Aspull Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected Aspull Surgery on the 5th November 2014 as part of our new comprehensive inspection programme.

We reviewed information provided to us leading up to the inspection and spent seven hours on-site speaking to seven members of staff, six patients and reviewed 18 comment cards which patients had completed leading up to the inspection. From all the evidence gathered during the inspection process we have rated the practice as good.

During our inspection the comments from patients were positive about the care and treatment they received.

Feedback included individual praise of staff for their care and kindness and going the extra mile.

Our key findings were as follows:

- Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions.
- The appointment system was reviewed by the patients participation group (PPG) and changes made to better meet the needs of patients. Majority of patients reported good access to the practice and a named GP and continuity of care, with urgent appointments available the same day.
- Staff understand their responsibilities to raise concerns, and report incidents.
- The practice is clean and well maintained.
- There are a range of qualified staff to meet patients' needs and keep them safe.
- Data showed us patient outcomes were at or above average for the locality. People's needs are assessed and care is planned and delivered in line with current legislation.
- The practice works with other health and social care providers to achieve the best outcomes for patients.

We saw several areas of outstanding practice including:

Summary of findings

The patient participation group (PPG) working with a specialist activities instructor have established weekly health walks, with two patients being trained as walk leaders.

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

Importantly the provider should:

We saw the practice had in place a detailed child protection and vulnerable adult's policy and procedure. Within the policy it stated 'All members of staff require child protection and safeguarding adult training as part of induction and renewed annually.'

Speaking with staff who acted as chaperones, they were clear of the role and responsibility but not all non-clinical staff had received training.

We noted whole prescription pads were issued to each GP for home visits, once these had been issued, no checks were in place to monitor the number or prescriptions used.

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 requires improvement for safe. Staff understood and fulfilled their responsibilities to raise concerns, and 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 people safe.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence (NICE) guidance is referenced and used routinely. People's needs are assessed and care is planned and delivered in line with current legislation. This includes assessment of capacity and the promotion of good health. Majority of staff have received training appropriate to their roles. The practice can identify appraisals and the personal development plans for staff. 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 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 NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice and a named GP and 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 an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Summary of findings

Are services well-led?

Good

The practice is rated as good for well-led. The practice had clear aims to deliver good outcomes for patients. Staff were clear about the aims and their responsibilities in relation to the practice. 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 had taken 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, regular performance reviews and attended staff meetings.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the population group of older people. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst 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, shingles vaccinations and end of life care. The care for patients at the end of life was in line with the Gold Standard Framework, working as part of a multidisciplinary team and with out of hours providers to ensure consistency of care and a shared understanding of the patient's wishes.

The practice was responsive to the needs of older people, with one of the GPs taking a special interest in care of the elderly. GPs, nurses and health care assistants provided 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 population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed longer appointments and home visits were available. All these patients had structured annual reviews to check their health and medication needs were being met. For those people with the most complex needs GPs worked with relevant health and social care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up vulnerable families and who were at risk. For example, children and young people who had a high number of A&E attendances.

Immunisation rates were high for all standard childhood immunisations.

Appointments were available outside of school hours and the premises were suitable for children and babies. All of the staff were very responsive to parents' concerns and ensured parents could have same day appointments for children who were unwell.

Nursing staff were mindful of symptoms of post natal depression and discussed this with new mothers.

Summary of findings

A midwife ran antenatal clinics weekly from the practice. Where patients were suspected to be victims domestic violence, this was recorded within patient records and staff were vigilant and made appropriate referrals where necessary with consent.

Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Staff were knowledgeable about child protection and a GP took the lead with the Local authority and other professionals to safeguard children and families.

Young people requiring sexual health advise were supported by the practice and/or referred to Brook a young people's sexual health service.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age people (including those recently retired and students). The practice was proactive in offering online services as well as a full range of health promotion and screening which reflects the needs for this age group. Patients were provided with a range of healthy lifestyle support including smoking cessation with referrals available to Health trainers. The practice had extended opening hour enabling people to make appointments outside normal working hours. Appointments could be booked online and up to four weeks in advance.

Find and treat, a service which provides opportunistic or planned health check for patients aged 40-74 years were in place, and consisted of height, weight and blood pressure checks and blood tests.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice had carried out annual health checks for people with learning disabilities and offered longer appointments for people where required. For patients where English was their second language, an interpreter could be arranged.

The practice provided care and treatment to asylum seekers placed within Wigan by providing patient centred, systematic and ongoing support.

Summary of findings

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and voluntary sector organisations.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). The practice maintained a register of patients who experienced mental health problems. The register supported clinical staff to offer patients an annual appointment for a health check and a medication review. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had in place advance care planning for patients with dementia.

The practice had sign-posted patients experiencing poor mental health to various support groups and voluntary organisations, including referrals to counselling services.

For patients who experienced difficulties attending appointments at busy periods they would be offered appointments at the beginning or end of the day to reduce anxiety.

Summary of findings

What people who use the service say

During our inspection we spoke with six patients and one member of the patient participation group. We reviewed 18 CQC comment cards which patients had completed leading up to the inspection.

The comments were positive about the care and treatment people received. Patients told us they were treated with dignity and respect and involved in making decisions about their treatment options.

Feedback included individual praise of staff for their care and kindness and going the extra mile. We reviewed the results of the GP national survey carried out in 2013/14 and noted 83% of respondents would recommend this surgery to someone new to the area and 74% of respondents say the last GP they saw or spoke to was good at involving them in decisions about their care.

Following recent alterations to the appointment system in consultation with the patient participation group, patients were happy they were able to get emergency on the day appointments and pre-bookable appointments in a timely manner. Results from the GP national survey 2013/14 showed 87% were able to get an appointment to see or speak to someone the last time they tried and 98% say the last appointment they got was convenient.

We saw the patient participation group conducted a number of surveys, which included extended hours and open access. The survey they carried out in 2013 was completed by 150 patients, results showed:

- Reception – a total of 70% said receptionists were very helpful and 22% fairly helpful.
- Opening times - a significant majority (79%) of the patients surveyed found the current opening times of the practice convenient.

Areas for improvement

Action the service SHOULD take to improve

We saw the practice had in place a detailed child protection and vulnerable adult's policy and procedure. Within the policy it stated 'All members of staff require child protection and safeguarding adult training as part of induction and renewed annually'. We noted from staff training records not all staff both clinical and non-clinical, had received annual updates, with four members of staff requiring adult safeguarding updates.

A chaperone policy was in place and we saw several notices alerting patients to the availability of a chaperone. Speaking with staff who acted as chaperones, they were clear of the role and responsibility but not all non-clinical staff had received training. The practice chaperone policy stated all non-clinical staff should be trained. Staff told us the GPs ask the patient if they would like the chaperone to stand in or outside of the dignity curtain. General Medical Council (GMC) Intimate examinations and chaperones (2013) guidance advises that chaperones should: 'stay for the whole examination and be able to see what the doctor is doing, if practicable.'

We noted whole prescription pads were issued to each GP for home visits, once these had been issued, no checks were in place to monitor the number or prescriptions used, speaking with one GP they told us they rarely wrote prescription ins patients home, where they did issues a hand written prescription they recorded this within the patient records, but did not enter the prescription number.

Summary of findings

Outstanding practice

The patient participation group (PPG) working with a specialist activities instructor have established weekly health walks, with two patients being trained as walk leaders, the walks have 10 to 12 people joining the walks each week.

Aspull Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector and a GP. The team included a practice manager and an expert by experience. Experts by Experience are members of the public who have direct experience of using services.

Background to Aspull Surgery

Aspull Surgery provides primary medical services in Aspull, a district of Wigan from Monday to Friday. The practice is open between 8:30am and 8:00pm Mondays and Thursdays, Tuesday and Friday 8:30am to 6:30pm and Wednesdays 8:30am to 1:00pm.The practice provides home visits for people who were not well enough to attend the centre.

The practice has three GP partners, two male and one female, supported by a nurse and health care assistants.

Aspull Surgery is situated within the geographical area of NHS Wigan Borough Clinical Commissioning Group (CCG).

Aspull Surgery is responsible for providing care to 5356 patients,

When the practice is closed patients were directed to the out of hours service.

Why we carried out this inspection

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

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information about the practice. We asked the practice to give us information in advance of the site visit and asked other organisations to share their information about the service.

We carried out an announced visit on the 5th November 2014. The inspection team spent seven hours at the practice. We reviewed information provided on the day by the practice, observed how patients were being cared for and reviewed a sample of anonymised patient records.

We spoke with six patients, seven members of staff and one member of the patient participation group. We spoke with a range of staff, including receptionists, the practice manager, three GPs, the practice nurse and health care assistant.

We reviewed 18 Care Quality Commission comment cards where patients and members of the public had shared their views and experiences of the service.

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

- Is it safe?
- Is it effective?
- Is it caring?

Detailed findings

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

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

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

Good

Are services safe?

Our findings

Safe Track Record

We found that the practice had systems in place to monitor patient safety. Reports from NHS England indicated that the practice had a good track record for maintaining patient safety. Information from the General Practice Outcome Standards showed it was rated as an achieving practice. Information from the quality and outcomes framework (QOF), which is a national performance measurement tool, showed that in 2013-2014 the provider was appropriately identifying and reporting significant events.

A system to report, investigate and act on incidents of patient safety was in place, this included identifying

potential risk and near misses. All staff we spoke with were aware of the procedure for reporting concerns and incidents. We reviewed significant event reports and saw that appropriate action had been taken and where changes to practice were required, this had been cascaded to staff during team meetings or sooner face to face communication where required.

We saw staff had access to multiple sources of information to enable them to maintain patient safety and keep up to date with best practice.

The practice had systems in place to respond to safety alerts.

The practice investigated complaints, carried out audits and responded to patient feedback in order to maintain safe patient care.

The practice had systems in place to maintain safe patient care of those patients over 75 years of age, with long term health conditions, learning disabilities and those with poor mental health. The practice maintained a register of patients with additional needs and or were vulnerable and closely monitored the needs of these patients, through multi-disciplinary meetings with other health and social care professionals.

We saw patients who required annual reviews as part of their care; a system was in place to ensure reviews took place in a timely manner. We heard from these patients that staff invited them for routine checks and to remind them of appointments at the clinics. We were told patients received up to three reminders and where necessary patients were called.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. The practice had in place arrangements for reporting significant incidents that occurred at the practice. We saw from the practice significant events log and speaking with staff, they had carried out detailed investigations and

provided detailed records of outcomes and actions taken in light of the significant events. Monthly staff meetings were in place, where significant events formed part of the agenda to discuss findings and plan action to be taken in light of significant events. All staff told us the practice was open and willing to learn when things went wrong. Staff told us learning from incidents was shared via team meetings and email.

Reliable safety systems and processes including safeguarding

All staff we spoke with were able to tell us how they would respond if they believed a patient or member of the public were at risk. Staff explained to us where they had concerns they would seek guidance from the safeguarding lead or seek support from a colleague as soon as possible.

We saw the practice had in place a detailed child protection and vulnerable adult's policy and procedure. Within the policy it stated 'All members of staff require child protection and safeguarding adult training as part of induction and renewed annually' we noted from staff training records not all staff had received annual updates, with four members of staff requiring adult safeguarding updates.

We saw procedures and child protection/adult protection flow charts were in place for staff to follow should they have concerns about a patient. Where concerns already existed about a family, child or vulnerable adult, alerts were placed on patient records to ensure information was shared between staff to ensure continuity of care.

We spoke with the GP who had responsibility for safeguarding children; they had completed training to level three and were knowledgeable about the contribution the practice could make to safeguarding patients.

Good

Are services safe?

A chaperone policy was in place and we saw several notices alerting patients to the availability of a chaperone. Speaking with staff who acted as chaperones, they were clear of the role and responsibility but not all non-clinical staff had received training. The practice chaperone policy stated all non-clinical staff should be trained. Staff told us the GPs ask the patient if they would like the chaperone to stand in or outside of the dignity curtain. General Medical Council (GMC) Intimate examinations and chaperones (2013) guidance advises that chaperones should: 'stay for the whole examination and be able to see what the doctor is doing, if practicable.'

Medicines Management

The practice held medicines on site for use in an emergency or for administration during consultations such

as administration of vaccinations. The practice had in place Standard Operating Procedures for controlled drugs in line with good practice issues by the National Prescribing Centre.

Medicines administered by the nurses at the practice were given under a patient group direction (PGD), a directive agreed by doctors and pharmacists which allows nurses to supply and/or administer prescription-only medicines. This had also been agreed with the local Clinical Commissioning Group.

GPs reviewed their prescribing practices as and when medication alerts were received. Staff told us information and changes to prescribing were communicated during meetings, or via email alerts. Staff told us they regularly discussed and shared latest guidance on changes to medication and prescribing practice.

We saw emergency medicines were checked to ensure they were in date and safe to use. We checked a sample of medicines including those used by the GP for home visits and found these were in date, stored safely and where required, were refrigerated. Records (An audit of medicines used) was kept whenever any medicines were used. Medicine fridge temperatures were checked and recorded daily to ensure the medicines were being kept at the correct temperature.

We saw an up to date policy and procedure was in place for repeat prescribing and medicine review. We saw within the ten patient records we reviewed, medicine reviews had taken place where required and all the patients we spoke with told us they had, had their medicine reviewed.

We were shown the safety checks carried out in relation to prescriptions being issued. The practice maintained a register to track prescriptions received and distributed. This was kept separate from the prescription pads which were securely locked away. Prescription pads held by GPs were locked away. A nominated member of staff was responsible for prescription ordering and management of prescriptions. We noted whole prescription pads were issued to each GP for home visits, once these had been issued, no checks were in place to monitor the number of prescriptions used, speaking with one GP they told us they rarely wrote prescriptions in patients home, where they did issues a hand written prescription they recorded this within the patient records, but did not enter the prescription number.

We saw prescriptions for collection were stored behind the reception desk, out of reach of a patient. At the end of the day we were told these are locked away in a secure cabinet. Reception staff we spoke with were aware of the necessary checks required when giving out prescriptions to patients who attended the practice to collect them, i.e. date of birth, address of patient.

Cleanliness & Infection Control

The practice was found to be clean and tidy. The toilet facilities had posters promoting good hand hygiene displayed.

We saw up to date policies and procedures were in place, the policy included protocols for the safe storage and handling of specimens and for the safe storage of vaccines. These provided staff with clear guidance for sharps, needle stick and splashing incidents which were in line with current best practice. The policy stated 'Infection Control training will take place for all staff on an annual basis and will include hand washing procedures and sterilisation procedures'. We saw from staff records not all staff had received training on an annual basis; this included the infection control lead who had not received training since December 2012.

All staff we spoke with were clear about their roles and responsibilities for maintaining a clean and safe environment. We saw rooms were well stocked with gloves, aprons, alcohol gel, and hand washing facilities.

The practice only used single use instruments, we saw these were stored correctly and stock rotation was in place.

Good

Are services safe?

A cleaning schedule was in place which gave detailed guidance to the cleaning staff. We noted a colour coding scheme in place was in line with good practice guidelines to ensure cleaning materials and equipment were not used across all areas. This was to prevent the spread of infection.

The practice carried out an annual infection control audit, which included, hand hygiene; consultation and treatment room(s); prevention and management of needle stick and sharps injuries and specimen handling.

We looked in four consulting rooms, including the treatment room where minor surgery took place. All the rooms had hand wash facilities and work surfaces which were free of damage, enabling them to be cleaned thoroughly. We saw the dignity curtains in each room were disposable.

Equipment

The practice manager had a plan in place to ensure all equipment was effectively maintained in line with manufacture guidance and calibrated where required. We saw maintenance contracts were in place for all equipment, this included the defibrillator and oxygen.

All staff we spoke with told us they had access to the necessary equipment and were skilled in its use.

Checks were carried out on portable electrical equipment in line with legal requirements.

The computers in the reception and consulting rooms had a panic alert system for staff to call for assistance.

Staffing & Recruitment

There were formal processes in place for the recruitment of staff to check their suitability and character for employment. The practice had a recruitment policy in place which was up-to-date We looked at the recruitment and personnel records for five staff. We saw in the main recruitment checks had been undertaken. This included a check of the person's skills and experience through their application form, personal references, identification, criminal record and general health.

Where relevant, the practice also made checks that members of staff were registered with their professional body, on the GP performer's list and had suitable liability insurance in place. This helped to evidence that staff met the requirements of their professional bodies and had the right to practice.

We were satisfied that checks had been carried out with the disclosure and barring service (DBS) for all but one member of clinical staff to ensure patients were protected from the risk of unsuitable staff. The practice manager told us they would apply for a DBS immediately following our inspection. For all other staff, the practice manager planned to risk assess the roles and responsibilities of the administration and reception staff to see if DBS checks were required.

Monitoring Safety & Responding to Risk

The practice had developed clear lines of accountability for all aspects of care and treatment. The GPs, nurse and health care assistants had been allocated lead roles to make sure best practice guidance was followed in connection with infection control, safeguarding and complaints. Speaking with GPs, practice manager and reviewing minutes of meetings we noted safety was being monitored and discussed routinely. Appropriate action was taken to respond to and minimise risks associated with patient care and premises. We saw evidence that clinical staff received regular cardiopulmonary resuscitation (CPR) training and training associated with the treatment of anaphylactic shock.

Arrangements to deal with emergencies and major incidents

There were plans in place to deal with emergencies that might interrupt the smooth running of the service. Within the business continuity plan there was clear guidance, with staff roles and responsibilities being clearly defined. A neighbouring practice had been identified as back up should it be required.

We saw fire safety checks were carried out and full fire drills were scheduled. This ensured that in the event of an emergency staff were able to evacuate the building safely.

Emergency equipment including a defibrillator and oxygen were easily accessible, and staff had received training in how to use the equipment. Staff told us they had training in dealing with medical emergencies including cardiopulmonary resuscitation (CPR).

We saw emergency procedures for staff to follow if a patient informed staff face to face or over the telephone if they were experiencing chest pains, this included calling 999 for patients where required. Staff were able to clearly describe to us how they would respond in an emergency situation.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Staff completed assessments of patients' needs and these were reviewed when appropriate. We saw within the ten patient records reviewed by our GP comprehensive assessments had taken place, test had been requested and referrals made within time frames recommended by the National Institute for Health and Care Excellence (NICE)

Speaking with the practice nurse they explained to us how they reviewed patients with chronic diseases such as asthma on an annual basis. We saw from The national Quality Outcome Framework (QOF) patients with diabetes had received appropriate tests and treatment and those patients with atrial fibrillation currently treated with anti-coagulation drug therapy or an antiplatelet therapy. We saw 100% of patients newly diagnosed with diabetes, had a record of being referred to an education programme to support them in managing their condition..

We were told the practice work on a 'find and treat' basis, 'find and treat' is an opportunistic or planned health check for patients aged 40-74 years, and consists of height, weight and blood pressure checks and blood tests. The practice nurse told us these checks had highlighted patients with for example undiagnosed diabetes. We saw from data provided by the practice in a three year period 1/10/2010 to 31/12/13, 11 patients had been identified as diabetic, five as hypertensive (a chronic medical condition in which the blood pressure in the arteries is elevated) and 23 with Hyperlipidaemia (Hyperlipidaemia means that people have too much lipid in their blood. The two most important lipids in the blood are cholesterol and triglyceride) From this appropriate healthy lifestyle advice could be provided, with support and treatment where required for patients.

We saw the practice maintained a register of patients with learning disability to help ensure they received the required health checks. We noted all patients' with learning disabilities had access to annual reviews using the nationally recognised template, recognised by the Royal College of General Practitioners (RCGP) and The Royal College of Nursing (RCN). Patients with a learning disability were supported by the nurse to make decisions through the use of care plans.

The practice nurse also carried out annual physical health reviews for patients diagnosed with schizophrenia, bi-polar and psychosis as a way of monitoring their physical health and providing health improvement guidance. The QOF provided evidence the practice were responding to the needs of people with poor mental health by ensuring, for example women with schizophrenia, bipolar affective disorder and other psychoses, had had a cervical screening test in the preceding five years.

We saw from QOF 100% of child development checks were offered at intervals that were consistent with national guidelines and policy.

We saw information available to staff, minutes of meetings and by speaking with staff, that care and treatment was delivered in line with recognised best practice standards and guidelines. Staff told us they received updates relating to best practice or safety alerts they needed to be aware of via emails and nursing staff told us they received regular updates as part of their ongoing training, and self-directed learning.

Staff referred to Gillick competency when assessing young people's ability to understand or consent to treatment. Ensuring where necessary young people were able to give informed consent without parents' consent if they are under 16 years of age.

Staff were able to describe how they assessed patient's capacity to consent in line with the Mental Capacity Act 2005, despite no formal written policy or guidance in being in place. We noted the nurse had completed training in relation to mental capacity. Speaking with the GPs they were aware this was an area they had limited experience and were aware of their professional responsibility to keep up to date to ensure they meet the needs of patients as and when required.

The practice worked within the Gold Standard Framework for end of life care, where they held a register of patients requiring palliative care. A pathway was in place to enable appropriate referrals and support packages for patients at the end stages of life. Multi-disciplinary care review meetings were held with other health and social care providers. Individual cases were discussed regularly between clinical staff to ensure patients and relatives needs were reviewed on a regular basis to meet patient's physical and emotional needs.

Good

Are services effective?

(for example, treatment is effective)

We were told for patients where English was their second language, a telephone interpretation service was available. This is in line with good practice to ensure people are able to understand treatment options available.

Management, monitoring and improving outcomes for people

Speaking with clinical staff, we were told assessments of care and treatment were in place and support provided to enable people to self-manage their condition. A range of patient information was available for staff to give out to patients which helped them understand their conditions and treatments.

Staff said they could openly raise and share concerns about patients with colleagues to enable them to improve patient's outcomes.

Speaking with staff they told us they benefited from regular clinical meetings, to share knowledge and discuss patient care.

The practice used the information they collected for the Quality and Outcomes framework QOF and their performance against national screening programmes to monitor outcomes for patients. QOF was used to monitor the quality of services provided. The QOF report from 2013-2014 showed the practice was supporting patients well with long term health conditions such as, asthma, diabetes and heart failure. They were also ensuring childhood immunisation were being taken up by parents. NHS England figures showed in 2013, 100% of children at 24 months had received the measles, mumps and rubella (MMR) vaccination.

Information from the QOF 2013-2014 indicated the practice had maintained this high level of achievement with 99.8% of outcomes achieved.

The practice had systems in place to monitor and improve the outcomes for patients by providing annual reviews to check the health of patients with learning disabilities, patients with chronic diseases and patients on long term medication.

Patients told us they were happy the doctors and nurses at the practice managed their conditions well and if changes were needed they were fully discussed with them before being made.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw there were inconsistencies among staff who had attended mandatory courses such as annual basic life support, infection control and adult safeguarding. Practice policies stated staff required annual update on infection control and safeguarding. We noted the infection control lead had not received training since 2012 and four staff had not yet completed adult safeguarding training.

A good skill mix was noted amongst the GPs, nurse and health care assistant, and patients had an option of seeing male or female GPs. We noted the GPs had additional qualifications in specialist areas such as minor surgery and gynaecology.

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

Speaking with staff and reviewing training records we saw all staff were appropriately qualified and competent to carry out their roles safely and effectively in line with best practice. However we noted the practice nurse required some clinical update in areas such as cytology.

The practice had a system for supervision and appraisal in place for all staff. We saw appraisals were up to date for all staff with the exception of the practice nurse who was last appraised in 2011 and the practice manager.

All staff we spoke with told us they were happy with the support they received from the practice. Staff told us they were able to access training and received updates. One receptionist told us they had the opportunity to complete a diploma in Business studies and were about to start a level three Diploma in Health and Social care after securing a new role as a health care assistant.

Working with colleagues and other services

We found the GPs, nurse and health care assistants at the practice worked closely as a team. The practice worked with other agencies and professionals to support

Good

Are services effective?

(for example, treatment is effective)

continuity of care for patients and ensure care plans were in place for the most vulnerable patients. GPs and nurses attended monthly a multi-disciplinary team meeting to ensure information was shared effectively.

A Midwife visited the practice weekly running a clinic for patients and work closely with the health visiting team; we noted the new health visitor allocated to the practice attended the last team meeting to establish links with the staff team.

The practice had links with the alcohol and drug services which they could refer patients, and counselling services which patients could be referred. The practice nurses told us they worked alongside the diabetic nurse, who supported patients who were insulin dependent in the community. Health trainers and the active lifestyle team were actively promoted within the practice with contact details available on the practice website.

Information Sharing

The GPs described how the practice provided the 'out of hours' service with information, to support, for example 'end of life care.' Information received from other agencies, for example accident and emergency or hospital outpatient departments were read and actioned by the GPs on the same day. Information was scanned onto electronic patient records in a timely manner.

The practice worked within the Gold Standard Framework for end of life care (EoLC), where they provided a summary care record and EoLC information to be shared with local care services and out of hour providers.

For the most vulnerable 2% of patients over 75 years of age, and patients with long term health conditions, information was shared routinely with other health and social care providers through multi-disciplinary meetings to monitor patient welfare and provide the best outcomes for patients and their family.

Consent to care and treatment

A policy and procedure was in place for staff in relation to consent. The policy incorporated implied consent, how to obtain consent, consent from under 16's and consent for immunisations. A consent form was in place for staff to complete and included details of where a parent or guardian signed on behalf of a child.

The policy did not include guidance for staff on how to take appropriate action where people did not have the capacity to consent in line with the Mental Capacity Act 2005. However all clinical staff we spoke with understood the principles of gaining consent including issues relating to capacity. Staff told us where they had concerns about a patient's capacity; they would refer patients to the GP.

GPs were able to outline a mental capacity assessment they would use to support them in making assessments of a patient's capacity and outlined the need to keep clear records where decisions were made in the best interest of patients who did not have capacity to make decisions. This showed us that staff were following the principles of the Mental Capacity Act and making detailed records of decisions to ensure patients or relatives were involved in the decision making process.

All staff we spoke with made reference to Gillick competency when assessing whether young people under sixteen were mature enough to make decisions without parental consent for their care. Gillick competency allow professionals to demonstrate they have checked the persons understanding of the proposed treatment and consequences of agreeing or disagreeing with the treatment. We were told this would be recorded within the patient's record.

We were shown forms for which consent other than implied consent would be recorded. This consent form, once signed would be scanned into patients' notes, this included vaccinations.

We were told for patients where English was their second language, a telephone interpretation service was available. This is in line with good practice to ensure people are able to understand treatment options available and give informed consent.

Health Promotion & Prevention

New patients looking to register with the practice were able to find details on the practice website or by asking at reception. New patients were provided with an appointment with a member of the nursing team for a health check.

The practice had a range of written information for patients in the waiting area, including information they could take away on a range of health related issues, local services and health promotion. Health trainers and the active lifestyle

Good

Are services effective?

(for example, treatment is effective)

team were actively promoted within the practice with contact details available on the practice website. Patients could be referred to a health trainer for additional support to improve healthy lifestyles.

We were provided with details of how staff actively promoted healthy lifestyles during consultations. The clinical system had built in prompts for clinicians to alert them when consulting with patients who smoked or had weight management needs. We were told health promotion formed a key part of patient's annual reviews and health checks, for example the nurse told us during physical health checks for patients with poor mental health they would discuss regular breast and testicular examinations.

The nurses provided lifestyle advice to patients this included, dietary advice for raised cholesterol, alcohol screening and advice, weight management and smoking cessation. Patients who wanted support to stop smoking could be referred to an in-house smoking cessation service.

A children's immunisation and vaccination programme was in place. Data from NHS England showed the practice was achieving high levels of child immunisation including the MMR a combined vaccine that protects against measles, mumps and rubella, Hepatitis C and Pertussis (whooping cough) Primary. We saw from QOF 100% of child development checks were offered at intervals that are consistent with national guidelines and policy.

The patient participation group (PPG) working with a specialist activities instructor have established weekly health walks, with two patients being trained as walk leaders, the walks have 10 to 12 people joining the walks each week.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

During our inspection we observed staff to be kind, caring and compassionate towards patients. We saw reception staff taking time with patients and trying where possible to meet people's needs.

We spoke with six patients and reviewed 18 CQC comment cards received the week leading up to our inspection. All were positive about the level of respect they received and dignity offered during consultations.

The practice had information available to patients in reception and on the website that informed patients of confidentiality and how their information and care data was used, who may have access to that information, such as other health and social care professionals. Patients were provided with an opt out if they did not want their data shared.

We saw all phone calls from and to patients were carried out in a private area behind reception and not at reception; we were told this helped to maintain patient confidentiality.

We observed staff speaking to patients, with respect. We spent time with reception staff and observed courteous and respectful face to face communication and telephone conversations. Staff told us when patients arriving at reception wanted to speak in private; they would speak with them in one of the consultation rooms at the side of reception. We also noted a sign at reception asking patients to stand back to allow other patients confidentiality at reception.

Looking at the results from the GP Patient Survey 2013, 74%of respondents were satisfied with the level of privacy when speaking to receptionists at the surgery.

The majority of the patients we spoke with were complimentary about the reception staff and this was also reflected in the National GP Patient Survey where 92% said the receptionists at this practice were helpful.

Staff were able to clearly explain to us how they would reassure patients who were undergoing examinations, and described the use of modesty sheets to maintain patient's dignity.

We found all rooms were lockable and had dignity screens in place to maintain patients' dignity and privacy whilst they were undergoing examination or treatment.

Care planning and involvement in decisions about care and treatment

The majority of the patients told us they were happy to see any GP and the nurses as they felt all were competent and knowledgeable. Most patients found that they had been able to see their preferred GP but they had to wait for appointments.

Patients we spoke with told us the GP and nurses were patient, listened and took time to explain their condition and treatment options. This was reflective of the results from the National GP Patient Survey in which 74% of respondents said the last GP they saw or spoke to was good at involving them in decisions about their care and 93% said the last GP they saw or spoke to was good at listening to them.

We saw from The Quality and Outcomes framework (QOF) data for 2012/13, 93.3% of patients with poor mental health had a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate.

A nurse took a lead on supporting patients with a learning disability, with the aim of developing care plans, for all patients at the practice registered with a learning disability.

Staff were knowledgeable about how to ensure patients were involved in making decisions and the requirements of the Mental Capacity Act 2005 and the Children's Act 1989 and 2005. However there was no policy and procedures in place for staff to support staff in this decision making process.

Staff told us relatives, carers or advocates were involved in helping patients who required support with making decisions. Where required independent translators were available by phone for patients where English was their second language.

We noted where required patients were provided with extended appointments up to 20 minutes for reviews with patients with learning disabilities to ensure they had the time to help patients be involved in decisions.

In reception we saw a notice board specifically for carers, where there was notices to guide patients to support and advice.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

All staff we spoke to were articulate in expressing the importance of good patient care, and having an understanding of the emotional needs as well as physical needs of patients and relatives.

From the National GP survey 83% of respondents stated that the last time they saw or spoke to a GP, the GP was good or very good at treating them with care and concern and 87% of respondents stated the last nurse they saw or spoke to was good at explaining tests and treatments.

Patients who were receiving care at the end of life had been identified and joint arrangements were in place as part of a multi-disciplinary approach with the palliative care team.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had an understanding of their patient population, and responded to meet people's needs.

The practice was proactive in working with patients and families, in a joined up way with other providers in providing palliative care and ensuring patient's wishes were recorded and shared with consent with out of hours providers at the end of life.

The practice had identified a higher than average number of patients had been prescribed Benzodiazepine, for long periods of time, which can lead to addiction. Benzodiazepine should be prescribed for short periods to ease symptoms of anxiety or sleeping difficulty. As a result the practice was working with patients on a reduction programme and offering patients the support of an external drugs counsellor to support them to reduce and ultimately cease taking the medication. We saw in the first part of 2014 the practice had achieved an 18% decrease in prescribing Benzodiazepine.

The practice was proactive in making reasonable adjustments to meet people's needs. Staff and patients we spoke with provided a range of examples of how this worked, such as accommodating home visits and booking extended appointments. Home visits were not only provided by GPs but nurses and health care assistants as well.

We saw where patients required referrals to another service these took place in a timely manner. This included referrals to health trainers and drug and alcohol services.

A repeat prescription service was available to patients, via the website, a box at reception or requesting repeat prescriptions with staff at the reception desk. We saw patients accessing repeat prescriptions at reception without any difficulties.

The practice had a Patient Participation Group (PPG) with 97 members, of which 10 met face to face, and 87 virtual members engaging via email and input into the practice newsletter. The PPG meet on a regular basis to review the findings from surveys and to discuss ways in which patient experience can be improved. One example was the successful appointment of a female GP and changes to the appointment system. The PPG produce a newsletter up to four times a year, which included practice developments and healthy lifestyle support. Speaking with the chair of the PPG they told us staff are very nice and go the extra mile for the PPG and patients.

Tackling inequity and promoting equality

The practice had taken steps to ensure equal access to patients, the website was accessible, and could be translated into different language if required.

The practice had recognised different patients' needs when planning services with GPs taking the lead in areas such as palliative care, older people, women's health and minor surgery.

The practice was on one level with access for people with disabilities, or pushchairs and specific parking spaces for patients with a disability. The practice had a hearing loop in place for patients with hearing impairments. A disabled toilet was available as were baby changing facilities.

The practice ensured that for patients where English was their second language they had easy access to an interpretation service. The practice had in place information in different languages, accessed via the website. These interpretation services ensured patients were able to make informed decisions about care and treatment.

The practice provided extended appointments where necessary and appointments were available from 6:30pm - 8:00pm on Mondays and Thursday enabling people to make appointments out of normal working hours.

Access to the service

The practice had proactively reviewed the appointment booking system, in light of feedback from patients and the PPG, the practice piloted a number of on the day appointments systems. Following the overwhelming feedback from patients they agreed alongside the PPG to enable patients to book on the day appointments from 10am every day, with 20 appointments being made available for those in urgent need of seeing a GP.

Patients were able to make appointments up to four weeks in advance by telephone or online via the practice website. For same day or emergency appointment patients were required to phone the practice at 10am to get an

Good

Are services responsive to people's needs?

(for example, to feedback?)

appointment. We saw from the National GP survey 96% of respondents found it easy to get through to the practice by phone and 87% of respondents described their experience of making an appointment as good.

Home visits were available for patients each day by telephoning the practice before 10am.

Patients were guided to out of hours service with information provided on the website and answerphone should patients call the practice out of hours.

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 there was a complaints procedure in place. We reviewed complaints made to the practice over the past twelve months and found they were fully investigated with actions and outcomes documented and learning shared with staff through team meetings.

Complaints information was displayed in the waiting area and available on the website. Patients we spoke with told us they knew how to make a complaint if they felt the need to do so.

The practice had a robust system in place to investigate concerns, with meetings held to discuss issues arising from complaints and incidents. We reviewed the log of serious incidents and concerns recorded over the past twelve months and found these were fully investigated with actions and outcomes documented and learning cascaded to staff.

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. Which included the following points:

- To be courteous, approachable, friendly and accommodating.
- Through monitoring and auditing continue to improve our healthcare services.
- Treat all patients and staff with dignity, respect and honesty.

Observing and speaking with staff and patients we found the practice demonstrated a commitment to compassion, dignity, respect and equality.

We spoke with seven members of staff and they all expressed their understanding of the core values, and we saw evidence of the latest guidance and best practice being used to deliver care and treatment.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at several of the policies and saw where these had been updated they were comprehensive and reflected up to date guidance and legislation.

The practice had monthly governance meetings, attended by clinical staff and managers. Quarterly these meetings were extended to incorporate multi–disciplinary meetings with external health and social care professionals. All staff told us of an open culture among colleagues in which they talked daily and sought each other's advice.

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

The practice had a clinical audit system in place to continually improve the service and deliver the best possible outcomes for patients. We saw audits to monitor patient experience and quality and to ensure treatment was being delivered in line with best practice. We were provided with a range of audits. These included annual audits of minor surgery and infection control, We saw from clinical audits outcomes and actions were recorded and any changes which resulted from the audits were shared with staff during team meetings and email correspondence.

From the summary of significant events we were provided with and speaking with staff we saw learning had taken place and improvements were made.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager provided us with details of the maintenance and equipment checks which had been carried out in the past twelve months. These guaranteed equipment was safe to use and maintained in line with manufacture guidelines. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. The practice had clearly set out leadership and governance roles among the GP partners, with GPs each taking a lead role in different areas for example, safeguarding, palliative care, complaints, minor surgery and care of the Elderly.

We spoke with seven 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.

We saw from minutes that team meetings were held regularly. 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, or with colleagues as and when required. Staff told us there was never a time when there was no one to speak to seek support, advice or guidance.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, a recruitment policy and a training policy, were in place to support staff. We were shown the staff handbook that was available to all staff, this included sections on health and safety, equality, leave entitlements, sickness, whistleblowing and bullying and harassment Staff we spoke with knew where to find these policies if required.

Are services well-led?

Good

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

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

The practice had gathered feedback from patients through the National Patient survey, PPG surveys, suggestion box, compliments and complaints.

We saw that there was a robust complaints procedure in place, with details available for patients in the waiting area and on the website. We reviewed complaints made to the practice over the past twelve months and found they were fully investigated with actions and outcomes documented and learning shared with staff through team meetings.

We reviewed the results of the GP national survey carried out in 2013/14 and noted 94% describe their overall experience of the practice as good.

The practice had an active patient participation group (PPG) with 97 members (10 face to face members and 87 virtual members). The PPG contained representatives from various population groups; including, older people and working age people. We saw in minutes of meetings the PPG were looking at different ways of recruiting people from minority ethnic groups and young adults to make the PPG more representative. The PPG met on a regular basis and the minutes of the meetings were publically available on the practice website.

One area of work the PPG had been actively involved was consulting patients about the daily open surgery, both staff and patients had given negative feedback over a period of time about this approach to appointments. The PPG over a period of 3 month piloted different approaches with the practice staff team, surveying patients along the way to identify the best approach. From this overwhelming patients, PPG and staff identified a system of daily appointments bookable on the day from 10am met the needs of patients in the best way. This was formally agreed with the PPG in August 2014.

The PPG worked with the practice manager to produce a Newsletter for all patients, which was available at reception and on the practice website. We saw in the latest newsletter produced in July 2014, the new female GP was introduced, details of the open surgery pilot and information on the health walks which take place from the practice on a weekly basis.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistle blowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning & 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, with the exception of the practice nurse who had not participated in an appraisal since 2011. Staff told us that the practice was very supportive of training and included enabling staff to gain qualifications such as Level three Diploma in Health and Social care or Diploma in Business studies.

The practice had completed reviews of significant events and other incidents and shared with staff via meetings and summaries emailed to staff on how the practice could improve outcomes for patients.