Trinity Court 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	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Outstanding ☆
Are services caring?	Good ●
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Good ●

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Trinity Court on 31 March 2015. Overall the practice is rated as outstanding.

Specifically we found the practice to be good for providing safe, caring and well led services. It was outstanding for providing effective and responsive services. The practice was good for providing services to families, children and young people, working age people, people experiencing poor mental health (including people with dementia) and those whose circumstances may make them vulnerable. It was outstanding for providing services to people with long term conditions and older people.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- The practice assessed patients' needs and planned their care following best practice guidance.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients felt listened to and were involved in their care and decisions about their treatment. Patients described the service they received as excellent and described the staff team as professional, caring and pleasant. Information about services and how to complain was available and easy to understand.
- Patients could obtain same day appointments or book two weeks in advance (or longer in specific circumstances).
- The practice had good facilities and was well equipped to treat patients and meet their needs. The practice had developed plans and a bid for funding from the Prime Minister's Challenge Fund to enable it to respond to future patient needs.
- There was a clear leadership structure and staff felt supported by management. The practice worked closely with its patient participation group (PPG) and proactively sought feedback from staff and patients. They listened to what patients told them and made improvements accordingly.

Summary of findings

We saw several areas of outstanding practice including:

- The practice had effective assessment, care planning and recall arrangements for patients with long term conditions. Their emergency admission rates for a number of long term conditions including diabetes, chronic heart disease and chronic obstructive pulmonary disease (COPD) were significantly below the national average. The practice also had low accident and emergency admission rates.
- The practice were involved in a project with Warwick Hospital to improve outcomes for patients with left ventricular failure (LVF), a potentially serious heart condition. They had invested in additional hours for one of the practice nurses to do this work and the nurse had completed enhanced training for this role. The project had been set up in line with a NICE initiative to improve accurate diagnosis and outcomes for patients with left ventricular failure (LVF), a potentially serious heart condition with potentially poor outcomes for patients. An early outcome of the project was that the practice had identified more patients with the condition (an increase from two to 57). The aim was to improve patients' symptoms, avoid hospital admissions and improve life expectancy.
- The practice was working closely with its two patient participation groups (PPGs). For example, it was involving them in discussions about the practice's bid for funding for the proposed expansion of the service. The practice also worked in partnership with the PPG which provided a medicines delivery service from the Claverdon branch surgery dispensary to patients unable to travel due to their health and mobility difficulties. This helped patients receive their medicines promptly and reduced pressure on their carers. The practice informed patients about the service and patients or their carers made specific arrangements for delivery direct with the PPG.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice used every opportunity to learn from internal and external incidents to help them improve. Information about safety was highly valued and was used to promote learning and improvement. Risks to patients and within the practice were assessed and well managed. There were enough staff to keep people safe. There were safe and well organised arrangements for the management of medicines at the main practice and at the dispensary at the branch surgery.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services. Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with National Institute for Heath and Care Excellence (NICE) guidelines and other locally agreed guidelines. We saw evidence to confirm that the GPs used these to influence and improve practice and outcomes for patients. The practice used the gold standards framework for ensuring that patents received the care and support they needed at the end of life. The practice used clinical audit to monitor the effectiveness of the care and treatment they provided. The practice were involved in a project with Warwick Hospital to improve outcomes for patients with left ventricular failure (LVF), a potentially serious heart condition, and were funding additional hours for one of the practice nurses to undertake the work involved. The aim of this work was to improve patients' symptoms, avoid hospital admissions and improve life expectancy.

The practice's emergency admission rates for a number of long term conditions including chronic heart disease (3.36% compared to 7.95%) and chronic obstructive pulmonary disease (COPD) (2.49% compared to 12.88%) were significantly below the national average. Data for the practice in respect of diabetes showed that the practice had performed better than the national average in all of the areas measured and their diabetes admissions rate was 0.76% compared with the national figure of 2.96%. The practice also had low accident and emergency admission rates in comparison with national data.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients told us their GP gave them the time

Summary of findings

and attention they needed and listened to them. Most patients we received information from were complimentary about the helpfulness of reception staff who recognised and accommodated their individual needs when they visited the practice.

Staff of local care homes described the service provided by the practice as supportive and professional and the approach of the GPs as humane. They were very satisfied with the care and treatment patients received and highlighted the caring approach of the GPs to patients' families.

Are services responsive to people's needs?

Outstanding ☆

The practice is rated as outstanding for providing responsive services. The practice was aware of the needs of their local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients could see a GP on the day they telephoned the practice or book appointments up to two weeks in advance. Appointments were available on Saturday mornings.

There was a clear complaints system with evidence demonstrating that the practice responded to issues raised although the level of information recorded would benefit from being more detailed. The practice had a positive approach to using complaints and concerns to improve the quality of the service.

One of the GPs provided an out of hours telephone service for local care homes as a first point of contact. Staff at the homes told us that GPs from the practice were readily available to patients' families and often telephoned them in the evenings or provided a telephone number for them to use. Staff from one home said that one of the GPs often called in to the home first thing or in the evening to see patients who were approaching the end of life.

The practice had good facilities and was well equipped to treat patients and meet their needs. There was also an on-site coffee shop within the building which the practice provided a financial subsidy to because they viewed it as a valuable asset for the practice and its patients. For example, an ante-natal group used it as a base for their informal support meetings.

The Claverdon branch surgery was in a rural location with limited public transport. The practice had worked with the PPG to arrange for one of the members to deliver medicines from the dispensary there to patients unable to travel due to their health and mobility difficulties. This was done by agreement with patients and reduced pressure on their carers. A PPG is a group of patients registered with a practice who work with the practice team to improve services and the quality of care.

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Are services well-led?

Good

The practice is rated as good for providing well-led services. The practice had open and supportive leadership and a clear vision for the future of the practice including expansion to meet increased demands. The practice promoted high standards and the team took pride in delivering a high quality service to its patients. There was a clear leadership structure and staff felt supported by management. The practice had well organised management systems and met regularly to review the delivery of care and the management of the practice. The practice had systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and responded to suggestions made. The practice had an active patient participation group (PPG) and worked with them closely and collaboratively. A PPG is made up of a group of patients registered with a practice who work with the practice team to improve services and the quality of care.

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The six population groups and what we found

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

Older people

Outstanding ☆

This practice is rated as outstanding for the care of older people. Patients over the age of 75 had a named GP and GPs carried out visits to patients' homes if they were unable to travel to the practice for appointments. The practice exceeded the national average for providing flu vaccinations to patients over the age of 65. The practice provided other professionals and its own staff with clear information about patients receiving end of life care who might need an urgent response if they requested medical assistance. They had a register of patients who needed care and support at the end of their lives and took part in meetings with other professionals involved in their care.

The practice was working in partnership with Age UK on an over 75's care project which was aimed at identifying and addressing unmet social need. In addition to this the practice provided enhanced clinical reviews for older patients and was recruiting an extended role nurse and a care co-ordinator for this work.

The practice provided medical care to patients living in two care homes. They carried out routine weekly visits and additional visits when needed as well as an out of hours telephone consultation service as a first line of contact for care home staff. Staff at one of the care homes told us that GPs often called in before or after their working day to see patients nearing the end of life. Staff at both homes said the GPs made themselves readily available to speak with patients' families.

People with long term conditions

Outstanding ☆

This practice is rated as outstanding for the care of people with long term conditions. The practice had effective assessment, care planning and recall arrangements for patients with long term conditions. Practice nurses and GPs had lead roles for the management of patients with long term conditions and the practice had identified patients at risk of unplanned hospital admissions.

The practice's emergency admission rates for a number of long term conditions including chronic heart disease (3.36% compared to 7.5%) and chronic obstructive pulmonary disease (COPD) (2.49% compared with 12.88%) were significantly below the national average. The practice had also achieved better results for aspects of diabetes management with a diabetes admissions rate of 0.76% compared with the national figure of 2.96% and had low accident and emergency admission rates.

Summary of findings

The practice used clinical audit to monitor the effectiveness of the care and treatment they provided and had were involved in a project with Warwick Hospital to improve outcomes for patients with left ventricular failure (LVF) a potentially serious heart condition .

Families, children and young people

Good

This practice is rated as good for the care of families, children and young people. The practice provided childhood immunisations and appointments for these could be booked throughout the week to provide flexibility for working families. The practice provided a family planning service and a range of options for contraception. The GPs and nurses worked with other professionals where this was necessary, particularly in respect of children living in vulnerable circumstances. They had systems to identify and follow up children living in disadvantaged circumstances and worked in partnership with other professionals such as health visitors to monitor their well-being. Immunisation rates were in line with the local clinical commissioning group average. Appointments were available outside of school hours and the premises were suitable for children and babies. Pregnant women from Eastern Europe were signposted to a specific antenatal service provided by local midwives where a Polish interpreter was available and interpreters for other languages could be arranged when needed.

The practice subsidised an on-site coffee shop which was used by patients including an antenatal support group.

Working age people (including those recently retired and students)

Good

This practice is rated as good for the care of working age people, recently retired people and students. The main practice opening hours were 8am to 5.45pm. Appointments were available for three hours on Saturday mornings and until 6pm on Fridays. A GP was on call from 5.45pm to 6.30pm four days a week with the exception of Thursdays when appointments were available at the practice until 9.30pm. The appointment system enabled patients to request same day appointments or to book appointments two weeks in advance. Patients could book appointments further ahead in specific circumstances. Patients could book appointments and order prescriptions online.

People whose circumstances may make them vulnerable

Good

This practice is rated as good for the care of people living in vulnerable circumstances. The practice had a learning disability (LD) register and all patients with learning disabilities were invited to attend for an annual health check. Longer appointments were

available for this and the practice used information in suitable formats to help them explain information to patients. The practice provided occasional care and treatment to homeless people and to patients staying temporarily at a local hostel. Staff recognised that these patients frequently had multiple health and social difficulties and encouraged them to come back to the practice for ongoing care.

Staff worked with other professionals to help ensure people living in difficult circumstances had opportunities to receive the care, support and treatment they needed. The practice worked in partnership with the Recovery Partnership, an integrated and recovery-focused treatment service for residents across Coventry and Warwickshire with a drug or alcohol problem. The staff team were aware of their responsibilities regarding information sharing and dealing with safeguarding concerns.

People experiencing poor mental health (including people with dementia)

Good

This practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice held a register of people experiencing poor mental health and invited them to attend for an annual health check. Patients with mental health needs received an annual health check and 90% had had an annual review in the last year as had 78% of patients with depression.

The practice had taken steps to ensure they had identified patients at the practice living with dementia and provided annual reviews for them. The practice had a high proportion of patients who were living with dementia including many of those in the two care homes. They were proactive in screening patients with memory problems which could indicate dementia related care needs; 85% percent of patients known to be living with dementia had had an annual review in the last year. These reviews had included reviews of medicines which had led to the practice reducing their prescribing of antipsychotic medicines used to manage behaviour viewed as challenging. As a result 43 out of 46 patients living at one care home had been taken off this type of medicine successfully.

Summary of findings

What people who use the service say

We gathered patients' views by looking at 19 Care Quality Commission (CQC) comment cards completed by patients. On the day of the inspection we spoke with nine patients two of whom were members of the practice's patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice team to improve services and the quality of care.

Data available from the NHS England GP patient survey results during 2013/2014 showed that the patients had reported positive views about the practice. The practice had a slightly higher than average score in respect of overall experience of the care they received (86.4% compared to 85.75%). In response to a question about trust and confidence in their GP 98% of patients who responded said that they trusted their GP and the nurse they saw and 90% said their GP was good at listening to them. Eighty five percent felt that their GP was very good or good at involving them in decisions about their care compared to the national average of 81%. The practice's NHS Friends and Family Test in January 2015 showed that 47 of the 48 patients who responded would recommend the practice nurses and 26 out of 27 who responded would recommend the GP they saw.

Information from patients we spoke with and from the comment cards gave a positive picture of their experiences. Several patients described the service they received as being excellent and described the staff team as professional, caring and pleasant. In some of the comment cards patients highlighted that their GP listened to them and gave them enough time during appointments. One commented that they always left the practice feeling the GP had listened to them and another remarked on the patience of GPs in listening to them. Other patients confirmed that the GPs and nurses explained the tests, treatment or medicines they needed clearly so they understood what was happening and why.

Most patients we received information from were complimentary about the helpfulness of reception staff who recognised and accommodated their individual needs when they visited the practice. One described a situation where they felt staff had gone above and beyond what would be expected when they were waiting to be seen with their unwell child.

We spoke with senior staff from two local care homes where some of the practice's patients lived. They described the service provided by the practice as professional and the approach of the GPs as humane. They were very satisfied with the care and treatment patients received. They told us the GPs were always happy to speak with patients' families and highlighted the caring approach they had towards them.

Patients told us they always found the practice clean and hygienic.

A small number of patients commented on occasions when reception staff had not been sensitive to their situation, although these appeared to be exceptions to most patients' experiences. One patient told us that they had experienced staff coming into the room without waiting for the GP to tell them they could come in.

Outstanding practice

- The practice had effective assessment, care planning and recall arrangements for patients with long term conditions. Their emergency admission rates for a number of long term conditions including diabetes, chronic heart disease and chronic obstructive pulmonary disease (COPD) were significantly below the national average. The practice also had low accident and emergency admission rates.
- The practice were involved in a project with Warwick Hospital to improve outcomes for patients with left ventricular failure (LVF), a potentially serious heart condition. They had invested in additional hours for one of the practice nurses to do this work and the nurse had completed enhanced training for this role. The project had been set up in line with a NICE initiative to improve accurate diagnosis and outcomes for patients with left ventricular failure (LVF), a potentially serious heart condition with potentially poor outcomes for patients. An early outcome of the project was that the practice had identified more

patients with the condition (an increase from two to 57). The aim was to improve patients' symptoms, avoid hospital admissions and improve life expectancy.

- The practice was working closely with its two patient participation groups (PPGs). For example, it was involving them in discussions about the practice's bid for funding for the proposed expansion of the service. The practice also worked in partnership with the PPG which provided a medicines delivery service from the Claverdon branch surgery dispensary to patients unable to travel due to their health and mobility difficulties. This helped patients receive their medicines promptly and reduced pressure on their carers. The practice informed patients about the service and patients or their carers made specific arrangements for delivery direct with the PPG.

Trinity Court Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP, practice manager, a CQC pharmacy inspector and an Expert by Experience.

Background to Trinity Court Surgery

Trinity Court Surgery is located in a large purpose built health centre which also accommodates a separately operated pharmacy and other NHS community health services. There is a coffee shop in the building which the practice subsidises for the benefit of its patients. The practice also has a branch surgery in the village of Claverdon, Warwickshire which we visited as part of this inspection. The branch surgery has a dispensary.

Trinity Court and the Claverdon branch surgery provide medical care across an area of 120 square miles in and around Stratford upon Avon. The practice has about 16,800 patients. The area does not have high levels of social or economic deprivation. The practice has a high proportion of older patients with 38% being over 65 compared to the national average of 27%. The practice has calculated that this will rise by 51% by 2030 partly due to older people moving to the area in retirement.

The practice has 10 GPs – six partners and four salaried GPs. Four of the GPs are male and six are female providing a choice for patients. There are five practice nurses, a nurse practitioner and a nurse prescriber. The practice also has two healthcare assistants and two phlebotomists (staff trained to take blood). The clinical team are supported by two practice managers (one at the main surgery and one at the branch) and an assistant practice manager, an IT administrator and a team of reception and administrative staff.

The practice has a patient participation group (PPG), a group of patients registered with a practice who work with the practice team to improve services and the quality of care.

The practice has a General Medical Services (GMS) contract with NHS England.

The practice provides minor surgery as one of the services available to patients.

The main practice opening hours were 8am to 5.45pm. Appointments were available for three hours on Saturday mornings and until 6pm on Fridays. A GP was on call from 5.45pm to 6.30pm four days a week with the exception of Thursdays when appointments were available at the practice until 9.30pm.

The practice does not provide general out of hours services to their own patients; however they do provide some out of hours services to two local care homes and to patients known to be nearing their end of life. These patients are provided with specific contact details. For other patients the practice website explains that patients should telephone the usual practice telephone number out of hours and follow the instructions provided. The website advises patients that a doctor may telephone them to assess their needs and they receive a home visit or be asked to attend the GP walk in centre based at Warwick Hospital which is operated by an organisation called Care UK.

Detailed findings

Why we carried out this inspection

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

Please note that references to the Quality and Outcomes Framework data in this report relate to the most recent information available to CQC at the time of the inspection.

How we carried out this inspection

Before this inspection, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. These organisations included South Warwickshire Clinical Commissioning Group (CCG) and the NHS England Area Team. We carried out an announced visit on 31 March 2015. We sent CQC comment cards to the practice. We received 19 completed cards which gave us information about those patients' views of the practice.

During the inspection we spoke with five of the GPs, two practice nurses, a healthcare assistant, the practice manager and assistant practice manager. We also spoke with nine patients, two of whom were members of the patient participation group (PPG), a group of patients registered with a practice who work with the practice team to improve services and the quality of care. In addition we had conversations with senior staff of two local care homes where patients registered with the practice lived.

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
- 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)

Good

Are services safe?

Our findings

Safe track record

The practice used information from national safety alerts, significant events and complaints to identify risks and improve patient safety. Staff knew how to report accidents and incidents and were aware of the system for sharing national patient safety alerts. The staff we spoke with were aware of their responsibilities to raise concerns, and described an open and supportive culture so they felt they could do this with confidence.

We saw that the practice had been recording significant event information since 2003 showing that they had an established system for monitoring safety.

Learning and improvement from safety incidents

The practice had a system for reporting, recording and monitoring significant events, incidents and accidents. The GPs, nurses and practice management team discussed significant events at weekly meetings and with members of staff individually when necessary. Staff explained that they reviewed past significant events at monthly protected learning meetings.to make sure learning and changes had been acted on. We noted that the information the practice recorded about these discussions were not always very detailed. We discussed this with the practice manager during the inspection and they agreed that it would be beneficial to make more comprehensive notes for future reference.

Staff told us about some changes made following incidents. A delivery of vaccines had not been put away in the refrigerator and so had to be sent for destruction. Following this the practice reviewed their 'cold chain' policy and made sure all staff were familiar with this. Dispensary staff at the Claverdon branch surgery told us about a medicines administration error following which the practice changed the management of certain medicines.

National patient safety alerts were checked by the practice and nurse managers and shared with members of the team. Staff we spoke with were aware of these. For example, two staff told us about a recent alert about automated electronic defibrillators (AED - a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). They checked the practice's AED and found it was not the type the alert was about. If an alert related directly to the care and treatment of one or more patients the practice wrote to them and followed up any necessary actions.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We saw evidence that staff completed safeguarding training for children and vulnerable adults at a suitable level according to their role. The contact information for relevant agencies was readily available. Staff were aware of their responsibilities and knew how to share information about safeguarding concerns.

One of the GPs was the lead for safeguarding vulnerable adults and children. They took part in weekly meetings with health visitors to discuss the needs of children and young people living in vulnerable circumstances including those with child protection plans in place. Children's safeguarding was also discussed every week at the practice's clinical meetings.

Staff at the practice knew who the safeguarding lead was and were aware of the range of patients whose circumstances might make them vulnerable. The practice used the electronic records system to highlight patients who may be vulnerable. This helped to make sure that staff had the information they needed when patients attended appointments. A member of staff described recognising changes in the behaviour of patients living with dementia and was aware that this might need consideration as a safeguarding issue. They were aware of the vulnerability of patients who may be victims of domestic violence and confirmed that they had access to information they could pass on to patients. Discreet information about domestic violence was available so patients who needed support could make a note of helpful contact information in privacy.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Staff told us that this role was

usually carried out by the nurses and healthcare assistants but reception staff occasionally did this. Those staff who carried out this role had received training to do so from the practice's nurse manager.

Medicines management

We visited the dispensing practice, Claverdon Surgery, and spoke with staff and observed their practice. Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. We saw that this process was working in practice. Blank prescription forms were handled in accordance with national guidance using clear recording systems and were kept securely at all times.

We found that the dispensary was well organised and that the dispensary team had systems to ensure they dispensed patients' medicines accurately. The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients.

We checked medicines stored at Claverdon Surgery 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. This described the action staff should take if there was a fault affecting the temperature of a refrigerator. The practice staff understood what they should do if this happened.

The practice had processes for checking that medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. A member of staff told us that they showed the vaccine expiry date to patients before administering the dose as an additional check.

The dispensary held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff.

Records showed that all members of staff involved in the dispensing process had received appropriate training and their practices were monitored regularly.

We looked at how medicines were managed at Trinity Court, which did not have a dispensary. The medicines kept at this practice were for direct administration to patients by nurses and GPs. We found that these medicines were stored securely and kept at the required temperature.

We found at both practices that the nurses administered vaccines using patient group directions (PGDs) that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of these and evidence that nurses had received appropriate training to administer vaccines.

At Trinity Court we found all prescriptions were reviewed and signed by a GP before they were given to the patient. The practice kept blank prescription forms securely and recorded when these were allocated to the GPs in accordance with national guidance.

The practice was aware that it had higher than average prescribing patterns for some types of medicines but recognised the importance of vigilance in prescribing and viewed this as a work in progress. They were however performing better than the CCG average for prescribing non-steroid anti-inflammatory medicines and another specific group of medicines used in the treatment of a wide range of conditions.

Cleanliness and infection control

All of the rooms we saw at the practice were visibly clean and tidy. General cleaning was carried out by a cleaning company and we saw cleaning schedules in each room to inform the cleaners what they were expected to do and how often. Patients told us they always found the practice clean and hygienic.

The nurse practitioner and practice manager were the named leads for infection control. They had undertaken further training to enable them to provide advice on infection control and carry out staff training. Staff completed training about infection control specific to their role and received annual updates.

The practice had an infection control policy and supporting procedures on the practice computer system for staff to refer to. We saw that there was a good supply of personal protective equipment (PPE) including disposable gloves, aprons and paper roll for treatment couches. The practice had delegated the task of maintaining supplies of PPE to one of the staff we spoke with. They took this responsibility

seriously and demonstrated that they carried it out conscientiously. There were disposable privacy curtains around treatment couches and a process for monitoring when they were changed. Specific equipment and products were available to deal with any bodily fluids that might need to be cleaned and staff knew where these were kept.

There was a sharps injury policy and procedure so staff had information about the action to take if they accidentally injured themselves with a needle or other sharp medical device. The practice had a process for confirming that staff were protected against Hepatitis B. All instruments used for minor surgery or examinations were single use and staff monitored these to ensure they were within their expiry dates.

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

The landlord for the building was responsible for overall facilities management including legionella precautions. Legionella is a bacterium that can contaminate water systems in buildings. The practice manager provided legionella reports to the landlord's management team each week to confirm that necessary checks had been completed within the practice's part of the building.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw maintenance logs and other records which showed equipment was tested and maintained regularly. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. We saw evidence of calibration of relevant equipment such as weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

The practice had an experienced and skilled staff team with clear responsibilities and lines of accountability. The overall staffing levels and skill mix at the practice ensured that they had sufficient staff to maintain a safe level of service to patients. The practice manager told us the nurses were flexible and provided cover for each other when one of them was away from work. The practice monitored staff working hours to support well-being. Cover was provided by part time staff and a bank of previous employees. The practice told us they had a good local reputation as an employer and had recently had 70 applicants for a receptionist post.

The practice had a recruitment policy and we saw evidence in staff files that the practice followed this and obtained the required information for any member of staff they appointed. We saw that the practice carried out checks through the Disclosure and Barring Service (DBS) for the majority of staff working at the practice. DBS checks identify whether a person has a criminal record or is on an official list of persons barred from working in roles where they will have contact with children or adults who may be vulnerable. The practice had risk assessments where they had decided they did not need to do DBS checks. For example, for staff who never had unsupervised contact with patients. However, this was not specified in the recruitment policy. We saw that the practice had thorough processes for checking the suitability and appropriate professional registration status of any locum GPs employed to work at the practice.

Monitoring safety and responding to risk

We saw that the practice had a health and safety policy and a range of relevant risk assessments carried out by a specialist company. The practice manager carried out visual health and safety checks throughout the building each day but did not keep a record of these. The practice manager took part in annual meetings with the landlord's property management team to discuss general maintenance and health and safety related issues including legionella, waste management and fire precautions. All staff had completed health and safety training.

The practice had systems for identifying patients who may be at risk. There were practice registers in place for patients in high risk groups such as those with long term conditions, mental health needs, dementia or learning disabilities. The practice team used alerts on the computer system to inform staff about individual patients who might be particularly vulnerable.

Arrangements to deal with emergencies and major incidents

The practice computer system had the facility of a panic alert button for staff to use if they needed to summon

Good

Are services safe?

urgent help from other members of the team. All staff at the practice had completed Cardiopulmonary Resuscitation (CPR) training and the practice had a system for monitoring when refresher training was due.

The practice had oxygen and an automated electronic defibrillator (AED). There were appropriate medicines available for use in a medical emergency at the practice. We saw evidence that staff checked these regularly to make sure they were available and ready for use when needed and the staff we asked knew where these were kept.

There was an emergency medicines box at the main practice which contained appropriate medicines for use when GPs visited patients in emergency situations. The contents of this were checked regularly by the practice's nurse prescriber. The GPs all had their own bags which they used for routine home visits. The GPs could access emergency medicines for home visits from the dispensary at the Claverdon branch surgery.

There was a fire risk assessment which was due for review in October 2015 and evidence that staff took part in fire drills and fire training.

The practice had a business continuity plan covering a range of situations and emergencies that may affect the daily operation of the practice. The plan was available to all staff on the practice's computer system at the main practice and at the branch surgery.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nurses showed that that they were aware of and worked to guidelines from local commissioners and the National Institute for Heath and Care Excellence (NICE) about best practice in care and treatment. Two of the GPs had lead roles for reviewing NICE guidance, summarising essential points and sharing this information with the team. This included presenting the information during weekly clinical meetings. NICE and local clinical guidelines were all available on the practice's computer system and the GPs and practice nurses knew where to find them. Data available to us showed that the practice had mainly average or higher than average achievement levels for the Quality and Outcomes Framework (QOF). QOF is a scheme which rewards practices for providing quality care and helps to fund further improvements.

One of the GPs was trained in dermoscopy and completed annual updates to maintain their knowledge and skill. A dermatoscope is equipment used to assist improved accuracy of diagnosis of melanoma, the most serious type of skin cancer, and other skin lesions. Dermoscopy can therefore enable more patients to receive their treatment at their GP practice rather than waiting for a hospital appointment. The GP provided an in-house second opinion service for their colleagues at the practice before patients were referred to secondary care. The practice had established through a dermatology referral audit during the last three months of 2014 that the majority of referrals made to secondary care had been appropriate. With the benefit of a confirmed diagnosis the audit showed that only a small number of patients referred to secondary care for treatment could have had their procedures carried out at the practice (seven out of 21 'two week wait' referrals and four out of 51 routine referrals).

The practice hosted an external screening service as part of a local project to screen for abdominal aneurisms in men over 65 and was also looking into using these for obtaining images of joints before administering joint injections.

The practice used iPads for visits to patients in their homes. This provided them with direct access to information about patients' medical history which was downloaded before the GPs started their visits and enabled them to record clinical information about patients during visits. The GPs saved this information direct to patients' main records when they arrived back at the practice.

Management, monitoring and improving outcomes for people

The practice had a high proportion of older patients with 38% of their patients being over 65. They provided medical care to patients living in several local care homes and an enhanced service to two specific care homes. Patients over the age of 75 had a named GP and same day appointments were available. The practice was working in partnership with Age UK on an over 75's care project which was aimed at identifying and addressing unmet social need. In addition to this the practice provided enhanced clinical reviews for older patients and was recruiting an extended role nurse and a care co-ordinator for this work.

GPs at the practice provided some out of hours telephone consultation cover to two care homes. The aim was to reduce the potential for unplanned admissions because they knew the patients and their circumstances well. Data provided by the practice about emergency admissions to hospital from care homes showed that the two homes receiving an enhanced service from Trinity Court were the lowest and fourth lowest of 20 in the area.

The practice had a high proportion of patients who were living with dementia. They were proactive in screening patients with memory problems which could indicate dementia related care needs. Eighty five percent of patients known to be living with dementia had had an annual review in the last year. The practice provided us with information about reviews of patients' medicines and in particular antipsychotic medicines used to manage behaviour viewed as challenging. This showed that of 46 patients at one care home, only three now remained on this type of medicine.

Patients with mental health needs received an annual health check and 90% had had an annual review in the last year as had 78% of patients with depression.

The practice had patient registers for nine long term conditions. These included asthma and chronic obstructive airways disease (COPD) which were their two most significant groups with 2,437 and 1,309 patients respectively. Other registers included diabetes, chronic heart disease, stroke, atrial fibrillation (a heart condition),

dementia, depression and learning disability. The practice were confident that their recall system was effective and provided flexible appointments so that patients could come to the practice when it was convenient for them rather than at set times. Patients with more than one condition which needed monitoring had one appointment where their overall health was checked so they did not need to visit the practice more than once.

The team were committed to helping patients avoid unplanned hospital admissions and for the period October 2013 to September 2014 the data value for emergency admissions was 46.32% compared with the national figure of 91.37%. The figures for accident and emergency admissions were 285 for the practice compared with the national figure of 332. The practice assessment tools to identify patients at risk and had care plans in place for them to help them manage their conditions. When these patients were admitted to hospital the practice contacted them within three days of discharge to check how they were.

The practice provided in house monitoring for patients taking anti-coagulants (blood thinning medicines). This included home visits for patients unable to visit the practice. They also provided anti-coagulant initiation for patients with Atrial Fibrillation (AF), a common heart condition.

The practice had a nurse responsible for supporting patients with diabetes, including insulin initiation. They told us that they aimed to review all patients with diabetes twice a year and we saw that 94% of patients had had medicines reviews during the last year. The nurse booked longer appointments for patients who were newly diagnosed, including those beginning to use insulin and those who found it more difficult to manage their condition. They gave these patients a designated telephone number to use if they needed help and spoke with them by telephone every two days. If the nurse had not heard from a patient they contacted them to check everything was alright. The practice referred patients to local diabetes support and training and worked closely with diabetes specialist nurses. QOF data for the practice in respect of diabetes showed that the practice had performed better than the national average in all of the areas measured. Other data we reviewed showed their diabetes admissions rate was 0.76% compared with the national figure of 2.96%.

The practice provided in house spirometry for patients with asthma and chronic obstructive airways disease (COPD). A spirometer measures the volume and speed of air that can be exhaled and inhaled and is a method of assessing lung function. The practice was a high prescriber of medicines for those conditions but had reduced the number of hospital admissions. Ninety eight percent of patients with COPD and 83% of patients with asthma had had a medicines review in the last year. Emergency admission rates for COPD were significantly below the national average. For example for the period October 2013 to September 2014 the data value for admissions for patients with COPD was 2.49% compared with the national figure of 12.88%. During the same period the practice's asthma admission figure was 0.69% compared with the national figure of 1.95%.

The practice had provided in-house 24 hour blood pressure monitoring and 24 hour electrocardiograms for 10 years. This avoided patients having to be referred to secondary care services for these tests. The practice was taking part in a pilot heart failure project in partnership with the cardiology department at Warwick hospital. They had invested in additional hours for one of the practice nurses to do this work and the nurse had completed enhanced training for this role. The project had been set up in line with a NICE initiative to improve accurate diagnosis and outcomes for patients with left ventricular failure (LVF), a potentially serious heart condition with potentially poor outcomes for patients. An early outcome of the project was that the practice had identified more patients with the condition (an increase from two to 57). The aim was to improve patients' symptoms, avoid hospital admissions and improve life expectancy. The practice had identified that this would increase their prescribing costs and had highlighted to NHS England that this would be offset by reduced accident and emergency and inpatient admissions.

The practice worked in partnership with the Recovery Partnership, an integrated and recovery-focused treatment service for residents across Coventry and Warwickshire with a drug or alcohol problem. One of the GPs prescribed those patients' medicines under supervision from a specialist drug and alcohol team. The practice had found that this arrangement was beneficial to those patients who

were often also living in vulnerable circumstances. They told us that it had also reduced the impact on routine appointments when those patients' needs were more difficult to manage appropriately.

One of the practice nurses had a specific interest in the needs of patients with learning disabilities and a learning disability nurse qualification. They carried out all of the annual reviews for those patients during longer appointments booked according to individual need. The practice used formats which were suitable for patients' communication needs including an easy to read letter with pictures about annual health checks, breast screening and testicular cancer.

The practice had a register of their patients who were receiving care and treatment at the end of life so the team were aware of these patients and could respond promptly when needed. The practice used the gold standards framework for end of life care and held weekly clinical meetings to discuss patient care and these always included discussions about patients receiving palliative care. We heard that some of the GPs at the practice provided out of hours care for patients close to the end of their lives so that they received care from a GP who knew them well. Senior staff from two local care homes confirmed that the GPs involved appropriate people in discussions about patients' care at the end of life and had worked closely with staff from the home to set up extensive care plans for those patients. Advanced care plans had been completed for all patients receiving palliative care and 97% had had an annual review during the last year.

Several of the patients we spoke with confirmed that they or family members received health checks for specific health conditions and that these were well organised and thorough. One patient described an occasion when a test result showed that a member of their family needed urgent treatment. They told us the practice did not give up trying to contact the patient until they had spoken with them.

Clinical audits are a process by which practices can demonstrate ongoing quality improvement and effective care. We saw evidence that the GPs had carried out full clinical audit cycles over a number of years. One audit related to patients taking blood thinning medicines. This showed that 81% were within the correct dosage range and that none of the patients' conditions were poorly controlled. We also saw audit information regarding contraceptive coil fitting which demonstrated good results and very low levels of complications. Another audit related to the care and outcomes for patients in the two care homes visited by the practice. This had highlighted the importance of falls prevention in reducing emergency hospital admissions. The practice had also completed an audit of its coding in relation to patients who may have dementia. This had resulted in an increase of prevalence from 60.3% to 68.56%. The practice had reflected on the importance of diagnosis and had taken advantage of training and guidance provided by the Clinical Commissioning Group (CCG). They told us this had increased their confidence in diagnosing and managing the care of patients living with dementia.

Effective staffing

The practice valued the benefits of ongoing learning and development. Staff told us that when they went on external courses they cascaded their learning to other members of the practice team. The nurse manager ran monthly education sessions for the nursing and healthcare team. Clinical staff were able to use protected learning time to take part in training organised by the CCG. Plans were being developed to improve the range of training and development opportunities available for non-clinical staff.

The GPs were up to date with their continuing professional development (CPD) requirements and had either been revalidated or had a date for this. (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).

All staff took part in annual appraisals that identified learning needs from which action plans were documented. Staff who needed additional support had the opportunity for more frequent structured supervision and all staff were able to arrange time to speak with the practice manager or nurse manager if needed. The nurse manager had a system for monitoring that the nurses were updating their training and maintaining their CPD required for their Nursing and Midwifery Council registration.

The practice nurses had a range of extended knowledge and roles and were able to demonstrate that they were trained to fulfil these duties. Those with extended roles supporting patients with long term conditions had completed appropriate training. The healthcare assistants

and phlebotomists (staff trained to take blood) supported the nursing team by carrying out a wide range of tasks. We spoke with a healthcare assistant who described her role at the practice enthusiastically and confirmed that they received any training necessary. A nurse told us there were no barriers to training requests. They nurses and healthcare staff we met understood the scope and limitations of their role and the tasks the practice delegated to them.

The practice had a structured induction process for new staff. We saw some variation in the level of detail recorded in different staff files and highlighted this to the practice manager. The practice was continuing to develop the range of training available to staff and were intending to introduce online training courses. This work had been postponed pending a decision about introducing common training programmes for practices involved in plans for a proposed GP federation.

We saw information to show that the practice had a process for managing poor performance by staff. The practice manager told us they aimed to address concerns early so they did not become major problems.

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. The practice had clear processes which staff understood to make sure all information was dealt with as quickly and efficiently as possible.

The GPs met regularly with community nurses, the community matron and rehabilitation team staff in respect of the care of older patients and were committed to avoiding unplanned hospital admissions for those with complex care needs. They took part in end of life and gold standard framework meetings to discuss the care needs of patients with cancer and those receiving palliative care for other conditions. The practice's lead GP for safeguarding held weekly meetings with health visitors to review the care of children and young people known to be living in vulnerable circumstances such as those with child protection plans in place. The practice referred patients to local diabetes support and training and worked closely with diabetes specialist nurses. The practice worked in partnership with the Recovery Partnership to support patients with drug and alcohol related needs.

The practice provided GP care to older people living in two local care homes. Senior staff at those homes confirmed that the practice worked with them closely. This included providing some out of hours telephone cover as a first point of contact so that care home staff could seek advice for a GP who knew patients at the home well.

The practice engaged with the South Warwickshire CCG and some were members of the Local Medical Committee (LMC).

Information sharing

Information was available for all staff on the shared drive of the practice's computer system. All of the staff we spoke with knew this and gave us examples of information they might look for such as policies and procedures and safeguarding information.

A GP showed us the system for making sure test results and other important communications about patients were dealt with. The system ensured that results were seen promptly by a GP so there were no delays in contacting patients if urgent action was needed. Administrative staff we spoke with understood the systems used by the practice and their individual role in making sure these worked smoothly. When GPs referred patients for tests in respect of suspected cancer they followed national and local guidelines in respect of the two week cancer referral targets. The practice's medical secretaries followed these referrals up to make sure patients received outpatient appointments.

The practice had clear systems for making information available to the out of hours and ambulance services about patients with complex care needs, such as those receiving end of life care.

The practice had recently re-introduced the used the Choose and Book system which enables patients to choose which hospital they will be seen in and to book outpatients' appointments in discussion with their chosen hospital. Staff had taken part in refresher training and we were told the system was working well.

The practice recognised the importance of confidentiality and had a confidentiality policy. The practice had

information in their practice booklet to inform patients about their rights regarding how their information was managed. This was available at the practice and on the website. Staff had discussed data protection and confidentiality during protected learning time sessions.

Consent to care and treatment

The practice had a policy to support staff in meeting the requirements of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions themselves. The practice had provided training to staff about the MCA which was supported by written guidance to refer to.

The practice team understood the importance of considering patients' ability to make informed decisions about their care and treatment and give consent for this. We found that there was good communication between the GPs, nurses and healthcare assistants to help ensure patients and their carers received the support they needed according to their individual circumstances. The practice used care plans to support patients with a learning disability and those living with dementia to make decisions about their care and treatment. The parent of a patient with particular care needs described being appropriately involved in decision making and told us that the GPs recognised their experience and awareness of their child's needs.

Members of the team could describe situations where they would need to consider whether or not a person had capacity to give consent to a procedure or treatment. Staff understood that they could not proceed with treatment if a person lacked capacity without a best interest decision being taken by relevant people involved in a patient's care. The manager of a local care home confirmed that the GPs understood the issues to be considered in respect of the MCA and worked sensitively with families and staff at the home when decisions needed to be made.

GPs and nurses with duties involving children and young people under 16 were aware of the need to consider Gillick competence. The Gillick Test helps clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment.

GPs confirmed that they always obtained written consent for minor surgery and we saw that the practice had consent forms for this and for contraceptive coil insertion procedures.

Health promotion and prevention

The practice provided women's health checks, blood tests, health checks, baby immunisations and health reviews for patients with long term conditions. Patients were offered support to stop smoking by the practice nurses. There was no set day for this so patients could book appointments which were convenient for them. The practice also provided electrocardiograms (ECGs) and spirometry (a spirometer measures the volume and speed of air that can be exhaled and inhaled and is a method of assessing lung function). One of the practice nurses provided diet and obesity management advice. New patient checks included screening for alcohol related problems. Patients we spoke with confirmed that they were invited for relevant health checks.

The practice had an informative website which provided links to news and information about a wide range of health and care topics and could display the information provided in 65 languages.

To provide flexibility for working parents, appointments for childhood immunisations were available throughout the week as well as at a weekly baby clinic run by the practice nurses. Childhood immunisation rates were in line with the CCG average. The practice was proactive in encouraging patients to have annual flu vaccinations. National data showed that the practice had achieved higher than the national average figures for providing flu vaccinations to patients aged 65 or over (79% compared with 73%) and for those in high risk groups (60% compared to 53%). Flu vaccination rates for pregnant women were 49% compared to the England average of 44%.

The practice nurses were responsible for the practice's cervical screening programme. The data available showed that the take up of screening at the practice was in line with the national average. Patients could also have long acting contraceptive devices and implants provided at the practice at appointment times to suit them.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

The practice provided chlamydia screening on request but staff told us they us they encouraged patients to attend the local specialist clinic where they could receive specialist advice, education and signposting to other relevant services.

The practice website contained links to NHS travel health information and patients could book appointments for travel vaccinations with the practice nurses on days and times convenient to them.

The nurses told us they frequently put patients in touch with other organisations which might benefit their health and wellbeing. These included healthy living initiatives at the local leisure centre and schools, a 'Men at Work' project and Age UK. Pregnant women from Eastern Europe were signposted to a specific antenatal service provided by local midwives where a Polish interpreter was available and interpreters for other languages could be arranged when needed.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We gathered patients' views by looking at 19 Care Quality Commission (CQC) comment cards patients had filled in. On the day of the inspection we spoke with nine patients, two of whom were members of the practice's two patient participation groups (PPG). The practice had one group in respect of the Trinity Court site and one for the Claverdon branch surgery. A PPG is a group of patients registered with a practice who work with the practice team to improve services and the quality of care.

Data available from the NHS England GP patient survey results during 2013/2014 showed that the patients had reported positive views about the practice. The practice score in respect of overall experience of the care they received was 85%, in line with the national average. The practice's NHS Friends and Family Test in January 2015 showed that 47 of the 48 patients who responded would recommend the practice nurses and in the March 2015 survey 26 out of 27 who responded would recommend the GP they saw.

Information from patients gave a positive picture of their experiences. Several said the service they received was excellent and described the staff team as professional, caring and pleasant. Patients were complimentary about the helpfulness of reception staff who recognised and accommodated their individual needs when they visited the practice. One described a situation where they felt staff had gone above and beyond what would be expected when they were waiting to be seen with their unwell child.

We spoke with senior staff from two local care homes where some of the practice's patients lived. They described the service provided by the practice as helpful, supportive and professional and the approach of the GPs as humane. They were very satisfied with the care and treatment patients received and highlighted that the GPs were also caring towards patients' families.

The practice had taken steps to make conversations at the reception desk as private as possible. This included playing background music and having a sign asking patients to wait some distance from the person in front of them.

Telephone calls from patients were dealt with by staff in a different area of the building so they could not be overheard. There was a sign to tell patients they could ask to speak to reception staff in a private room if needed.

A small number of patients commented on occasions when reception staff had not been sensitive to their situation although these appeared to be exceptions to most patients' experiences. One patient told us that they had experienced staff coming into the room without waiting for the GP to tell them they could come in.

Care planning and involvement in decisions about care and treatment

Patients were positive about the way they were treated and confirmed that they felt listened to. Other patients confirmed that the GPs and nurses explained the tests, treatment or medicines they needed clearly so they understood what was happening and why.

Results from the GP patient survey during 2014 showed that in response to a question about trust and confidence in their GP 98% of patients who responded said that they trusted their GP and the nurse they saw; 90% said their GP was good at listening to them. Eighty five percent felt that their GP was very good or good at involving them in decisions about their care compared to the national average of 81%.

The practice had registers identifying those patients with the highest level of need who were most likely to require urgent medical assistance or have an unplanned hospital admission. The practice confirmed that they had developed care plans for these patients. For example, 85% of patients living with dementia had care plans. The manager of one local care home highlighted that the GPs had worked with them to develop care plans for patients at the home and that they had involved patients, families and staff in doing this. Ninety seven percent of the practice's patients needing care at the end of their lives had advanced care plans.

Patient/carer support to cope emotionally with care and treatment

One of the PPG representatives told us they often heard from other patients about occasions when the GPs went above and beyond what might be expected. For example, a family had told the PPG about what they felt was the

Good

Are services caring?

excellent care they received at the end of a person's life. They also described a situation where a GP had identified some information about a patient's care and telephoned them about this outside usual practice hours.

Staff at the care homes told us that GPs from the practice were readily available to patients' families and often telephoned them in the evenings or provided them with their telephone number so they could be contacted. One of the homes told us that one GP often called at the home before or after surgery even without a visit request to see patients nearing the end of life.

The practice website provided links to the NHS Choices information library containing a wide range of information to support patients and their families. Whilst this did not include specific information about carers we confirmed during the inspection that patients who were carers were encouraged to register this with the practice. This information was flagged in their records so that the practice was aware of their role and could direct them to local carers' organisations for practical support and advice. Carers were provided with cards identifying them as carers so that that if anything happened to them the emergency service would be aware that the person they looked after may need assistance.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

There was a pharmacy in the same building as the practice. This was open for 100 hours a week providing a convenient facility for patients to collect prescriptions. There was also an on-site coffee shop which the practice provided a financial subsidy to because they viewed it as a valuable asset for the practice and its patients. For example, an ante-natal group used it as a base for their informal support meetings.

Patients with diabetes could book appointments with the practice nurse in advance or on the day they needed to be seen. The nurse booked longer appointments for those patients who were newly diagnosed including those beginning to use insulin and those who were finding it more difficult to manage their condition. They gave these patients a designated telephone number which they could use if they needed help and spoke with them by telephone every two days. If the nurse had not heard from a patient they contacted them to check everything was alright.

The practice had a register of patients with mental health support and care needs. Each person on the register was invited for an annual review of their overall health. The team had been proactive in identifying patients who may be living with dementia and had a dementia register. GPs told us that they reviewed these patients' needs annually.

The practice used the gold standard framework for end of life care and had a register of patients receiving palliative care. They had a clear system for making sure members of the team, including reception staff and those who answered the telephones, were aware of patients who were at the end of their lives and might need an urgent response from the team. Although the practice provided information about patients in these circumstances to local out of hours and ambulance services three of the GPs provided direct out of hours cover for patients at the end of life by providing patients or their carers with their telephone details. They used a buddy system to cover for each other if one of them was away.

One of the GPs provided an out of hours telephone service for local care homes as a first point of contact. They did this to minimise the potential for patients being admitted to hospital unnecessarily by an out of hours GP who did not know the person. They acknowledged that they could not always be available but explained that the care home staff knew they could telephone them as the first option. Staff at both homes said the GPs visited willingly when needed so patients received treatment promptly.

Patients we spoke with gave us several examples of ways the practice had met their needs. For example one patient told us that their child had specific care needs and was always fitted in to be seen on the same day when they were unwell. A carer for a person who was unable to go to the practice told us that a GP always visited promptly when their family member needed to be seen.

The practice nurses and GPs visited patients at home if their health or mobility meant they were unable to go to the practice so that they were not disadvantaged by this. The practice nurses did home visits one day a week for blood tests, monitoring of anti-coagulant (blood thinning medicines), flu vaccinations and reviews for long term conditions.

Claverdon Surgery was in a rural location with limited public transport. Because of this the practice had liaised with the patient participation group (PPG - a group of patients registered with a practice who work with the practice team to improve services and the quality of care) which provided a delivery service of medicines (apart from controlled drugs) to elderly patients and others with mobility problems due to their health. This was convenient for patients reduced the pressure on their carers. The PPG member delivered patients' monthly repeat prescriptions and other medicines as needed. Patients were asked whether they wished to use the service and communicated direct with the PPG about specific delivery arrangements.

One of the GPs was a clinical assistant for colonoscopy at a local hospital. The practice was looking into establishing a community based rapid access flexible sigmoidoscopy service for patients from local GP practices providing. This is a procedure used to examine the rectum and lower part of the colon, for example when patients experience rectal bleeding. The practice was in discussion with local hospital consultants regarding this.

Tackling inequity and promoting equality

The practice building was purpose built on three floors with a passenger lift for patients unable to use the stairs to the consulting rooms upstairs. There were automatic entrance doors to make it easier for patients with mobility difficulties and families with prams and pushchairs to get in and out of

the building. Although there was a lift, staff arranged appointments in the ground floor rooms for patients who found the lift difficult to use. The building had been designed with wide corridors to assist patients who used wheelchairs. The practice had a car park with spaces for patients with disabilities and there was also a large pay and display car park next to the building.

Staff confirmed that they were occasionally approached for care by patients who were homeless. The practice used the practice address to register them as temporary patients and tried to obtain contact information for them so they could stay in touch with them. Patients from a local hostel were also registered at the practice while staying there. Staff described these patients as frequently having multiple health and social difficulties and so they encouraged them to come back to the practice for test results and ongoing care.

The practice had a high number of patients from Eastern Europe although in general the practice did not have a diverse population. Staff told us that depending on the circumstances they used a telephone interpreting service, an electronic translation service or arranged for an interpreter to be present during appointments for any patients who were unable to converse in English. Information about interpreting arrangements was displayed in the waiting room. The practice website had a translation service offering 65 languages which patients could use to translate the content. GPs had the facility to print up to date NHS patient information leaflets during consultations with patients and it was possible to select other languages for this. Pregnant women from Eastern Europe were signposted to a specific antenatal service provided by local midwives where a Polish interpreter was available and interpreters for other languages could be arranged when needed.

The practice had a portable induction loop to assist people who used hearing aids. The practice website provided details of a designated telephone number for patients with hearing difficulties to use if they needed medical when the practice was closed. The practice website had a sound option for patients to use if they had difficulty reading text for any reason.

The practice had an equality and diversity policy which was included in the staff handbook. They intended to arrange equality and diversity training for staff and we did not identify any indication of discrimination on any grounds during the inspection.

Access to the service

The main practice opening hours were 8am to 5.45pm. Appointments were available for three hours on Saturday mornings and until 6pm on Fridays. A GP was on call from 5.45pm to 6.30pm four days a week with the exception of Thursdays when appointments were available at the practice until 9.30pm. A representative of the Claverdon PPG told us that patients who went there for their appointments experienced some delays in obtaining appointments with their preferred GP.

Patients were able to book appointments two weeks in advance or on the day they needed to be seen. Patients could also arrange appointments to see the nurse practitioner on Saturdays. The practice provided same day five minute emergency appointments during the morning and the afternoon and staff told us that the GPs worked co-operatively to make sure any patient who needed to be seen on the same day would be. Staff confirmed that same day urgent appointments were always available for children. None of the patients who completed comment cards said it was difficult to obtain an appointment but three mentioned long waits to be seen, particularly later in the day. One added that they felt this was understandable at a busy practice. The practice and PPG had identified that some patients felt frustrated that they sometimes could not book appointments further than two weeks in advance. As a result the GPs now gave patients who needed to do this for a specific reason a written slip to take to reception so that staff there knew this was necessary. The practice had added a reply facility to appointment text reminders so patients who needed to cancel could do so quickly and easily.

Results from the GP patient survey during 2014 showed that the practice's scores for access were mixed. For example 70% described their experience of making an appointment as good compared to the local Clinical Commissioning Group (CCG) figure of 77%. However, 82% were satisfied with the practice's opening hours compared with 79.8% CCG average and 89% said that the last appointment they made was convenient for them.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Patients could book appointments in person, by telephone and online. The practice was planning to introduce the use of social media as an avenue for communicating with patients in the future and was also considering introducing Skype for selected types of patient consultations.

The practice provided information about out of hours arrangements on their website and in a leaflet available in the practice. The out of hours service in Warwickshire was run by an organisation called Care UK and was based at Warwick Hospital. Three of the GPs provided some direct out of hours cover for patients nearing the end of life and had a buddy system to cover when one of them was away. One also provided some out of hours telephone cover as a first point of contact to two local care homes so that staff could seek advice from a GP who knew patients at the home well.

Listening and learning from concerns & complaints

The practice had a system for handling complaints and concerns. This included a complaints procedure, a detailed complaints leaflet for patients as well as basic information on the practice website and in the main practice leaflet. The practice manager held the lead responsibility for complaints handling and patients were asked to contact them with any concerns. The practice's processes for complaints were in line with contractual obligations for GPs in England.

We saw evidence to show that the practice discussed concerns and complaints at team meetings and used these to help them improve the service. We saw evidence that the practice had responded to complaints and addressed these but we identified that the written records of discussions with the staff team could be more detailed. This would help the practice when they audited complaints and reviewed progress towards any necessary improvements.

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. During the inspection the practice showed that they had a firm grasp on their future aims and a desire to continually improve and develop. They had identified that they would need to expand in the future due to increasing demand for primary care services in Stratford on Avon. We established that the practice had business planning arrangements and that these were reviewed every month.

The practice was starting to plan for the eventual retirement of the practice manager and GPs at the practice were actively involved as board members of South Warwickshire Ltd GP Federation. The practice had submitted a bid for funding to the Prime Minister's Challenge Fund for expansion of the practice to enable them to meet growing local demand on the service. Their initial bid had been put together within a short timescale and whilst this was unsuccessful they had worked on developing their proposals with a view to re-submitting these.

Governance arrangements

The GP partners and nurses all had lead roles and specific areas of interest and expertise. These roles included specific lead roles at the practice such as reviewing guidance from the National Institute for Health and Care Excellence (NICE), minor surgery, safeguarding, learning disability, dementia and prescribing. Some of the GPs also performed lead roles in non-clinical areas such as finance and human resources. They were engaged with the wider local medical community and attended Clinical Commissioning Group (CCG) meetings and some were actively involved in the Local Medical Committee.

The practice had policies and procedures to support the effective management of the practice. These were available for all staff on the practice's computer system. Most staff referred to this at some stage during our discussions with them. All the members of the team we met understood their roles and responsibilities within the practice.

We saw examples of clinical audit cycles which demonstrated that the practice reviewed and evaluated the care and treatment patients received.

The practice held a variety of regular meetings and events to provide opportunities for communication, team building and shared education and learning. These included weekly meetings for the GPs and practice management team from both the main and branch surgeries. The nursing and healthcare assistant team had meetings every month. These were used for general updates and to cascade information from training courses members of the team had completed. They also reviewed individual cases at the meetings or had speakers to talk about specific topics such as contraception. Staff confirmed that the outcomes of significant events were reviewed at whole team meetings which took place three to four times a year. There were formal partners' meetings each month and an annual business planning meeting. A part time salaried GP told us they did not work on the weekly meeting day but that the practice paid them for additional hours when they were able to attend. They said this enabled them to feel part of the team.

The practice had recently introduced a telephone recording system to enable telephone calls to be monitored and reviewed in the event of concerns or complaints.

The practice used information from a range of sources including their Quality and Outcomes Framework (QOF) results and the CCG to help them assess and monitor their performance. The practice was 'buddied' with other nearby practices with whom they took part in meetings to share good practice.

Leadership, openness and transparency

During the inspection the practice told us about the challenges they had faced in recent times due to changes within the staff team. This period of change had come to an end and the team were positive about working together to build the team for the future. Staff we spoke with were positive about working at the practice which they described as patient focussed. They told us the team were close and supportive and everyone was included. They said they felt valued and that it was a nice team with good teamwork. One of the healthcare team commented that there was a low turnover of staff in the nursing and healthcare team which was therefore close and supportive. Staff said they could approach the GPs and management team and one gave us an example of asking a GP for advice about a patient earlier that day.

Are services well-led?

Good

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

Seeking and acting on feedback from patients, public and staff

The practice had two well established patient participation groups (PPG). A PPG is a group of patients registered with a practice who work with the practice team to improve services and the quality of care. There were two groups because patients had chosen to set up one for the main surgery and one for the branch. During the inspection we met representatives from both groups. One of them told us the practice viewed the PPG as a 'critical friend' and that the practice manager and a GP always attended the meetings. One of the PPG representatives told us that the practice was involving them in discussions about the practice's bid for funding for the proposed expansion of the service. There were plans in hand to discuss the proposals at a forthcoming PPG meeting.

The PPG representatives gave us examples of improvements the practice had made in response to the PPG and other sources of information. For example, the practice had seen comments on NHS Choices criticising the problem getting appointments on Mondays. They had not waited for the PPG to raise this but had got on and recruited additional reception staff. Another improvement was that staff now let patients know if their GP was running late.

The practice and the PPG were working together to raise the profile of the PPG and this included developing regular newsletters and a designated noticeboard. The PPG and practice were aware that the profile of the PPG did not match the practice population and were looking at ways to encourage a more diverse mix of patients to become involved.

We saw the results of the practice's 2014 patient survey which was administered by the PPG. This showed that overall patients were positive about the practice with 95% satisfied with their consultation with their GP. The report included an action plan based on the results of a patient survey [CB1] during 2013/14. Changes the practice had made included the GPs giving slips for patients to take to reception if there was a specific reason why they needed to book appointments further than two weeks in advance and adding a reply facility to appointment text reminders so patients who needed to cancel could do so quickly and easily. The practice had introduced the NHS Friends and Family test as another way for patients to let them know how well they were doing.

Throughout the inspection members of the practice staff team told us they felt supported. They said the partners and practice management team were approachable and that they felt valued and listened to. None of the staff we spoke with had any anxieties about raising concerns.

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. Staff said there were lots of opportunities for learning, teaching, sharing and referring issues within the team so that everyone benefitted. Staff told us that when they went on external courses they cascaded their learning to other members of the practice team. The nurse manager ran monthly education sessions for the nursing and healthcare team. Clinical staff were able to use protected learning time to take part in training organised by the CCG. Plans were being developed to improve the range of training and development opportunities available for non-clinical staff.

In addition to the various team meetings which took place throughout the year members of staff each had a half day protected learning time every month. Clinical staff received supervision and appraisal and the practice intended to develop this by introducing a system known as 360 degree appraisal. This is a system of appraisal which gathers feedback about individual from a number of sources, typically including colleagues and people who use services.

The PPG members we met told us that the nurse practitioner had been to a PPG meeting to talk about the specialisms of the nurses and healthcare staff to improve their awareness of the range of services provided.

In the past Trinity Court had been a training practice but they were not currently providing places for GP trainees but hoped to start doing so again. A GP trainee is a qualified doctor who is training to become a GP through a period of working and training in a practice.