The Gainsborough Practice

Quality Report

Warfield Green Medical Centre
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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

The Gainsborough practice is located in a purpose built medical centre on the outskirts of Bracknell in Berkshire. Approximately 10,000 patients are registered at the practice. We carried out an announced comprehensive inspection of the practice on 14 October 2014. This was the first inspection of the practice since registration with the CQC.

The practice was going through a period of transition. The appointments system had changed on 1 October with the introduction of a named GP for all patients to support continuity of care. The change had been made in response to patient feedback from earlier patient surveys. Patients who responded to satisfaction surveys had expressed a strong preference for continuity of care coupled with easier access to appointments. Two new partners had joined the practice in the last three years and another partner was retiring in December 2014.

We spoke with ten patients during the inspection. We met with two members of the patient participation group and spoke with three GPs and a range of practice staff.

Gainsborough practice was rated good overall.

Our key findings were as follows:

- the practice operated safe systems that enabled the identification, assessment and management of risk. Medicines were managed safely in a clean and well kept environment.
- GPs treated patients in accordance with national and local guidelines. Staff were trained and knowledgeable. The practice worked with other services to ensure patients with complex needs were cared for appropriately.
- patients told us and we observed that they were treated with care and compassion. Staff were careful to maintain confidentiality of patient information.
- the practice was undertaking a major change of appointment system to respond to patient feedback. Patients valued continuity of care and the practice was responding by introducing a named GP for every patient.
- the practice was well led. There was a clear vision and business plan and we found all staff committed to delivering patient centred care in a timely manner.

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 safe. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents. 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. Appropriate systems were in operation to reduce the risk of cross infection and to ensure staff were fit and appropriately qualified to carry out their roles.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. NICE guidance was referenced and used routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This includes assessment of capacity and the promotion of good health. Staff received training appropriate to their roles and further training needs were identified and planned. The practice could evidence past appraisals. A new appraisal system was in implementation. Multidisciplinary working was evidenced.

Are services caring?

Good

The practice is rated as good for caring. Data showed 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 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.

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 the clinical commissioning group (CCG) to secure service improvements where these were identified. The practice was in the process of major change to the appointment system. Patients had been kept informed of the rationale for change to give greater focus on continuity of care and become more responsive. An additional day per week of GP time would be available on the appointment of a new partner. Urgent appointments were available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system

Summary of findings

with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff, although there was no formal route to ensure this happened, and other stakeholders.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision and strategy to deliver this. 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 regular governance meetings took place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). Staff had received inductions, appraisals and attended staff meetings.

Summary of findings

What people who use the service say

The 2014 national GP survey results for The Gainsborough based on 113 (42%) responses showed that patients were generally happy with the care and treatment they received from the GPs and nurses. The results in regard to access to appointments were not as positive and placed the practice as an average performer compared to other practices in the clinical commissioning group. The practice was aware of the results. Changes to the appointment system had been made and were implemented on 1 October 2014.

The 2014 satisfaction survey conducted by the practice participation group (PPG) had focussed on general satisfaction and access to services. The survey was completed by 537 patients. The results reflected similar views to the national survey in regard to accessing appointments and seeing the GP of choice to maintain continuity of care. However, over 83 per cent of respondents found the opening times of the practice suitable to their needs once they had accessed an appointment.

During the inspection on 14 October 2014 we spoke with 10 patients and received 10 comment cards from patients who had visited the practice over the previous two weeks. We also spoke with two representatives of the PPG. Most of the patients we spoke with were extremely positive about the service they received and the comment cards reflected similar views. The less positive comments we received focussed on the availability of appointments and previous difficulties accessing the patient's GP of choice.

Areas for improvement

Action the service SHOULD take to improve

- source a translation service for patients whose first language is not English.
- share the learning from significant events and complaints with the practice team in a structured manner.

The Gainsborough Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP, a practice manager specialist advisor and an expert by experience. Experts by experience are members of the team who have received care and experienced treatment from similar services.

Background to The Gainsborough Practice

The Gainsborough practice is based in a purpose built medical centre which is shared with the branch surgery of another practice in the Bracknell clinical commissioning group (CCG). Approximately 10,000 patients are registered with the practice. The practice does not have a large number of patients in the older and younger age groups compared to the rest of the CCG and nationally. The practice does have a larger number of working aged patients than the national average. Six GP partners operate the practice, four female and two male. One partner is full time and the other five make up 3.75 full time GPs. The practice is accredited to provide training for GPs and one GP in training was in post at the time of inspection. The practice is awaiting confirmation to train a second GP.

The GP partners are supported by three practice nurses and a health care assistant (HCA). There is a practice manager and a team of reception and administration staff. Services are provided via a General Medical Services (GMS) contract. The GPs at the practice are active within the CCG. A GP regularly attended the CCG meetings.

The practice is located at:

Warfield Green Medical Centre

1 County Lane,

Whitegrove,

Warfield,

Bracknell,

Berkshire

RG42 3JP

The practice has opted out of providing out of hours services to their patients. There are arrangements in place for services to be provided when the surgery is closed and these are displayed at the practice, in the practice information leaflet and on the website.

Why we carried out this inspection

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

We carried out this comprehensive inspection of the practice 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. The practice had not been inspected before and that was why we included them.

Detailed findings

How we carried out this inspection

Before visiting the practice we reviewed a range of information we hold. We also received information from local organisations such as NHS England, Healthwatch and the Bracknell and Ascot Clinical Commissioning Group (CCG). We carried out an announced inspection visit on 14 October 2014. During our inspection we spoke with a range of staff, including GPs, practice nurses, the practice manager, a health care assistant (HCA) and reception and administration staff.

We observed how patients were being cared for and talked with 10 patients and reviewed personal care or treatment records. We reviewed 10 comment cards completed by patients, who shared their views and experiences of the service, in the two weeks prior to our visit.

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

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

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

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

The practice had fewer patients in older age groups than the national average and a higher number of patients of working age. The number of patients recognised as suffering deprivation was lower than the local and national average.

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients.

We reviewed safety records and incident reports and minutes of meetings for the last year where these were discussed. This showed the practice had managed these consistently.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last year and these were made available to us. A slot for significant events was on the practice meeting agenda and a formal review was conducted every quarter. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and told us they would feel able to do so. We reviewed all the incidents for the last year and the records were completed in a comprehensive manner. Evidence of action taken as a result was shown to us. For example an incident occurred when moving a patient from first to ground floor for a diagnostic test. The wheel of the practice wheelchair had jammed, the practice purchased a new wheelchair.

National patient safety alerts were disseminated by the practice manager. Medicine alerts were forwarded to GPs and medical equipment alerts to practice nurses. GPs and nurses we spoke with confirmed that they fed back to the practice manager when action had been completed and the practice manager kept a record of the outcomes.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young patients and adults. Practice training records made available to us showed that all staff, who had completed their probationary period, had received relevant role specific training on safeguarding. New staff were briefed during induction on the basics of safeguarding and were advised where the practice policy was kept. We asked members of medical, nursing and administrative staff about their knowledge of safeguarding. Staff knew how to recognise signs of abuse in older patients, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. The contact details for the child protection team and safeguarding authority were accessible in a shared folder on the practice computer network. Staff we spoke with knew where to find this information.

The practice had a dedicated GP appointed as lead in safeguarding vulnerable adults and children. This GP had been trained to the relevant level three in safeguarding children. All staff we spoke with were aware who the lead was and who to speak to in the practice if they had a safeguarding concern. All GPs were trained to level three in safeguarding children.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments. For example, children who were fostered and patients with mental health needs. We spoke with the health visitor who worked with the practice. They confirmed that GPs worked with them on any alerts relating to child safety and that they were informed by GPs of any concerns relating to looked after children.

GPs attended case conferences for child protection cases when required. When GPs could not attend they provided reports.

A chaperone policy was in place and visible on the waiting room noticeboard and in consulting rooms. Chaperone training had been undertaken by all nursing staff. Reception and administration staff did not carry out chaperone duties. Some of the patients we spoke with confirmed they had been offered a chaperone when required.

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system called EMIS web which collated all communications about the patient including scanned copies of communications from hospitals.

Good

Are services safe?

Medicines Management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. Staff we spoke with were able to describe the actions they would follow if a fridge failed. However, this process was not written into the practice medicines management procedures. We reported this to the practice nurse and they told us they would amend the policy to include remedial action required upon a fridge failure.

There was a system in place to store, transport and administer flu vaccines. These were ordered in at an appropriate time for administration to older patients and those in at risk groups (mainly patients with long term medical conditions).

Processes were in place to check medicines were within their expiry date and suitable for use. We checked a sample of seventeen medicines all were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw that prescribing was a regular item on the practice meeting agenda. Minutes of meetings contained evidence that the prescribing of anti coagulants (blood thinning medicines) in weekly packs had been reviewed. The minutes of an annual prescribing review meeting with the CCG pharmacy advisor showed that the practice was taking action to review patterns of hypnotics and anti-psychotic prescribing. The annual prescribing report contained evidence that the practice was working on local prescribing initiatives.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. Up to date copies of these directions were held. A member of the nursing staff was qualified as an independent prescriber and they received regular supervision and support in their role as well as updating in the specific clinical areas of expertise for which they prescribed.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in the practice. The protocol complied with the legal framework and covered all required areas. For example, how staff who generate prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary.

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

All prescriptions were reviewed and signed by a GP before they were given to the patient. Prescription pads and blank prescriptions were received and stored securely. The practice paid close attention to security of prescriptions. For example, when a locum GP undertook a house visit they were only given one prescription rather than a pad of prescriptions.

Cleanliness & 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. Cleaning materials and cleaning equipment were held securely and separation of cleaning materials used for treatment areas and non-treatment areas was in place. The curtains in consultation and treatment rooms were disposable. There was a policy in place requiring these curtains to be replaced every six months. We looked at five sets of curtains and all had been replaced within the last three months.

The practice had a lead for infection control. There was evidence the member of staff had undertaken appropriate training in infection control and management. All staff had access to, and most staff had completed, training about infection control. Training records we looked at confirmed this. Some staff had started work at the practice in the last three months and they had not yet completed this training. We saw evidence the lead had carried an infection control

audit in the last year. There was evidence that action to meet improvements identified in the audit had been taken. For example, the practice had introduced a procedure for spillage of bodily fluids and had a spill kit in place.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection 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. For example, reception staff were able to describe the procedure for receipt of specimens.

Hand hygiene signage was displayed in consultation rooms, treatment rooms and all toilets. Hand washing sinks with hand gel and hand towel dispensers were available in treatment and consultation 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.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out examinations, assessments and treatments. The practice manager told us that equipment was tested and maintained regularly. There were records confirming 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. For example, weighing scales and blood pressure monitors.

Essential maintenance and safety checks were carried out on the building. For example, the electrical wiring had been checked and certified safe and the boiler had been replaced.

Staffing & Recruitment

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

There was a staff rota 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. The practice employed locums, who were appropriately vetted, to cover GPs in times of unplanned absence to ensure patient services were maintained. We were told locums were employed very rarely.

Monitoring Safety & Responding to Risk

The practice had systems and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of medicines and emergency equipment. The practice also had a health and safety policy. Relevant health and safety information was displayed for staff to see.

Identified risks were discussed at practice meetings. For example, when it was identified an additional diagnostic machine was needed for the registrar. This was discussed and the machine was supplied.

Support was given to patients referred to hospital who encountered problems in booking their appointments which could have resulted in them not receiving care and treatment. Staff assisted these patients to ensure the appointment was made. We were given examples of when this system supported older patients or those with mental health needs.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff who had been in post for over six months had received training in basic life support. Basic life support training was held on an annual basis for all staff. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). The staff we asked knew the location of this equipment. We saw records which confirmed these were checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. This included

Good

Are services safe?

medicines for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check 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 could impact the daily operation of the practice. Each risk was described and actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. 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 that some staff had undertaken fire risk training in the last year and staff told us fire drills were undertaken. The fire evacuation routes and exits were well signposted and fire extinguishers had been serviced within the last year.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with were familiar with current best practice guidance. They accessed guidance from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were discussed and actions agreed. We found from our discussions with the GPs that thorough assessments of patients' needs were carried out and these were reviewed when appropriate. The results of the assessments and reviews were entered in the patient's records on forms which included the appropriate guidelines.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work which allowed the practice to focus on specific conditions. GPs and nurse we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us they referred to colleagues with specific expertise in certain conditions. For example, skin diseases. There was a system in place whereby GPs informed reception and administration staff of the treatment and care being provided to patients the staff had supported. Staff had a better understanding of the patient's journey through care and treatment and this supported their decision making.

National data showed the practice was in line with referral rates to hospital and other community care services for all conditions. The GPs we spoke with used national and local standards for referral of patients to hospital. These standards were held on a shared folder on the practice computer system. There was a system in place for GPs to review each other's non-urgent referrals to validate that referral standards were being followed.

We saw no evidence of discrimination when making care and treatment decisions. The decision to refer was based on clinical need.

Management, monitoring and improving outcomes for patients

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, child protection alerts management and medicines management. The information staff collected was available for use in audits. Staff also had specific roles in ensuring patients who required regular reviews of their treatment and medical conditions were called in to receive these reviews.

The practice showed us clinical audits that had been undertaken in the last two years. The GPs were aware that all audits required completion by revisiting the audit to check that action had been taken on the findings. We reviewed one completed audit cycle for minor surgery. The re-audit showed improved results. Other audits we reviewed showed that GPs had identified the need to complete the cycle of audit in 2015. For example, the audits on joint injections and care plans.

We found clinical audits were often linked to medicines management information and the effective use of medicines. For example, we saw an audit regarding the monitoring and prescribing of blood thinning medicines, prescribing of medicines for the treatment of rheumatoid arthritis and insulin. The practice had a prescribing plan agreed with the CCG and was working to achieve the targets contained in the plan. The record of the CCG medicines management review showed the practice to be performing well against local targets. For example, prescribing of medicines for diabetes was in line with local targets.

The practice also used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. For example, 96% of patients with diabetes had completed a full review of their condition in 2013/14. The practice met all the minimum standards for QOF in asthma and chronic obstructive pulmonary disease (lung disease) This practice was not an outlier for any QOF clinical targets in the last year.

There was a system to check patients receiving repeat prescriptions had their medicines reviewed by the GP. Patients we spoke with told us they were reminded to have their medicines reviewed. The patient record system flagged up the fact that a review was required when the GP went to prescribe medicines.

GPs in the surgery undertook minor surgical procedures in line with their registration and NICE guidance. The staff were appropriately trained and kept up to date. They also regularly did clinical audits on their results and used them in their learning.

Good

Are services effective?

(for example, treatment is effective)

Effective staffing

Practice staffing included medical, nursing, reception, administrative and managerial staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. A good skill mix was noted amongst the GPs with three having additional diplomas in sexual and reproductive medicine, and one with a diploma in diabetes care. 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.

All staff undertook annual appraisals which identified learning needs. We heard that a revised appraisal system had been introduced by the new practice manager which included feedback form colleagues and objective setting. Discussions with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example nurse prescribing. The practice was a training practice, doctors who were in training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. Feedback from the trainee was positive.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. The nurse prescriber was able to demonstrate they had appropriate training to fulfil this role. Training records showed us that nurses held appropriate qualifications to support clinics for patients with long term conditions such as diabetes and chronic pulmonary obstructive disease (extreme shortness of breath).

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. Blood results, X ray results and reports from out of hours providers were received electronically. These were sorted to ensure they were seen by the patient's named GP. The GPs had a system to review these on a daily basis. Action required on test results was recorded and allocated to staff. For example, if the GP decided they wished to see the patient for an appointment the reception staff were tasked with making the appointment. When a GP was away there was a procedure to allocate their results and electronic correspondence to a named colleague. Letters from the local hospitals, including discharge summaries, were received by courier mail or by electronic transfer. Hard copy letters received were placed in the GPs post trays and were reviewed within a day of receipt. GPs were responsible for ensuring all action required to support patient care was taken.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services are services which require an additional level of service provision above what is normally required under the core GP contract). Systems were in place to review these patients.

The practice held multidisciplinary team meetings every month to discuss the needs of patients with complex needs, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, palliative care nurses and health visitors and decisions about care planning were documented. We spoke with a district nurse and health visitor who attended these meetings. They told us they worked well and that the meetings were structured to address specific patient groups. For example, discussions relating to children at risk were scheduled at the start of the agenda to enable the health visitor to attend. Health professionals we spoke with told us this system worked well and remarked on the usefulness of the forum as a means of sharing important information. One patient we spoke with told us that the co-ordinated care they received from their GP and midwife had been very well organised.

The practice provided services to the students at two local boarding schools. GPs visited the schools to see students who required advice and treatment. The records of consultation and treatment for these patients were held on paper.

Information Sharing

The practice used various electronic systems to communicate with other providers. For example, there was a shared system with the local out of hours (OOH) provider to enable patient data to be shared in a secure and timely manner. A system called special notes was used to ensure the OOH service was briefed on new information and requirements of patients who were receiving end of life care. The practice made all referrals to acute hospitals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff gave us examples of how, in the past, they had

Good

Are services effective?

(for example, treatment is effective)

supported patients to obtain their appointments using this system. Some elderly patients and those with mental health problems sometimes found the system difficult to manage. Patients with a possible diagnosis of cancer were referred within 24 hours of the diagnosis. The referral was made via fax and if the practice did not receive and acknowledgement that the referral had been received there was a system to follow up.

The practice had signed up to the electronic Summary Care Record and had plans to have this fully operational by 2015. (Summary Care Records provide healthcare staff treating patients in an emergency or out-of-hours with faster access to important clinical information about the patient).

The practice had systems in place to provide staff with the information they needed. An electronic patient record called EMIS web was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. There were systems in place to receive newly registered patient records from the patient's previous GP. Staff had been trained to summarise the incoming information to ensure a full record of the patient's healthcare and treatment needs was available to GPs and nurses.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. The GPs we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. We were told how relatives and advocates were involved in supporting decision making when appropriate.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. Carers were encouraged to support these patients during consultations, provided the patient agreed to their presence. There was evidence that the practice worked closely with carers to ensure patients with a learning disability received and annual health check-up. The practice completed 98% of health checks for this group last year and 88% had been completed this year. The outstanding health checks were planned to be completed by March 2015. All GPs and nurses demonstrated an understanding of Gillick competencies. (These help GPs and nurses to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures written consent was obtained. An audit of joint injections carried out in 2013 found that written consent had not been obtained in all cases (verbal consent was documented in patient records). The GP who carried out the audit had set action to ensure all patients gave written consent to joint injections.

Health Promotion & Prevention

We noted a culture amongst the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18-25 and offering smoking cessation advice to smokers. There was a letter from the local health promotion team complimenting the practice on their achievement in encouraging chlamydia screening. The practice was a high performer in this health promotion activity.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities and all of these patients were offered, and encouraged to take up, an annual physical health check. Practice records showed 98%received a check up in the previous year (health checks and QOF targets are measured between April and March and not on a calendar year). The practice had also identified the smoking status of 78%of patients over the age of 16 and actively referred patients to the local smoking cessation counselling service. Similar mechanisms of identifying at risk groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 85% which was better than others in the CCG. There was a policy to send reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend annually.

The practice took part in the national chlamydia, mammography and bowel cancer screening programmes.

Good

Are services effective?

(for example, treatment is effective)

There was evidence that they were among the top performers within the CCG for chlamydia screening. There was a system to follow up patients who did not attend these screening programmes.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for childhood immunisations was above the national target of 90%. There was a procedure for following up non-attenders.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent patient satisfaction data available for the practice. This included information from the national patient survey and a survey of 537 patients undertaken by the practice's patient participation group (PPG). The evidence from these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated as good or very good for patients having confidence in their GP (95%) and for being treated with care and concern (83%). The practice was also above average for its satisfaction scores on GPs giving patients enough time and nurses involving them in decisions about care and treatment. Eighty six per cent of respondents said the GPs gave them enough time. The practice satisfaction survey conducted in 2014 focussed on access to appointments. Both the practice and PPG were aware this was an issue arising from previous surveys and patient comments.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 10 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered a good care and treatment service and staff were helpful and caring. They said staff treated them with dignity and respect. Two comments were less positive but there was no common theme to these. We also spoke with 10 patients on the day of our inspection. All told us they were satisfied with the care and treatment provided by the practice and said their dignity and privacy was respected.

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 both consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. However, the results of the national survey showed the practice scored below average for patients being concerned their discussions could be overheard at reception. We observed staff treating patients with kindness and speaking quietly to individual patients to maintain confidentiality.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. Calls from patients wishing to make an appointment or seek information could be taken from behind two partitions which helped keep patient information private. To avoid patients waiting on the phone, calls were also taken at reception at times of high demand. We observed the reception staff avoided using patient names when responding to calls and checked the patient details by using their date of birth. We saw that patients with mobility difficulties were treated with kindness and respect by staff and they were able to use the waiting facilities with comfort.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed generally showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice at average or above average in these areas. For example, data from the national patient survey showed 77% of practice respondents said the GP involved them in care decisions and 92% felt the GP was good at explaining treatment and results.

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

There was evidence that care plans were in place for patients with long term conditions and for patients who may develop conditions that would require longer term care and treatment. GPs we spoke with told us they involved patients in planning care and the few patients we spoke with who were subject to care plans confirmed this.

Good

Are services caring?

We were told that relatives supported the few patients whose first language was not English. Whilst the number of patients who required translation support was few it was not always appropriate to have relatives and friends present during confidential consultations.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with told us they received emotional care and support from the GPs and staff at the practice when this was needed.

Notices in the patient waiting room and on the patient website also signposted patients to a number of support groups and organisations. For example, local voluntary organisations. The practice's computer system alerted GPs if a patient was also a carer. There were leaflets in the waiting room about carer support groups.

We heard from patients how the GPs and nurses supported patients with long term conditions to both understand their condition and cope with the consequences. Some patients told us how they had been supported when diagnosed with cancer.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs. The practice strategic plan identified there was a younger population registered with the practice compared to others in the CCG and services were planned to meet the needs of this group.

The practice had gone through an exercise of allocating every patient a named GP during the last three months. If a patient preferred an alternative GP to the one allocated they were able to contact the practice and seek to change. The system had been changed in response to patient feedback in relation to continuity of care. From 1 October 2014 all appointments were made with the patient's named GP to provide a better understanding of the patient's ongoing care and treatment needs. Patients living in care homes had a named GP as did patients on care registers. For example, one GP took responsibility for patients with a learning disability who lived in supported care homes. Longer appointments were available for patients who needed them and those with long term conditions. Home visits were made to local care homes by the patient's named GP on the day they were requested.

The practice had achieved and implemented the gold standards framework for end of life care. They had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patients and their families' care and support needs. The district nurse we spoke with confirmed that liaison with the practice GPs in the support of this group of patients was good and that any changes in the needs of patients were communicated quickly and clearly.

Home visits were carried out for patients with a learning disability who lived in supported accommodation. The patient could feel more comfortable in their home environment and a carer could be present to support the patient, if needed, during the consultation. Patients with mental health problems were able to book longer appointments if needed and had a named GP to support their care and treatment on a consistent basis.

Tackling inequity and promoting equality

The practice had a larger number of patients with a learning disability registered than other practices in the clinical commissioning group. This had arisen because the GPs had previously supported patients with a learning disability when they lived in a local hospital setting. These patients had a named GP and were given the option to receive their care and treatment either at their home or at the practice. We were given examples of the practice supporting patients who were homeless and we heard that the practice had an open registration policy for all patients who lived within the practice area.

A carers' register was in place. Carers could request a home visit if they found it difficult to leave the person they cared for. Information on support services for carers was provided via leaflets in the waiting room or from the patients GP or the nurse they received treatment from.

Three of the GPs were able to offer translation in four languages. The practice provided equality and diversity training via e-learning. Some of the staff we spoke with confirmed that they had completed the equality and diversity training in the last twelve months. Completion of this training module was expected of all staff. However, no timescale was set for the completion.

The practice was situated over three floors. Patient services were provided from the ground and first floor with the majority on the ground floor. Lift access was provided to the first floor. We observed patients with mobility difficulties using the lift without problems. The corridors on the ground floor were of sufficient width to enable patients in wheelchairs or mobility scooters to turn. This made movement around the practice easier and helped to maintain patients' independence.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed easy access to the treatment and consultation rooms via a touch pad controlled automated door. Accessible toilet facilities were available for all patients attending the practice and baby changing facilities were provided. There were facilities to produce written information in large print for patients with a visual impairment. However, the practice did not have, and there were no plans to provide, an induction loop (system to amplify voice) for patients with hearing impairment.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

Bookable appointments were available from 8:30am to 5:20pm on weekdays. Urgent appointments and telephone consultations were available with a patient's named GP. The practice was open from 8am to 6.30pm every weekday. There was a mix of pre-bookable and urgent on the day appointments every day. Patients we spoke with told us they had not experienced a problem in booking an appointment on the day. Feedback from patients showed that booking appointments in advance had been a cause of concern. The practice had introduced a new appointment system on 1 October 2014 aimed at tackling this issue.

The practice did not offer early morning, late evening or weekend appointments. We were told these had been available and were ceased when it was found the appointments were not being used by patients of working age for whom they were targeted. The results of the national patient survey and the last patient participation group satisfaction survey showed that the majority of patients found the opening hours acceptable. The registered manager and practice manager told us they were in consultation with other local practices on the subject of providing seven day a week services shared between the practices.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments. The recent change in the appointment system had been publicised on the website, via a message on the telephone system and on notices in the waiting room. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. However, some of the patients we spoke with were not clear on how they could obtain medical advice and support when the practice was closed.

Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

The opportunity to book appointments online was limited to patients who required specific health checks. The practice plan for 2015/16 included upgrading the practice website to accommodate online booking of routine appointments. Telephone consultations were available every day to enable patients who could not attend the surgery to receive medical advice from their named GP.

Listening and learning from concerns & complaints

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

We saw that information was available to help patients understand the complaints system. The complaints process was displayed on a noticeboard and was included in the practice information leaflet and on the patient website. Some of the patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice. The practice complaints procedure included the contact details for both the Ombudsman and the local office of NHS England. This informed patients about who they could contact if they were not happy with the outcome of a complaint handled by the practice.

We looked at the complaints log for 2014. This contained 15 complaints of which 14 had been resolved in accordance with the practice complaints procedure. The complaints had been acknowledged, investigated and responded to in a timely manner. One complaint was ongoing and remained within the time limit the practice set for response. The practice learnt from complaints. For example the way the practice recorded contact details for the relatives and carers of patients with complex health needs had been improved to ensure someone could be contacted when a care issue arose.

The practice reviewed complaints annually. Individual complaints received were discussed at practice meetings in the month they were received. We saw minutes of the meetings confirming this. Learning from complaints was shared amongst GPs and nurses.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's two year plan. The practice vision and values included 'To be a medical practice of choice, delivering healthcare and learning to the highest quality'. Patient participation featured in the practice vision. We heard how the PPG constantly strove to involve more patients in working with the practice. Through promotion within the practice and on the website.

We spoke with ten members of staff. All were clear in their desire to offer the best service they could to patients. We were told the practice held annual 'away days' in the past, the last one was held three years before our inspection. These were to be reintroduced to encourage all staff to share in planning the future of the practice services.

All of the staff we spoke with told us the partners treated them with fairness and respect and we saw this was one of the practice core values.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity. We looked at seven of these policies and procedures. All seven policies and procedures we looked at had been reviewed in the last year and were up to date. Minutes of the practice meetings showed that performance issues such as QOF achievement were discussed. The practice used an action monitoring form to support decisions made at practice meetings. If action had not been completed on schedule the matter was reviewed and rescheduled.

The practice had completed a number of clinical audits, for example reviewing the care and treatment of patients with Parkinsons disease, minor surgery outcomes, management of patients on blood thinning medicines, effectiveness of joint injections and fitting of coils.

There was a nominated Caldicott Guardian (a person responsible for ensuring safe keeping and appropriate use of information). There was an information governance policy in place and the practice had quality assured the processes in operation for accessing and storage of patient data.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. We spoke with ten members of staff and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns. Staff also said that they found all the GPs approachable and could raise any issues, confident in the knowledge the matter would be considered.

Team meetings were held at different intervals depending on the staff involved. For example, nurses met every four to six weeks. Team leaders and GPs met three times a month at the practice meeting. Managers fed back issues from the practice meeting to their teams. 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 team away days were to be reintroduced by the practice.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example the recruitment protocol and induction checklist which were in place to support staff. We reviewed the staff handbook that was available to all staff, this included sections on equality and harassment and bullying at work. The policies were held in a shared folder on the practice computer network. Staff we spoke with knew where to find these policies if required.

Practice seeks and acts on feedback from users, public and staff

The practice had gathered feedback from patients through patient surveys, complaints received and a suggestions box. We looked at the results of the annual patient survey and 78% of patients agreed online booking facilities would be useful. The practice offered a limited range of appointments, for example health checks, that could be booked online as a result of this feedback. Further expansion of online booking was in the practice two year plan to follow the introduction of the named GP appointment system. The named GP system was being introduced in response to earlier surveys which showed patients valued continuity of care from the same GP.

The practice had an active patient participation group (PPG) which had a core membership of 12 members. The PPG met three or four times per year. They prepared the annual patient satisfaction survey in consultation with the

Are services well-led?

Good

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

practice, reviewed results and set the action plan arising from the results. The action plan had been published on the patient website and had been made available at reception.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. We heard how extensive discussions and training with staff had been undertaken to ensure everyone understood and could operate the new appointment system. One member of staff explained how the training had included scenarios relating to booking appointments to enable staff to better support patients.

The practice had a whistle blowing policy which was available to all staff in the employee handbook. Staff were aware of where the handbook was held.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their development through training and day-to-day supervision and support. We looked at five staff files and saw that regular appraisals took place. Staff told us previous appraisals had not resulted in goals and development plans being set. Staff we spoke with told us they were looking forward to their appraisal with the new practice manager who had revised the appraisal system to include feedback from colleagues. There was an appraisal plan in place for all staff to receive an appraisal by April 2015. Staff told us that the practice was very supportive of training. Minutes of meetings showed us that guest speakers and trainers attended for specific topics.

The practice was a GP training practice and we spoke with the registrar who was in post. They told us they found the GPs were very supportive and they received good supervision from the GP trainer. The practice had applied to host a second registrar. An inspection had taken place earlier in the year and approval for the second registrar was expected in the near future.

The practice manager was also responsible for health and safety and quality monitoring in the practice. There were processes and procedures to ensure a safe environment and quality was maintained. For example the fire risk assessment had been reviewed and control of infection audits were undertaken and action taken upon the findings.