Alma Road Surgery

Quality Report

Alma Road Surgery, Alma Road, Romsey, SO51 8ED
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Alma Road Surgery on 18th November 2014. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services to all its patients in a safe environment. The practice is also rated as good for the six population groups which are older people, people with long term conditions, families, children and young people, working age people (including those recently retired and students), people whose circumstances may make them vulnerable and people experiencing poor mental health (including people with dementia).

The practice was above average for its satisfaction scores on consultations with doctors and nurses with 98% of practice respondents saying the GP was good at listening to them and 96% saying the GP gave them enough time.

Data from the national patient survey showed 91% of practice respondents said the GP involved them in care decisions and 93% felt the GP was good at explaining treatment and results. Both these results were above average when compared to the CCG area.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- The practice delivered effective end of life care in line with the gold standards framework.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.

Summary of findings

- Patients said they found it easy to make an appointment with their named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The practice had a positive relationship with the patient reference group.

Area of outstanding practice:

- The practice had well developed systems for childrens safeguarding which was appropriately integrated with partner agencies to support the protection of vulnerable children and young people.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

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

Are services effective?

Good

The practice is rated as good for providing effective services.

Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health.

Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services.

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent

Summary of findings

appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints took place and evidence showed this learning was shared with staff and other stakeholders.

Are services well-led?

Good

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

The practice had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this.

There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.

There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The practice had an active patient reference group. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people.

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

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

Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met.

For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

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

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.

Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

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

Summary of findings

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had offered and carried out annual health checks for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

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

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with six patients. All of the patients we spoke with told us they saw the same GP and it was never a problem getting an appointment. They also told us that everything was always explained to them in a way they could understand and that they had enough time to discuss their needs.

All of the patients we spoke with told us the practice appeared clean and they felt safe. They also told us they would recommend the practice to their friends and family.

We received 11 comment cards on the day of our inspection. All of the comments received were positive and told us that the practice was caring and supportive and treated its patients with respect.

We reviewed data from the national patient survey which showed that 100% of patients asked had confidence and trust in the last GP they saw or spoke to. Also, 98% of patients were able to get an appointment to see or speak to someone the last time they tried.

Outstanding practice

The practice had well developed systems for childrens safeguarding which was appropriately integrated with partner agencies to support the protection of vulnerable children and young people.

Alma Road Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included another CQC inspector, a pharmacist, a GP specialist advisor and a practice manager.

Background to Alma Road Surgery

Alma Road Surgery is a seven GP practice in Romsey, Hampshire in the South of England. There are approximately 12,500 registered patients. Patients see their own named GP wherever possible.

There is a range of outpatient, rehabilitation and some surgical services. These include Family Planning, Well Woman, Well Man, Minor Operations, ear syringing, blood sample taking (phlebotomy) and Overseas travel advice.

There practice dates back from the early 19th century. The existing premises was built in 1965 and two extensions have taken place since then. In 1995 they acquired the old Telephone Exchange next door and this has been converted for surgery use. The practice has plans to further extend the premises in order to meet increased demand of the service.

There are nine consultation rooms and four Practice Nurse treatment rooms. There is wheelchair access and toilet facilities for the disabled, as well as a nappy changing area.

Appointments are available from 8am to 7:30pm on Monday to Wednesday and from 8am to 6pm Thursday and Friday. The practice is also open from 8:30am to 9:30am on the first Saturday of the month.

The practice has opted out of providing out-of-hours services to their own patients and refers them to Care UK via the 111 service.

The practice has a higher number of frail and elderly patients when compared to the England average.

The practice has seven GP partners who work with two nurse practitioners (a nurse practitioner is a registered nurse who has completed advanced coursework and clinical education beyond that required of the general registered nurse role). The GPs and the nurse practitioners are supported by two practice nurses and two treatment room nurses along with three health care assistants.

The GPs and nursing staff are supported by a team of reception and administration staff. There is a dispensary at the practice which means prescription medication is able to be collected by those patients that live further than one mile away from the practice.

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

Alma Road, Romsey, SO51 8ED

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions.

Our inspection was carried out on 18 November 2014 to check whether the provider was 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.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew about the practice. Organisations included the local Healthwatch, NHS England, and the clinical commissioning group.

We asked the practice to send us some information before the inspection took place to enable us to prioritise our areas for inspection. This information included; practice policies, procedures and some audits.

We also reviewed the practice website and looked at information posted on NHS Choices.

During our visit we spoke with a range of staff which included GPs, nursing and other clinical staff, receptionists, administrators, secretaries and the practice manager. We also spoke with six patients who used the practice. We reviewed comment cards where patients and members of the public shared their views and experiences of the practice before and during 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 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 included:

- 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
- People experiencing poor mental health (including people with dementia)

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. 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. For example, dealing with patients who faint in the waiting area.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last three years and we were able to review these. Significant events was a standing item on the practice meeting agenda and a dedicated meeting was held monthly to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

The practice manager showed us the systems used to manage and monitor incidents. We tracked two incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result of the incident. This included reviewing practice policies and procedures. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by meetings, email and discussion to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at meetings to ensure all staff were aware of any action that needed to be taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed a dedicated GP as a lead in safeguarding vulnerable adults and children. They could demonstrate they had the necessary level three safeguarding training to enable them to fulfil this role. The other GPs also had level three safeguarding training or could show they were working towards it. All of the staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

GPs were using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone.

Good

Are services safe?

The practice had systems in place to identify and follow up children, young people and families living in disadvantaged circumstances (including looked after children, children of substance abusing parents and young carers). The practice also attended child protection case conferences where appropriate. Reports are sent if staff were unable to attend.

There were systems to highlight vulnerable patients as well as systems for reviewing repeat medications for patients with co-morbidities/multiple medications

Medicines management

We checked medicines stored in the dispensaries and medicine refrigerators and found they were stored securely. Practice staff monitored the refrigerator storage temperatures and appropriate actions were taken when the temperatures were outside the recommended ranges. The room temperatures where medicines were stored were monitored and controlled in the dispensary.

Processes were in place to check medicines were within their expiry date and suitable for use including expiry date checking. Expired and unwanted medicines were disposed of in line with waste regulations.

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

Staff explained how the repeat prescribing system was operated including the use of a patient held envelope to contain repeat prescription requests and other healthcare documents. For example, how staff generated prescriptions, monitored for over and under use and how changes to patients' repeat medicines were managed. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary.

There was a system in place for the management of high risk medicines which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. Staff told us that high risk medicines were not "on repeat" and when requested, a GP would generate the prescription, if appropriate. Whilst most prescriptions were for 28days, prescriptions of shorter durations may be issued where clinically appropriate.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The practice held stocks of controlled drugs (CD) (medicines that require extra checks and special storage arrangements because of their potential for misuse). For example, CDs were stored in a dedicated safe, access to them was restricted and the keys held securely. Records were kept of who had collected the CDs and when they delivered to patients homes. There were arrangements in place for the destruction of controlled drugs.

The practice had a system in place to assess the quality of the dispensing process including the preparation of Monitored Dosage Systems and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary.

The practice had established a limited medicines delivery service including monitoring the delivery of medicines. They also had arrangements in place to ensure people having their medicines delivered were given all the relevant information they required. Medicines requiring refrigeration were not supplied via this route.

Monitored Dosage Systems were offered to those patients where the practice had identified that the patient would benefit from the system. Dispensary staff opportunistically offered Dispensing Review of Use of Medicines (DRUM)

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits for each of the last three years and that any

improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed. An example of this was the practice changing the cleaning contractor.

An infection control policy and supporting procedures were available for staff to refer to which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. For example, the use and disposal of gloves. There was also a policy for needle stick injury and staff knew the procedures to follow in the event of an injury.

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

The practice had a policy 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 regular checks in line with this policy 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; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

We looked at several staff recruitment records and these 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. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were 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. Newly appointed staff had this expectation written in their contracts.

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

Monitoring safety and responding to risk

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

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager had shared the recent findings from an infection control audit with the team.

Staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. Staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment.

Arrangements to deal with emergencies and major incidents

Good

Are services safe?

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. The notes of the practice's significant event meetings showed that staff had discussed a medical emergency concerning a patient and appropriate learning had taken place.

Emergency medicines were available in secure areas of the practice and all staff knew of the locations. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. These included medicines for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating 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 if the heating system failed.

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

Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the practice risk log. We saw an example of this where there had been recent changes of the senior partner and the practice manager and the mitigating actions that had been put in place to manage this.

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.

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. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

The senior GP partner showed us data from the local CCG of the practice's performance for antibiotic prescribing, which was comparable to similar practices. The practice had also completed a review of case notes for patients with high blood pressure which showed all were receiving appropriate treatment and regular review. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, which also required the most at risk patients to be closely followed up.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients with suspected cancers. This included being referred and seen within two weeks. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice had a system in place for completing clinical audit cycles. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures).

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

Good

Are services effective?

(for example, treatment is effective)

Practice staffing included medical, nursing, managerial and administrative 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.

We were told, and training records confirmed this, that all members of staff involved in the dispensing process were either undertaking or had received appropriate dispensing training.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example basic life support and infection control.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, administration of vaccines. Those with extended roles that included seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

GPs undertook regular training including that provided by the clinical commissioning group. This kept GPs up to date with how to promote best practice. GPs and nursing staff met regularly to talk about individual patient's care needs. Treatment options were discussed to ensure best practice was promoted and followed.

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 a policy outlining 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 were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy to action hospital communications was working well in this respect. The practice undertook a yearly audit of follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses 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.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner.

Patient information was stored on the practice's electronic record system which was held on practice computers that were all password protected. This information was only accessible to appropriate staff.

All staff who worked at the practice were made aware of the Caldicott provision (this sets out a number of general principles which health and social care organisations should use to protect patient/client personal information). We saw this referred to in the induction process and staff were aware of their responsibilities.

The practice had an area which contained historical paper patient records. This was located away from the public areas of the practice and accessed only by authorised staff via key coded doors.

Reception and administration staff had systems in place to add to patient records information that was received from other healthcare providers. We saw that information was transferred to patient records promptly following out of hours or hospital care.

Good

Are services effective?

(for example, treatment is effective)

Regular clinical meetings had time set aside for information sharing with other services such as health visitors and midwives and these meetings were recorded.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff, for example with making do not attempt resuscitation orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions.

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Health promotion and prevention

The practice had met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among 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 to 25 years and offering smoking cessation advice to smokers.

The practice's performance for cervical smear uptake was 80.7%, which was higher than average in the CCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend. There was also a named nurse responsible for following up patients who did not attend screening. Performance for mammography, 78.6% and bowel, 70.4%, cancer screening in the area were all higher than average for the CCG and a similar mechanism of following up patients who did not attend was also used for 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 all immunisations was above average for the CCG, and again there was a clear policy for following up non-attenders by the named practice nurse. For example, 99.2% of registered 5 year old children had received their first measles, mumps and rubella (MMR) vaccination.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2014 and a survey of nearly 300 patients undertaken by the practice's patient reference group (PRG). The evidence 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 'among the best' for patients who rated the practice as good or very good. The practice was also above average for its satisfaction scores on consultations with doctors and nurses with 98% of practice respondents saying the GP was good at listening to them and 96% saying the GP gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 11 completed cards and all were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with six patients on the day of our inspection. All told us they were satisfied with the care 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 consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff. We were shown an example of a report on a recent incident that showed appropriate actions had been taken. There was also evidence of learning taking place as staff meeting minutes showed this has been discussed.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 91% of practice respondents said their GP involved them in care decisions and 93% felt the GP was good at explaining treatment and results. Both these results were above average compared to the CCG area.

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. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

Good

Are services caring?

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered a bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

GPs had their own patient lists which meant they had a closer relationship with patients which appeared to work well at times of crisis. Staff told us GPs made house calls, telephoned or sent a card as appropriate. Patient records showed if the patient was 'cared for' or 'cared for someone'. This meant appropriate advice and support could be offered.

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 NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. For example, there is a larger than average elderly population and the practice has taken steps to meet the increasing demands of this population group.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient reference group (PRG). This included a new appointment system.

Tackling inequity and promoting equality

The practice had access to online and telephone translation services.

The practice was accessible to disabled patients who required level access. We saw a disabled person's parking space close to the entrance door. A wheelchair accessible washroom was available and there was also a baby changing facility for parents with babies to use.

The reception desk was low which accommodated wheelchair users without them needing to move to a separate area.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team meetings. Records seen of minutes of team meetings confirmed this.

Access to the service

Appointments were available from 8am to 7:30pm on Monday to Wednesday and from 8am to 6pm Thursday and Friday. The practice is also open from 8:30am to 9:30am on the first Saturday of the month.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for patients who needed them and for those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to three local care homes on a specific day each week, by a named GP and to those patients who needed one.

Patients were satisfied with the appointments system. All patients had a named GP. Patients we spoke with confirmed that they could see their own doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. 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. For example, one patient we spoke with told us how they needed an urgent appointment and were seen their own GP on the same day.

The practice's extended opening hours was particularly useful to patients with work commitments. This was confirmed by two patients who told us they did not have to take time off work as they could attend an appointment on the way home because of the later opening.

Patients could request repeat prescriptions via the practice web page, in person, by hand or by post.

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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We saw that information was available to help patients understand the complaints system. This included posters displayed in the waiting area, summary complaints leaflet available and information on the practice website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

There was a complaint tracker that included the date the complaint was received, the date the complaint was acknowledged and an update section which detailed what action had been taken.

We looked at four complaints received in the last 12 months and found all of these were dealt with in a timely way and resolved to a satisfactory conclusion for all parties.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on.

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 and strategy. We were shown the practice's business plan which outlined

planning objectives for future years and reviewed what resources were currently in place. The practice's vision described how it intended to continue to provide high quality services. The document outlined

how the vision would be achieved. Areas covered included clinical performance analysis, monthly quality meetings and staff performance and development. We were shown information to confirm that the business plan was being followed.

The practice was also planning to extend the premises in order to meet the increasing population and the future demands on the service.

Governance arrangements

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and there was a dedicated lead GP for safeguarding. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported 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. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice nurse told us about a local peer review system they took part in with neighbouring GP practices. We looked at the report from the last peer review, which showed that the practice had the opportunity to measure its service against others and identify areas for improvement.

The practice held monthly governance meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

The practice held a quarterly dispensary meeting, attended by the partner responsible for the dispensary and dispensary staff at which incidents involving medicines were discussed

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at six of these policies and procedures and found they had been regularly reviewed and updated. Staff had received training specific to each policy and were able to demonstrate their knowledge understanding when questioned.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We also noted that team away days were held every six months.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies that included recruitment procedures and management of leave and sickness which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had an active patient reference group (PRG). The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PRG. The results and actions agreed from these surveys are available on the practice website.

Feedback from patients was used to help the practice to learn and improve. The PRG told us that they felt involved in the service and the practice senior management engaged with the PRG and acted on their feedback. This included the discussion on appointments and opening times.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Are services well-led?

Good

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

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

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.

Staff told us that they could contribute their views to the running of the practice and that they felt they worked well together as part of the practice team to ensure they continued to deliver good quality care.

The practice took account of complaints to improve the service and significant events were discussed and learnt from through regular quality meetings.