Sandy Lane Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Sandy Lane Surgery on 22 April 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well led services. It was also good for providing services for older people, people with long term conditions, families, children and young people, the working age population and those recently retired, people in vulnerable circumstances and people experiencing poor mental health

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, reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of those relating to telephone access to the practice.
- 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.
- 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 the management.

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

Importantly the provider should:

- Monitor and review telephone access to the practice to support patients to book appointments.

Summary of findings

- Ensure that patient group directions (PGD) are in date and current. PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.
- Work with and involve the patient participation group (PPG) in changes made to the service. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

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 through practice meetings and emails 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 and the practice had systems in place to review staffing on an on going basis.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average locally and nationally. For example, the practice's performance for cervical smear uptake was 81%, which was above the national target of 80%.

Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely. However, there was no systematic way of assessing, processing or monitoring which NICE guidelines were appropriate for the needs of this service. Patients' 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 and met six weekly to discuss the care provided to terminally ill patients.

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. For example, 91% of respondents said the GP, and 99% said the nurse was good at listening to them. This was above the CCG regional average of 85% and 84% respectively. 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 had systems in place to maintain confidentiality.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. However, patients said they did not find it easy to make appointments due to poor telephone access to the practice. Urgent appointments were available the same day and the practice used a GP triage system to allocated appointments to patients. 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. We saw there was learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held weekly practice meetings. There were systems in place to monitor and improve quality and identify risk. There was a patient participation group (PPG) which met twice yearly at the practice and a virtual PPG for patients who were unable to attend the PPG. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. However, the PPG were not always consulted before changes in the practice were made. 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 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, the hospital avoidance strategy. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

They maintained a register of patients who were housebound and worked with the adult community nurse service for the management of these patients. They were running a pilot to support frail elderly patients which was commissioned by the clinical commissioning group (CCG).

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 who were at risk, for example, children and young people who had a child protection plan in place. Immunisation rates were relatively high for all standard childhood immunisations. We saw that 88% of preschool children and 86% of school age children had received the appropriate 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. The premises were suitable for children and babies with baby changing facilities available within the practice. We saw good examples of joint working with midwives and health visitors.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice offered some online services such as pre-bookable appointments with the practice nurse and prescription repeat requests. There was also a full range of health promotion and screening that reflected 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 with a learning disability. It had carried out annual health checks for people with a learning disability and offered longer appointments for people with a learning disability. There was a network of canals within the practice area meaning there were from time to time tourists and visitors who needed to register with the practice as a temporary patient. A protocol for the registration and care of this group of patients was in place.

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. They knew 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). Eighty-nine per cent of people experiencing poor mental health had an agreed care plan in place and 69% of patients with dementia had received an annual health 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 told patients experiencing poor mental health how to access support groups such as MIND and SANE that provide care and emotional support for patients, their families and carers. However, there was no formal system in place to follow up patients experiencing poor mental health who had frequently attended the accident and emergency (A&E) department.

Summary of findings

What people who use the service say

All of the seven patients we spoke with on the day of our inspection were complimentary about the care and treatment they received. We reviewed the two patient comments cards from our Care Quality Commission (CQC) comments box that had been placed in the practice prior to our inspection. We saw that comments about the care they received were positive however concerns about telephone access to the practice was a common theme expressed by patients. Patients told us the staff were helpful, professional, caring and treated them with dignity and respect. They said the nurses and doctors listened and responded to their needs and they were involved in decisions about their care. Patients told us that the practice was always clean and tidy.

The results from the national patient survey carried out during January-March 2014 and July-September 2014 showed that 83% of patients said that their overall experience of the practice was good or very good and that 74% of patients would recommend the practice to someone new to the area. This was slightly below the Clinical Commissioning Group (CCG) regional average of 87% and 78% respectively.

Areas for improvement

Action the service SHOULD take to improve

The provider should actively monitor and review telephone access to the practice to support patients to book appointments.

The provider should ensure that patient group directions (PGD) are in date and current. PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.

The provider should work with and involve the patient participation group in changes made to the service. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

Sandy Lane Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

A Care Quality Commission (CQC) lead inspector. The lead inspector was accompanied by a GP specialist advisor, a practice manager specialist advisor and an expert by experience. Experts by experience are members of the inspection team who have received care and experienced treatments from a similar service.

Background to Sandy Lane Surgery

Sandy Lane Surgery provides primary health care to patients living in Rugeley, Staffordshire. The surgery is located in a purpose built health centre which has been open since January 2007. Onsite parking is available.

A team of four GPs; a GP registrar; two nurse practitioners; four practice nurses; a health care support worker; two phlebotomists (a person trained to take blood from a vein for tests and investigations) a practice manager and 18 administrative staff provide care and treatment for approximately 11,200 patients. There are two female and two male doctors. The practice is a training practice for GP registrars to gain experience and higher qualifications in general practice and family medicine. The practice does not provide an out-of-hours service to its own patients but patients are directed to the Staffordshire Doctors Urgent Care Service when the practice is closed.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 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 (Regulated Activities) Regulations 2014, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

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 are:

- Older people
- People with long-term conditions
- Families, children and young people

Detailed findings

- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before carrying out our inspection, we reviewed a range of information that we held about the practice and asked other organisations to share what they knew. Prior to our inspection we spoke with representatives from two care homes, a health visitor, a district nurse and a spokesperson from the patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. We did this to help us to understand the care and support provided to patients by the practice.

We carried out an announced inspection on 22 April 2015 at the practice. During our inspection we spoke with the two GP partners; a salaried GP; a GP registrar; a nurse and a health care support worker; two receptionists; an administrator; the practice manager and seven patients. We observed how patients were cared for. We reviewed two comment cards where patients and members of the public shared their views and experiences of the service.

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, one of the practice nurses described to us how they had reported an incident regarding a child who had become distressed and ran off from their carer.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last two 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 two years and we were able to review these. Significant events were a standing item on the practice meeting agenda 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 and they felt encouraged to do so. The senior GP partner and the practice manager reviewed significant events on an annual basis and fed back to staff at practice meetings and through emails. We saw that significant events had been categorised and when trends were identified, action had been taken. For example, a trend in prescribing errors had been identified and action had been taken to prevent the errors occurring again.

Staff used significant event forms and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We tracked three significant events and saw records were completed in a comprehensive and timely manner. 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 the practice manager 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. For example, the prescribing of a medicine used for treatment of epilepsy.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children, young people and vulnerable 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 aware of their responsibilities in doing this. They knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in and out of normal working hours. Contact details were easily accessible and were available in the practice's safeguarding policies.

The practice had appointed a dedicated GP as the lead for safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All the staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients, such as patients with a learning disability or dementia 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. We saw that the practice held a register of 40 children who had safeguarding needs. However, there was no system in place for identifying children and young people with a high number of accident and emergency attendances who may need additional support.

There was a chaperone policy for staff to refer to. Information informing patients of their right to have a chaperone present during an intimate examination was displayed on the waiting room noticeboard and on consulting room doors. (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).

Good

Are services safe?

All nursing staff, including health care assistants, had been trained to be a chaperone and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy and we saw schedules that confirmed staff acted in accordance with this policy.

Processes were in place to check medicines were within their expiry date and suitable for use. Most of the medicines we checked were within their expiry dates, however, we saw that 10 hepatitis B vaccinations had expired in February 2015. The practice nurse told us they would dispose of the medicines and checked that no patients were booked in that day to receive this vaccine. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, the practice had a high antibiotic prescribing rate. The senior GP told us that they had changed their triaging system to reduce the number of antibiotic prescriptions given. We saw that they had also carried out an audit of patients who had been prescribed antibiotics to help them to determine the appropriateness of the prescribing. We saw that where patients had been on long term antibiotic treatment, their care had been reviewed and changes made if appropriate to do so.

The practice nurses administered vaccines using patient group directions (PGDs) that had been produced in line with legal requirements and national guidance. PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. We saw that most of the PGDs were in date and evidence that the practice nurses had received appropriate training to administer vaccines. However, we saw that three of the PGDs had expired in March 2015. The practice was unaware of this and told us they would get them updated. The health care assistant administered certain injections to patients under patient specific directions (PSDs). PSDs are written instructions, from a qualified and registered prescriber for a medicine including the dose, route and frequency or appliance to be supplied or administered to a named patient after the prescriber has assessed the patient on an individual basis. We saw that they had received the appropriate training to do this and that this was overseen by a GP.

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. We saw that several prescribing audits had been carried out to monitor the prescribing of these medicines. For example, the prescribing of a medicine used to control the clotting of the blood.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. We saw that the cleaning was carried out by an external cleaning company and that clinical staff were responsible for cleaning their clinical rooms.

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. We saw evidence that the lead had carried out monthly spot checks to monitor the effectiveness of the cleaning. Where issues had been identified action had been taken to improve the cleanliness of the practice.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and masks were available for staff to use. Staff were able to describe how they used these to comply with the practice's infection control policy. We saw records that demonstrated that staff had received immunisations such as hepatitis B to protect them from health care acquired infections. There was a policy for dealing with needle stick injuries and staff knew the procedure to follow in the event of an injury. We saw that the practice had a system in place for the disposal of clinical waste and that this was carried out by a suitable company.

Good

Are services safe?

Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment and consulting rooms. Notices about hand hygiene techniques were displayed above the sinks.

The practice had a system in place for the management of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records that confirmed a legionella risk assessment had been completed by the landlord in May 2013. A nurse practitioner described the procedures they followed to manage the potential risk of the growth of legionella.

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. We saw records that demonstrated all portable electrical equipment had been tested in November 2014 to ensure they were safe to use. We saw records that demonstrated that all medical devices had been calibrated in November 2014 to ensure the information they provided was accurate. This included devices such as weighing scales, blood pressure measuring devices carbon monoxide monitoring equipment.

Staffing and recruitment

We looked at the records of three members of staff and saw that they contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable adults and children. However, there was no evidence that the physical and mental health of the staff had been assessed to ensure they were fit and able to carry out their role. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. However it did not include the importance of ensuring gaps in employment history are explained or the need to ensure staff were physically and mentally fit to carry out their roles. There was a separate DBS policy which clearly outlined when staff needed a DBS check and we saw evidence that this had been risk assessed. For example, clinical staff were required to have an enhanced DBS check and non-clinical a standard DBS check. There was a system in place for checking that the professional registration of nurses were in date however, there was no system in place to ensure that the professional registrations of the GPs who worked at the practice were in date.

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 that following a review of staffing levels within the practice that changes to staffing hours and work activities had been made to reflect the needs of the service. We saw that the need to recruit an additional GP had also been identified. 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.

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.

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. We saw records that demonstrated that annual and monthly checks of the building had been carried out. This included a fire risk assessment; lift maintenance checks by a suitable company and multiple risk assessments for the control of substances hazardous to health (COSHH). Health and safety information was available for staff in the electronic staff hand book and we saw that staff had completed training in health and safety and moving and handling.

The GPs, practice manager and receptionists informed us there were sufficient appointments available for high risk patients, such as patients with long term conditions, older patients, and babies and young children. We saw that throughout March 2015 the practice had monitored the number of telephone calls made to the practice and the number of face to face and telephone consultations that had been provided to patients. Data from other months was not available to demonstrate if the changes to the appointment system had improved access to appointments. There was a system in place that ensured patients with long term conditions were invited for regular

Good

Are services safe?

health and medicine reviews, and followed up if they did not attend. Discussion with patients and representatives from two care homes where the practice provided a service for confirmed this.

Arrangements to deal with emergencies and major incidents

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 (a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked monthly. We looked at a documented significant event that had occurred at the practice. It showed that staff had responded effectively to a recent medical emergency and that learning points had also been identified and shared with staff. For example, the need to purchase a portable privacy screen to provide privacy for patients who received emergency medical treatment within the reception area.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis (a severe allergic reaction) and low blood sugar. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included the loss of domestic services, flood and loss of premises. We saw that the business continuity plan included action plans to manage these risks and contact numbers of companies and maintenance services the practice could call up on.

The practice was able to demonstrate that the landlord of the building had carried out a fire risk assessment. Records showed that staff were up to date with fire training and staff told us that regular fire alarm testing was carried out. We saw that there was a sign on the door of the room where the oxygen was stored to alert the fire service of the presence of oxygen if a fire were to occur at the practice.

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. However, there was no systematic way of assessing, processing or monitoring which NICE guidelines were appropriate for the needs of this service. 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 led 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.

The practice showed us data from the local Clinical Commissioning Group (CCG) of the practice's performance for antibiotic prescribing, which was above that of other practices in the region. We saw that the practice had completed an audit of antibiotic prescribing in July 2014. As a result of this audit we saw that seven patients had the use of long term antibiotics discontinued (because there had been no recent request in the past six months) and two patients had telephone medication reviews. The practice had identified older, house bound and frail elderly patients who had multidisciplinary care plans documented in their care notes to implement the hospital avoidance strategy.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. The GPs used national standards for the two week wait for the referral of suspected cancers. Data from NHS England for 2013 -2014 showed a practice value of 0.47 for patients referred under the two week wait system for suspected cancers. This was above the national value of 0.4 which showed the practice were proactive in referring patients with suspected cancer.

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 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 data manager to support the practice to carry out clinical audits.

The practice showed us eight clinical audits that had been undertaken in the last year. Four of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, a monthly auditing of patients prescribed a medicine for the treatment of nausea and vomiting.

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). For example, we saw an audit regarding the prescribing of antibiotics. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 92% of patients with diabetes had received a diabetic and foot risk assessment in the last 12 months. The practice met all the minimum standards for QOF in diabetes, asthma, chronic obstructive pulmonary disease (lung disease). This practice had achieved 99.3% of QOF points which was above the national average.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had

Good

Are services effective?

(for example, treatment is effective)

been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used.

The practice worked in line with 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. As a consequence of staff training and better understanding of the needs of patients, the practice had increased the number of patients on the register to 14.

Effective staffing

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 essential training identified by the practice such as annual basic life support. We noted a good skill mix among the GPs with two having additional diplomas in obstetrics and gynaecology and one GP with a diploma in family planning. The practice manager told us that all of the GPs were up to date with their yearly continuing professional development requirements and all had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

There was a system in place for all staff to receive an annual appraisal. We saw that learning needs were identified from which personal development plans were documented. We looked at three staff files and saw that annual appraisals had been completed. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. As the practice was a training practice, GP registrars were offered extended appointments and had access to a senior GP throughout the day for support. GP registrars are qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine. We received positive feedback from the GP registrar we spoke with.

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

We saw that the practice used trends in significant events to identify any areas of improvement required for staff. For example, where issues around prescribing had been identified, this had been raised and discussed with the appropriate member of staff.

Working with colleagues and other services

The practice worked with other service providers to meet patients' 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. Staff were aware of their responsibilities 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.

The practice was commissioned for the new enhanced service to prevent avoidable hospital admissions 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 practice had identified the most vulnerable patients registered with the practice and that they all had a care plan in place. We spoke with representatives from two care homes who confirmed that the patients living in the homes all had care plans in place to reduce the risk of a hospital admission.

The practice held six weekly multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs. These meetings were attended by district and palliative care nurses and decisions about care planning were documented in a shared care record. The practice had recently started to work with a care co-ordinator to support frail elderly patients registered with the practice.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the Staffordshire Doctors Urgent Care

Good

Are services effective?

(for example, treatment is effective)

GP out-of-hours service to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made referrals to other services through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

The practice had signed up to the electronic Summary Care Record. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours). We saw that the practice had developed a leaflet informing patients about the summary care records and their right to opt in or out of the system. This leaflet was given to all new patients who registered with the practice in the patient welcome pack.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system to coordinate, document and manage patients' care. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

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. Prior to our inspection we spoke with representatives from two care homes where the practice provided care to patients. They told us that when a do not attempt cardio-pulmonary resuscitation (DNACPR) decision had been made regarding a patient, that the patient and their family were fully involved in those decisions. They told us the GPs reviewed these decisions at regular intervals with the patient and important others. People are able to make the decision that they do not wish receive cardio-pulmonary resuscitation in the event of severe illness. These decisions must be recorded and authorised by a medical professional. There are clear guidelines and timescales to abide by and the decision must be reviewed to ensure it still stands.

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. Practice data showed that 89% of people experiencing poor mental health had an agreed care plan in place and 69% of patients with dementia had received an annual health review. 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 competency. Gillick competence is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

There was a practice policy for documenting consent for specific interventions. For example, parents signed consent forms for their child to receive childhood immunisations. We saw that parental verbal consent was also recorded in the child's electronic records with a record of the relevant risks, benefits and complications of the procedure.

Health promotion and prevention

Childhood vaccinations and child development checks were offered in line with the Healthy Child Programme. We saw data that demonstrated the practice was in line with the regional Clinical Commissioning Group (CCG) average in the uptake of childhood immunisations. We saw that 88% of preschool children and 86% of school age children had received the appropriate immunisations.

The practice offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that the practice had carried out 152 of these checks over the last 12 months. Patients over 75 years of age had a named GP to provide continuity of care.

The practice had several ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients experiencing poor mental health and patients with a diagnosis of dementia. We saw that 89% of people experiencing poor mental health had an agreed care plan in place and 69% of patients with dementia had received an annual health review. We saw that the practice had offered smoking cessation advice to 2.8% of their patients and as a result of this, 58% of these patients had stopped smoking.

The practice's performance for cervical smear uptake was 81%, which was above the national target of 80%. There was a policy to offer telephone reminders for patients who

Good

Are services effective?

(for example, treatment is effective)

did not attend for cervical smears and the practice monitored patients who do not attend. Data from Public Health England showed that 56.4% of patients identified as at risk of bowel cancer had received screening for bowel cancer and 73.6% of women eligible for breast screening had received breast screening.

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 carried out during January-March 2014 and July-September 2014 and a survey of 554 patients undertaken by the practice's patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey carried out during January-March 2014 and July-September 2014 showed that 83% of respondents said that their overall experience was good or very good and 74% of respondents would recommend the practice to someone new in the area. These results were slightly below the regional Clinical Commissioning Group (CCG) average of 87% and 78% respectively. The practice was above the CCG regional average for its satisfaction scores on consultations with doctors and nurses. For example, 91% of respondents said the GP, and 99% said the nurse was good at listening to them. This was above the CCG regional average of 85% and 84% respectively. We looked at the results of the Family and Friends test which asked patients whether they would recommend their GP practice to their friends and family if they needed similar care or treatment. We saw that 80% of respondents said they were extremely likely or likely to recommend this practice to their friends and family.

Patients completed CQC comment cards to tell us what they thought about the practice. We received two completed cards which were positive about care experienced. Patients said they felt the practice offered a caring and staff were helpful and caring. They said staff treated them with dignity and respect. The two comment cards and the seven patients we spoke with however all identified poor telephone access to the practice and the lack of continuity in seeing the same GP.

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 / 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 position of the open reception desk within the waiting room made it difficult for confidential conversations to take place. Reception staff that we spoke with were aware of the difficulties but had systems in place to maintain patient's confidentiality. These included taking patients to private rooms to continue a private conversation and transferring confidential telephone calls to a private room if a person rang the surgery for investigation results.

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 she 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.

Care planning and involvement in decisions about care and treatment

Information from the national patient survey carried out during January-March 2014 and July-September 2014 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 survey showed 85% of practice respondents said the GP was good at involving them in care decisions and 84% felt the GP was good at explaining treatment and results. Both these results were above the regional CCG average of 78% and 79% respectively.

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

Good

Are services caring?

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

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 89% of respondents to the national patient survey carried out during January-March 2014 and July-September 2014 said the last GP they saw or spoke with was good at treating them with care and concern. This was above the regional average of 81%. The patients we spoke to on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and patient website also told patients how to access a number of support groups and organisations. Patients were asked to inform reception staff if they were a carer, or are cared for by another person. This alerted staff to any possible needs in this role. We saw that the practice's computer system alerted GPs if a patient was also a carer.

The practice had a system in place to support patients known to them who had suffered a recent bereavement. A GP we spoke with told us if they were aware that a patient had suffered a recent bereavement that they rang the patient to offer support. They also signposted them to CRUISE or Staffordshire Cares Purple Pages (Purple Pages is a directory of services and activities which helps people of all ages to live a healthier and more independent life). One of the receptionists we spoke with confirmed this.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

In most areas we found that the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS England Local 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.

The practice had a patient participation group (PPG) and a virtual PPG (VPPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The practice had listened to the concerns from the PPG and VPPG regarding the appointment system and made changes to the way in which appointments were allocated. However, we saw an email sent to the VPPG informing them of the changes the practice had made to the appointment system. There was no evidence that the PPG had been involved in discussions about these changes before they were implemented. We spoke with a member of the PPG prior to our inspection who confirmed that sometimes decisions about changes to the service were made without involving the PPG. The PPG had also raised concerns about the poor telephone access to the practice. We asked the practice if they had an action plan in place to address these concerns but they did not.

Tackling inequity and promoting equality

The practice provided equality and diversity training through e-learning for all staff and we saw training certificates that confirmed this. Staff we spoke with confirmed that they had completed the equality and diversity training. We looked at the training matrix in place at the practice and saw that it identified when the training would need to be updated by each member of staff.

The practice recognised the needs of different groups in the planning of its services. The practice was situated on the ground floor of the building. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice. Facilities for patients with mobility difficulties included disabled parking; step free access to the electronic entrance door of the practice; disabled toilets; a low level counter at the reception desk and a hearing loop for patients with a hearing impairment.

The practice population were mainly English speaking but for patients whose first language was not English, staff had access to a translation service to ensure patients were involved in decisions about their care.

The practice provided care and support to several house bound elderly patients and patients living in seven care homes. Patients over 75 years of age had a named GP to ensure continuity of care. Patients with learning disabilities were provided with annual health reviews at the practice.

There were no homeless patients registered with the practice but the practice informed us they had a policy to accept homeless patients and any patient who lived within their practice boundary irrespective of culture, religion or sexual preference. There was a network of canals within the practice area meaning there were from time to time tourists and visitors who needed to register with the practice as a temporary patient. A protocol for the registration and care of this group of patients was in place.

Access to the service

The practice was open from 8.00 am to 6.30 pm, Monday to Friday (excluding Bank Holidays) and appointments were available throughout the day. The practice ran a 'GP first' triage system. Patients could ring the practice between 8am and 2pm and were triaged by a GP who then allocated appointments accordingly. We saw that patients who required longer appointments were provided with these. Patient groups with special needs such as older patients, children and patients with long term conditions could also access the GP triage system between 2pm and 6.30pm.

However, all the data we reviewed showed that patients were not satisfied with telephone access to the practice. Data from the national patient survey carried out during January-March 2014 and July-September 2014 showed that only 47% of respondents found it easy to get through on the phone compared with the CCG regional average of 80%. Twenty per cent of respondents with a preferred GP usually got to see or speak to that GP compared with the CCG regional average of 64%. Only 55% of respondents described their experience of making an appointment as

Good

Are services responsive to people's needs?

(for example, to feedback?)

good or very good compared with the CCG regional average of 77%. The practice's own survey carried out on 2103 which consisted of 554 responses, showed that 26% of respondents felt it was not easy to contact the practice by telephone. The patients we spoke with on the day of our inspection and the comment cards we reviewed supported these findings. We spoke with a spokesperson from the PPG who told us that they had raised their concerns about this with the practice. We asked the practice what they had done to address this issue. There was no action plan in place to address and monitor this and a risk assessment had not been completed to monitor the impact on patients.

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 with nurses through the practice's website. Pre-bookable practice nurse appointments were available up to two weeks in advance. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. When the practice was closed, patients were directed to the Staffordshire Doctors Urgent Care out of hours service.

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. Standard Form at reception.

We saw that there was a practice leaflet informing patients how to complain both to the practice and to the other authorities such as the Care Quality Commission, NHS England and the Ombudsman. Patients we spoke with were aware of the process to follow if they wished to make a complaint. Patients were informed how to complain on the practice's website and the complaints policy was also displayed in the reception area.

We tracked three complaints and found they were responded to and dealt with in a timely manner and that there was openness and transparency when dealing with them. We saw practice meeting minutes that demonstrated that complaints were a regular agenda item and that learning from them was shared with staff so they were able to learn and contribute to any improvement action that might have been required.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's statement of purpose and that staff had actively signed up to vision at their appraisal.

The practice vision stated, 'Our vision is traditional General Practice enhanced by modern services to accommodate everyone's needs'. Their values included to provide a high standard of medical care; ensure high quality, safe and effective services; to be committed to their patients' needs; to act with integrity; to be courteous, approachable, friendly and accommodating; to understand the needs of their patients and involve them in decisions about their care and to provide accessible healthcare which is proactive to healthcare changes, efficiency, innovation and development. We spoke with 10 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the practice's intranet. We looked at 12 of these policies and procedures and saw that they had been reviewed annually.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control, a GP lead for safeguarding and a lead for clinical governance. We spoke with 10 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 higher than national standards with a practice value of 99.3%. A data quality team was responsible for monitoring QOF data. We saw that QOF data was regularly discussed at the weekly team meetings and action plans were produced to maintain or improve outcomes. For example, from the QOF data, the practice had identified that the number of patients with diabetes who had received a specific blood test to monitor their diabetes was low. As a result of this, one of the GP partners had recently taken on a lead role in monitoring and improving this.

The practice had an on going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, the practice had completed an audit of antibiotic prescribing in July 2014. As a result of this audit we saw that seven patients had antibiotics discontinued (because there had been no recent request in the past six months) and two patients had telephone medication reviews.

The practice had arrangements for identifying, recording and managing risks. We saw that risk assessments had been completed and that the practice was aware of the challenges it faced and the areas it performed well in. However, there was no formal risk log to record and monitor the risks on to provide an overarching view of the risks the service faced overall.

The practice held weekly team meetings where governance issues were discussed. Leads from the nursing team, reception team and administrative team attended these meetings with the GP partners and they cascaded the information to their department at monthly meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

Practice meetings were held on a weekly basis and departmental meetings were held 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 the practice meetings. The practice had a whistle blowing policy which was available to all staff to access by the practice intranet. Whistle blowing occurs when an internal member of staff reveals concerns to the organisation or the public, and their employment rights are protected. Having a policy meant that staff were aware of how to do this, and how they would be protected.

The practice manager was responsible for the human resource policies and procedures. We reviewed a number of policies, for example recruitment and new employee induction procedures which were in place to support staff.

Are services well-led?

Good

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

We were shown the electronic staff handbook that was available to all staff which included sections on equality, security and health and safety. Staff we spoke with knew where to find the handbook if required.

Seeking and acting on feedback from patients, public and staff

The practice had a patient participation group (PPG) and a virtual PPG (VPPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The PPG consisted of 12 members mainly of retirement age. The VPPG consisted of 200 members and consisted of patients from all age groups so was more reflective of the practice population.

The practice had gathered feedback from patients through its PPG and VPPG, the national patient survey and complaints received. The practice had listened to the concerns from the PPG and VPPG regarding the appointment system and made changes to the way in which appointments were allocated. However, we saw an email sent to the VPPG informing them of the changes the practice had made to the appointment system. There was no evidence that the PPG had been involved in discussions about these changes or that they had been given the opportunity to comment before the changes were introduced. We spoke with a member of the PPG prior to our inspection who confirmed that sometimes decisions about changes to the service were made without involving the PPG. The PPG had also raised concerns about the poor telephone access to the practice. We asked the practice if they had an action plan in place to address these concerns but they did not.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. One member of staff told us that they had asked for specific training around chaperoning at the staff away day and this had happened. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

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 three staff files and saw that regular appraisals took place which included a personal development plan. The practice manager showed us how their annual staff appraisal was used to develop the yearly business plan for the practice. Staff told us that the practice was very supportive of training and that they had monthly protected learning time. We saw a schedule of staff training that confirmed this.

The practice was a GP training practice for GP registrars (qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine). The GP partners were responsible for the induction and overseeing of the training for GP registrars. We spoke with a GP registrar on the day inspection who told us the practice was very supportive of their learning needs.

The practice had completed reviews of significant events and other incidents and shared learning from them with staff at meetings to ensure the practice improved outcomes for patients. For example, following a medical emergency that had occurred in the reception area, the need to purchase a portable privacy screen had been identified. Reception staff told us that a screen had not been bought yet but they had access to a disposable curtain.