP surgeries to work together to improve services, promote health and improve quality of care. We also spoke with six patients who used the practice. We did not receive any comments cards from patients, from a box left in the practice approximately two weeks before the inspection. We spoke with representatives from four residential homes where patients were registered with the practice.

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

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

We also looked at how well services are provided for specific groups of 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 living in vulnerable circumstances

Good

Are services safe?

Our findings

Safe track record

The practice was able to demonstrate it had a good track record for safety. Practice staff used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents 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. Actions had been taken to minimise the risk to patients and learning had been identified and implemented to reduce the risk of reoccurrence. There were records of complaints and significant events and we were able to review these. For example one significant event related to a prescription being given to the wrong patient. Learning points had been identified and actions taken to reduce this happening again. We noted that an annual review of complaints and significant events had taken place to identify trends.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Staff including receptionists and clinical staff were aware of the system for raising significant events and felt encouraged to do so. We saw evidence that significant events and complaints were discussed and analysed at weekly GP meetings to identify where any lessons could be learned and actions were identified to minimise the risk of re occurrence. The findings were disseminated to relevant staff via a number of meetings held with different staff groups at the practice. We were told that actions had been completed following significant events however this was not clear from the records we looked at. There was scope to improve the process for checking that identified actions had been completed following significant events and complaints.

We looked at the records of significant events and saw these had been completed in a comprehensive and timely manner. We looked at three significant event analyses and saw evidence of action taken as a result. One significant event involved a delay in a test result being given to a patient. This event had been reviewed and learning identified and implemented. A system had been put into place where the GP who reviews patients' results now communicates those results to patients by text or by telephone. Another significant event identified a need for additional learning by a GP in order to deal more effectively with responding to patients who may become aggressive.

National patient safety alerts were disseminated to the appropriate practice staff by email and if they were urgent a paper copy was put into the GPs post box. These were also shared at the weekly GP meeting to ensure all GPs and the lead nurse were aware of any that were relevant to the practice and where they needed to take action. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. For example one related to the use of a medication to relieve feelings of sickness or vomiting which might be harmful to the heart. We saw that all patients on a repeat prescription were reviewed and their treatment stopped or changed appropriately and this was justified in the patient's notes.

Reliable safety systems and processes including safeguarding

The practice had a range of documentation to advise staff of their role and responsibility in relation to safeguarding children and vulnerable adults. This included contact information for safeguarding professionals external to the practice and flow charts for making a safeguarding referral. 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 safeguarding knowledge. Staff were knowledgeable about how to safeguard people from the risk of abuse and 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 to staff at the practice. The practice had appointed a dedicated GP as the lead in safeguarding vulnerable adults and children. They had been trained to level three and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern.

The practice held a register of people living in vulnerable circumstances and there was a system to highlight vulnerable patients on the practice's electronic patient

records. This included information to make staff aware of any relevant issues when patients attended appointments, for example children subject to child protection plan. The practice had systems to manage and review risks to vulnerable children, young people and adults. There were systems in place to identify and follow up children who had a high number of A&E attendances. They were regular multi-disciplinary vulnerable families meetings held where the needs of vulnerable mothers and children were discussed to ensure they were getting sufficient support and care.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who serves as a witness for both a patient and a medical practitioner as a safeguard for both parties during a medical examination or procedure and is a witness to continuing consent of the procedure.) There were clear notices displayed by all examination couches outlining the availability of chaperones. We saw evidence that staff undertaking chaperoning had appropriate Disclosure and Barring service (DBS) checks in place and there was evidence that they had received training to undertake this role. Disclosure and Barring Service checks help to ensure a person's suitability to work with vulnerable patients.

Medicines management

We noted the arrangements in place for patients to order repeat prescriptions. Patients were able to view and order repeat prescriptions online, 24 hours a day. Patients we spoke with told us they received their repeat prescriptions promptly and did not experience delays in the supply of their medicines. There was a process in place issuing repeat prescriptions. For patients whose repeat prescription request identified that they were due for review, the prescription clerk sent a task to the GP to review the medicines, which included inviting patients to attend for a medicine review. If patients were already booked in for an appointment a task was sent to the GP to review the patient's medicines during the consultation. If patients had any queries regarding their prescriptions, the GP was advised of this and the prescription clerk informed the patient of the outcome where appropriate. All prescriptions, including those for controlled drugs were issued in hard copy and were manually signed by a GP. Prescriptions could be collected from the practice and were also collected by a number of pharmacies where patients could collect their dispensed medicines, where it was more convenient. 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 by practice staff 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). Controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. We checked the actual number of controlled drugs against the number recorded in the controlled drugs record book and these matched for all the controlled drugs held at the practice.

Records demonstrated that vaccines and medicines requiring refrigeration had been stored within the correct temperature range. Staff described appropriate arrangements for maintaining the cold-chain for vaccines following their delivery. There was a policy for this although we noted that there was no review date documented.

Cleanliness and infection control

We observed the premises to be clean and tidy. The cleaning was undertaken by an external company. We were told there were cleaning schedules in place and cleaning records were kept. There was no evidence that spot checks were undertaken by the practice. We spoke with the practice manager and the partners about this and they agreed that they would start undertaking and documenting spot checks of the quality of the cleaning undertaken. 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 undertaken further training to enable them to provide advice on the practice infection control policy. Some staff had received infection control training specific to their role and some staff had completed this training by e-learning. Further face to face training had been planned for all staff to receive infection control training. We saw that infection control measures were discussed at meetings held at the practice, for example a checklist was in place for cleaning toys and telephones at least once a week. The lead nurse was in the process of undertaking an in-depth infection

control report, which identified the risks in each room. There was a plan to update the current generic infection control policy into one which was specific to the identified needs and risks of the practice.

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 and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with liquid soap, sanitising gel and paper towel dispensers were available in treatment rooms.

The practice had arrangements in place for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). We saw records that confirmed the practice was carrying out checks to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment which included weighing scales, an electrocardiogram machine and blood pressure measuring devices. The certificate was dated June 2014 and was due to be retested in June 2015.

Staffing and recruitment

The practice had a recruitment and employment checks policy that set out the standards it followed when recruiting clinical and non-clinical staff. We looked at three staff files which all 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). We saw that regular checks were undertaken to ensure that clinical staff had up to date registration with the appropriate professional body.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. We saw records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements. There were arrangements in place to ensure that extra staff were employed, if required, to deal with any changes in demand to the service as a result of both unforeseen and expected situations, such as annual leave or adverse weather conditions.

Monitoring safety and responding to risk

The practice had systems and processes in place to manage and monitor risks to patients, staff and visitors to the practice. These included monthly safety checks of the building, staffing and dealing with emergencies and equipment. Records showed that essential risk assessments had been completed and where risks were highlighted, measures had been put in place to minimise the risks. Various risk assessments had been reviewed recently, including fire safety. There was no formal risk register, however we were assured that these risks were being monitored by the Practice Manager and the partners at the practice. We saw that any newly identified risks, including risks to patients, significant events, complaints or infection control were discussed at the weekly GP meetings.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw evidence that the staff at the practice had received training in medical emergencies such as anaphylaxis and basic life support skills. The staff that we spoke with confirmed this. There were emergency medicines and equipment available so that staff could respond safely in the event of a medical emergency. Emergency equipment included access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Oxygen is widely used in emergency medicine, both in hospital and by emergency medical services or those giving advanced first aid. Having

Good

Are services safe?

immediate access to functioning emergency oxygen cylinder kit helps people survive medical emergencies such as a heart attack. Processes were in place to check whether emergency medicines and equipment were available and within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. Staff we spoke with knew the location of the emergency medicines and equipment. We noted that areas where oxygen was stored were not marked with 'hazardous substance' notices.

The practice had an emergency call icon on all of their computer screens. Staff we spoke with were aware that if pressed, this alerted staff in other parts of the building to an emergency situation and requested them to respond to it. There was a fire policy with actions to take in the event of fire and an evacuation plan was in place.

The practice had a disaster recovery plan which covered a range of areas of potential risks relating to foreseeable emergencies such as flood or loss of water supply as well as staff incapacity. The plan demonstrated to some extent how these risks could be mitigated to reduce the impact on the delivery of the service. This plan was updated three years ago and did have some out of date staff lists but the overall plan was fit for purpose.

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 local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. Patients told us that they were reviewed regularly for their long term conditions.

The GPs told us there was a lead GP for a number of long term conditions, for example heart disease, dermatology and diabetes. They served as a source of expertise for colleagues in the practice and were responsible for ensuring new developments or specific clinical issues were discussed at the relevant practice meetings. There were a number of clinics held at the practice including those for asthma and chronic obstructive airways disease, family planning, minor surgery and diabetes. A diabetes specialist nurse regularly visited the practice to meet with the nurse lead for diabetes to review patients with complex diabetes. These ensured that services were provided to effectively meet the needs of the patients.

All GPs we spoke with used national standards for patients with suspected cancers to be referred and seen within two weeks. We saw minutes of meetings where regular reviews of elective and urgent referrals were made and that improvements to practice were shared with all clinical staff. The practice made effective use of the specialist knowledge and expertise of the GPs at the practice. For example, referrals were made to one of the GPs who specialises in dermatology. There was evidence that this had reduced the number of referrals which had been made to secondary care services and had resulted in patients being seen more locally.

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

There was evidence of effective structuring of patient records which was undertaken by clinicians. This included the use of templates to ensure that care and treatment provided was comprehensive, standardised and took into account best practice guidance.

The practice showed us three clinical audits that had been undertaken. One of these was a completed audit cycle where the practice was able to demonstrate the improved outcomes for patients. For example, the practice had increased the objective clinical measures of asthma (for example oxygen saturations or respiratory rate) from 51.4% to 76.3% of patients. A further improvement had been made in having a clear plan of follow up in their GP surgery within two working days, which had increased from 24% to 38%. A further clinical audit was undertaken in response to an alert published by the Medicines and Healthcare Products Regulatory Agency (MHRA). This related to patients prescribed a medicine commonly used in the treatment of epilepsy, where exposure to children in utero may raise the risk of development disorders and/or congenital malformations. The practice had identified patients of child bearing potential who had been prescribed valproate medicines in the past six months. Recommendations were identified, which were discussed at a practice meeting and changes to practice undertaken. For example contraceptive counselling to be included as part of the epilepsy yearly review.

The practice also used the information they collected for the Quality and Outcomes Framework (QOF) and their performance against national screening programmes to monitor outcomes for patients. The Quality and 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. The practice had a total achievement of 87% in the year 2013 to 2014. The advised that their total achievement for 2014 to 2015 was 94% although this had not been

Good

Are services effective?

(for example, treatment is effective)

published. The published QOF data showed that the practice had a higher prevalence of some clinical conditions, including for example, depression, heart failure, learning disability, depression and mental health, than the CCG and England average. The practice scored higher than the CCG and England average for the way it treated the majority of these conditions.

Effective staffing

All new staff underwent a period of induction when they first started to work at the practice. Files we checked, and staff we spoke with confirmed this to be the case and staff told us they found it a useful introduction to their role. There were role specific induction packs for staff, which included an induction pack for locum GPs.

The practice staff included medical, nursing, managerial and administrative staff. We reviewed three staff files and saw that all staff were up to date with attending training deemed mandatory by the provider, such as basic life support, safeguarding and health and safety. The 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 and cervical cytology.

All GPs were up to date with their yearly continuing professional development requirements and all either had 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).The practice had process in place for the annual appraisal of its staff, which included agreeing personal objectives as part of the appraisal process. We saw that the majority of staff had received an annual appraisal. We noted that dates had been booked for those staff who had not received an annual appraisal and staff we spoke with confirmed these dates had been agreed with them.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X-ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had guidance in place which outlined the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There was a buddy system in place to cover GP's who were not working at the practice each day to ensure that patient correspondence was reviewed in a timely way.

The practice was commissioned for the enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services are services which require an enhanced level of service provision above what is normally required under the core GP contract.) The GPs contacted the majority of patients within 24 hours and all patients within two days of them being discharged from hospital, in order to follow up on their care and treatment. We saw that the process in place for responding to hospital communications was working well in this respect.

The practice held multidisciplinary team meetings on a monthly basis to discuss the needs of complex patients, for example those with mental health needs or vulnerable patients. These meetings were attended by GPs and district nurses and other professionals as needed and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information. The practice had a palliative care register and records we saw showed that meetings took place monthly with a range of professionals to discuss the palliative care and support needs of patients and their families and ensure there was a joined up approach to their care and treatment.

Information sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. The system enabled alerts to be communicated about particular patients such as information about children known to be at risk, or those who were carers. All staff were fully trained to use the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

The practice used several electronic systems to communicate with other providers. For example, there was

Good

Are services effective?

(for example, treatment is effective)

a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. The practice used the Choose and Book system for making referrals. (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 signed up to the electronic Summary Care Record. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

Patients were asked for their consent to both share their medical records with other services and for the practice to be able to view information which had been entered by other services. We saw that information was shared appropriately between the other services involved in patient's care. We saw evidence of formal information sharing arrangements with the district nurses and school nurses. We saw that information regarding patients who were at the end of life was shared with the out of hours provider. This ensured that care and support would be seamless if the patient needed a GP out of hours. The practice worked collaboratively with other agencies and community health professionals and regularly shared information to ensure timely communication of changes in care and treatment.

Consent to care and treatment

We saw that the practice had a consent policy and consent forms. The clinicians we spoke with described the processes to ensure that consent was obtained from patients whenever necessary. We were told that written and verbal consent was recorded in patient notes where appropriate. Patients we spoke with confirmed that their consent was obtained before they received care and treatment.

Clinicians demonstrated an understanding of legal requirements when treating children. The practice nurse confirmed consent was always obtained from parents prior to immunisations being given. All clinical staff we spoke with demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment.) The practice used a template to record Gillick competency.

We found that the majority of clinical staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. The Mental Capacity Act is designed to protect people who cannot make decisions for themselves or lack the mental capacity to do so. The practice had a Mental Capacity Act policy available for staff. The majority of 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. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity.

All staff were aware of patients who needed support from nominated carers, and clinicians ensured that carers' views were listened to as appropriate. This was supported by the patients we spoke with during the inspection and from the feedback from the representatives of patients who lived in care homes.

Health promotion and prevention

There was a large range of up to date health promotion information available at the practice and on the practice website, with information to promote good physical and mental health and lifestyle choices. The practice website referred patients to a range of information supplied by NHS Choices. This included information on family health, minor illness and long term conditions including for example asthma and coronary heart disease. NHS health checks were offered to all patients between the ages of 40-75 years with about a 40% take up rate. Appointments were also available with a nurse for advice on smoking cessation, family planning and weight reduction.

We saw that new patients were invited into the surgery when they registered, to find out details of their past medical and family health histories. They were also asked about their lifestyle, medications and offered health screening. The new patient health check was undertaken by a health care assistant or a nurse. If the patient was prescribed medicines or if there were any health risks identified then they were also reviewed by a GP in a timely manner.

We looked at the most recent Quality and Outcomes Framework (QOF) data and noted that the practice had scored higher than the Clinical Commissioning Group (CCG) and England average for cervical cytology primary and child health surveillance. They had scored above the CCG but below the England average for primary prevention of cardiovascular disease.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with

Good

Are services effective?

(for example, treatment is effective)

current national guidance. Information about the range of immunisation and vaccination programmes for children and adults were available at the practice and on the website. We noted they were in line with the Clinical Commissioning Group (CCG) average for the percentage of children receiving childhood vaccinations. Clinical staff we spoke with told us about the arrangements in place for following up patients who did not attend for their immunisations.

The practice had numerous ways of identifying patients who needed additional support. The practice kept a register of patients with dementia and offered them an annual health check. On the day of the inspection, we found that 66% had received a health check. The practice also kept a register of patients with a learning disability and we were told that 41 of the 70 patients with a learning disability (59%) had attended for an annual health check. There was a process in place for following up those who did not attend, although the practice were in the process of reviewing this to ensure that verbal contact was made with those who had not responded to written correspondence.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

There was a person centred culture and staff and management were committed to working in partnership with patients. During our inspection we overheard and observed good interactions between staff and patients. We observed that patients were treated with respect and dignity during their time at the practice. We spoke with six patients all of whom told us that staff were caring, they were treated with respect and their privacy was maintained. Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and clinical room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

The reception was located in the entrance to the practice, which was separate to the waiting room area, although patients waiting at reception could overhear conversations at the reception desks. There was a notice asking patients to respect other patients' privacy and staff we spoke with told us that they would support patients to a private room if they were upset or if they were sharing sensitive information. There was a notice informing patients that they could request to speak in a private room. We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private.

We looked at data from the National GP Patient Survey, which was published on 8 January 2015. 396 surveys had been sent out with 129 being returned, which was a response rate of 33%. The survey showed satisfaction rates for patients who thought they were treated with care and concern by the nursing staff (73%) and for whether nurses listened to them, 80% reported this as being good or very good. Satisfaction rates for patients who thought they were treated with care and concern by their GP was 80% and for whether the GP listened to them, 85% reported this as being good or very good. 90% of respondents described their overall experience of the practice as fairly good or very good and 81% of patients stated they would recommend the practice. These results were average when compared with other practices in the CCG area.

Care planning and involvement in decisions about care and treatment

Patients at the practice were registered with a named GP and we witnessed the reception staff booking appointments with the patients' own GP to ensure continuity of care. Patients we spoke with on the day of our inspection commented positively on having a named GP and told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.

Data from the national GP patient survey, published on 8 January 2015, showed 74% of practice respondents said the GP involved them in care decisions, 77% felt the GP was good or very good at explaining tests and treatments and 77% said the GP was good at giving them time. In relation to nurses: 69% said they involved them in care decisions; 76% felt they were good at explaining tests and treatments and 84% said they were good at giving them enough time. These results were average when compared with other practices in the Clinical Commissioning Group (CCG) area.

Patient/carer support to cope emotionally with care and treatment

The practice took part in the Carers' Prescription Scheme to support those providing care for elderly and chronically ill family members. Information about local carers' support groups was available to patients in the waiting room and could be easily accessed by patients. This information was also available on the practice's website which also provided additional information about carers and caring, for example on housing, taking a break and finances.

When a new patient registered at the practice they were asked if they were a carer and offered appropriate support. The practice identified patients who were also carers on the computer system so staff and clinicians were automatically alerted to patients who were also carers. This ensured that the practice staff were able to take cares responsibilities into account, for example when scheduling face to face or telephone consultations.

Good

Are services caring?

Staff at the practice offered emotional and practical support for those who had recently suffered a bereavement. Staff told us that if families had suffered a bereavement, their usual GP contacted them by telephone or home visit as appropriate. Staff told us families who had suffered bereavement were identified and the electronic records system was updated to inform all staff at the practice. This helped to ensure that when a bereaved patient attended the practice, staff were able to respond appropriately. We saw that patients who had died were noted and discussed at the monthly multidisciplinary team meetings. In addition to the support provided by the practice staff, we were told that patients were referred to local external organisations that provided specialist services.

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. The practice worked collaboratively with other agencies and community health professionals in order to effectively meet patients' needs. Patients we spoke with on the day of our inspection and representatives from four care homes where patients were registered with the practice, told us they were satisfied that the practice was meeting their needs.

Patients were registered with a named GP and we saw evidence of continuity of care which was provided by that approach. Patients who needed to be seen urgently were not always able to be seen by their named GP although this was encouraged for routine appointments. Patients could choose to be registered with a male or female GP according to their preference. Longer appointments were available for people who needed them, which included patients with a learning disability. Home visits were available to patients who were housebound because of illness or disability.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). PPGs are a way for patients and GP surgeries to work together to improve services, promote health and improve quality of care. For example, a new telephone triage system has been established to improve access to GPs.

Tackling inequity and promoting equality

The practice understood and responded to the needs of patients with diverse needs and those from different ethnic backgrounds. We spoke with one patient, whose first language was not English. They told us the GPs they saw were very good at repeating information slowly to ensure they understood. Staff told us that translation services were available for patients who did not have English as a first language. Patients who needed to use the translation service were identified on the computer system and arrangements were made for the translation service to be used during their consultation. Longer appointments were available for patients who needed them, including those who needed an interpreter. Information was available behind the reception desk informing patents that a translation service was available. The practice's website could be read in other languages. There was a self check in screen which could be accessed in twelve different languages. There was a fixed induction loop at reception and a portable loop for use during consultations if this was needed.

The practice was situated in a one story building, with consultation rooms upstairs. However all the rooms on the ground floor were accessible in a wheelchair. Staff we spoke with told us that patients who were not able to mobilise up stairs were seen in a ground floor room. Patients we spoke with confirmed that his happened. The waiting area was large enough to accommodate patients with wheelchairs and prams. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

The practice opened every week day between the hours of 8am and 6pm. Extended hours appointments were available on Mondays and Tuesdays from 6pm to 8pm, with two GPs and a practice nurse appointments available during these hours. This was particularly useful for patients with work commitments or those who for example, may want to attend the practice without their children being present.

Information was available to patients about appointments in the practice leaflet and on the practice website. This included how to arrange appointments, telephone consultations and home visits. Appointments could be booked by telephone, in person or online. Patients were also able to make and cancel appointments online, 24 hours a day. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. The practice ran a 'Doctor First' telephone consultation service which ensured patients with the most complex or acute needs had telephone access on the day to a GP and, where required, a face to face consultation.

We looked at data from the National GP Patient Survey, which was published on 8 January 2015. 396 surveys had been sent out with 129 being returned, which was a response rate of 33%. We found that 88% of patients described their experience of making an appointment as fairly good or very good and 94% said the last appointment

Good

Are services responsive to people's needs?

(for example, to feedback?)

they got was convenient. These results were in line with other practices in the Clinical Commissioning Group. Patients we spoke with during the inspection reported they were satisfied with the opening hours, that it was relatively easy to get through to the practice on the phone, they were able to get an appointment at a time that suited them and with a GP that they knew, and were rarely kept waiting for more than 10 minutes for their appointment once they arrived. We saw that patients in urgent need of treatment had been able to make appointments on the same day of contacting the practice.

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. There was a designated responsible person who handled all complaints in the practice.

Information was available to help patients understand the complaints system and how to make a complaint. This was provided in the practice patient information leaflet and on the practice website. More comprehensive information was available but this had to be requested from reception. This information should be easily available for patients to access independently. Most patients told us they felt able to complain if they had concerns, although they were not aware of the practice's complaints procedure.

We looked at the process for recording complaints and found that there had been 20 since the beginning of 2014. We were told by the practice manager that one complaint had resulted in a formal meeting, whereas the other complaints had been resolved by letter. We looked at four complaints which had been received during this time frame. These had been acknowledged, investigated and a response had been sent to the complainant. Complaints had been dealt with in a timely way and an apology had been given where this was appropriate. The practice discussed and reviewed complaints at the weekly GP meetings in order to identify areas for improvement and share learning.

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 vision to provide high quality, evidence based medical care. We found evidence of this during the inspection. Staff told us this vision was embedded in their day to day work, by doing their best for patients. The deputy practice manager told us that all the training and support staff receive is based on the aim of providing the best possible care to patients. Staff spoken with told us they knew the vision was to provide high quality care and they knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures, however there was not a clear system for how they could be accessed by staff. The majority of the staff we spoke with were not clear where policies were kept and were therefore not able to easily access them. We looked at a sample of the policies and procedures and most did not have a review date on them. We found that the majority of these had not been adapted to the specific needs of the practice. There was not a robust process in place for policies to be approved, disseminated and reviewed. Following our inspection we were told that improvements had started to be made in this area. Approved policies were now stored on the shared drive of the practice computer system and also in hard copy in a policy file.

There was a clear leadership structure with named members of staff in lead roles. There was a nominated Partner and a lead nurse who had responsibility for infection control, another GP partner was the lead for safeguarding and the Practice Manager was the lead for Health and Safety. All of the staff we spoke were clear about their own roles and responsibilities and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. The practice had completed clinical audits which it used to monitor quality and systems to identify where action should be taken. The practice had arrangements for identifying, recording and managing risks. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. Any risks identified were discussed at the weekly GPs meeting.

Leadership, openness and transparency

We saw from minutes that a number of staff meetings were held. These included a weekly GP meeting, a monthly heads of department meeting, a monthly reception and administration staff meeting and nurses meetings. Nurses meetings occurred daily on an informal basis and also on a formal basis, although the frequency of these was irregular. The majority of staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at department meetings.

Staff we spoke with were not aware of a whistleblowing policy. The majority of staff we spoke with told us that they were easily able to raise any concerns and that they would be listened to. Following the inspection, the provider sent us their whistleblowing policy, which was now available to all staff in paper copy and electronically on any computer within the practice.

Seeking and acting on feedback from patients, public and staff

Feedback from patients had been obtained through patient surveys, the friends and family test and complaints. Patients were encouraged to feedback their views and information was provided on the practice website, in the practice leaflet and at the practice on ways to do this. We found evidence that the practice listened and responded in a timely way to formal and informal feedback.

The practice had an active patient participation group (PPG). (PPGs are a way for patients and GP surgeries to work together to improve services, promote health and improve quality of care.) The practice had gathered feedback from patients through a patient survey which had been carried out during December 2013 and January 2014. 50 surveys per GP partner had been collected. The survey results were presented at a PPG meeting in February 2014. The views of the PPG and practice staff were obtained and proposed changes were discussed and agreed. We were told that a new telephone system had been installed to aid the improvement of access to receptionists and a new telephone triage system had been established to improve availability to GPs. We also noted that the practice had increased the number of mobile telephone numbers they held so that appointment reminders could be sent by text

Are services well-led?

Good

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

message. Patients we spoke with confirmed that text reminders were sent and that they found these useful. The results and actions agreed from the survey were available on the practice website.

The practice collated feedback from patients from the 'friends and family' test, which ask patients, 'Would you recommend this service to friends and family?' We found that 100% of patients who completed the feedback forms in December 2014, February 2015 and March 2015 would recommend the practice to family and friends. In January 2015, 67% and in April 80% of patients said they would recommend the practice to family and friends.

The practice had gathered feedback from staff through staff meetings, appraisals and informal discussions. The majority of staff we spoke with felt that any suggestions they had for improving the service would be taken seriously and they would be listened to. Most staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

There was a willingness to improve and learn across all the staff we spoke with. Not all the staff we spoke with told us they felt valued and well supported. Clinical staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We were told that staff regularly attended local peer support meetings, which included practice manager meetings and diabetes meetings. The practice also closed for staff training for one afternoon four times a year. This training had recently involved reception staff undertaking role play in dealing with difficult situations.

The practice had completed reviews of significant events and other incidents and shared with staff at a range of meetings to ensure the practice improved outcomes for patients. Records showed that clinical audits were carried out as part of their quality improvement process to improve the service and patient care. Complete audit cycles showed that essential changes had been made to improve the quality of the service and to ensure that patients received safe care and treatment. The results of patient surveys were also used to improve the quality of services.