Collingwood Road Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Collingwood Road Surgery on 18 March 2015. Overall the practice was rated as good.

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

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed, addressed and shared with staff during meetings.
- Risks to patients were identified, assessed, and well managed.
- Patients' requirements were evaluated and care was designed and provided following best practice guidance.
- Staff had received training suitable to their roles and any further training needs had been recognised and planned for.
- Patients said they were treated with compassion, dignity and respect and they were included in the care and decisions made about their treatment.
- Information about services and how to complain was readily available and easy to understand. Complaints were investigated and responded to appropriately.
- The practice had suitable facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice

proactively sought feedback from staff and patients, which it acted on.

Summary of findings

Importantly the provider should:

- Implement formal risk assessment procedures to assess which staff may require a criminal records check.

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 their responsibilities around raising concerns, and reporting incidents and near misses. We saw significant events were reported and investigated. The investigations showed lessons had been learnt and shared to support improvement with those that could be affected. Risks to patients and staff were identified, assessed and well managed. There were procedures in place for identifying vulnerable adults and children and to share information with relevant agencies appropriately. We saw records that enough staff were working at the practice each day to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were above average for their locality and where there were areas for improvement the practice was proactive in developing these. Staff referred to guidance from National Institute for Health and Care Excellence and ensured patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing patient capacity and promoting good health. Staff had received role specific training and where further training needs had been identified the practice was open to plan and meet these needs. There was evidence of appraisals, training and development for staff within their role specific requirements. Staff worked with multidisciplinary teams to ensure that patients received effective personalised care and treatment.

Are services caring?

Good

The practice is rated as good for providing caring services. Data from patient surveys showed that patients rated the practice about average for aspects of care, such as how GPs and nurses explained their care to them, involving them in making decisions and listening to them. Information to help patients understand the services available were easy to follow. We also saw that staff treated patients with kindness and respect, while maintained confidentiality. We received positive remarks on the comment cards we left for patients to complete about their care at the practice. Patients also commented they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. The patients we spoke with during the inspection were also positive about the care they received.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the local Clinical Commissioning Group (CCG). A CCG is a group of General Practices that work together to plan and design local health services in England. They do this by commissioning health and care services.

The practice had a flexible pre-bookable appointments system with emergency and urgent same day appointments available daily. They also operated extended hours, providing appointments outside normal surgery times for working people and students. The majority of patients said they could be seen by a named GP, there was continuity of care, and if they had urgent medical problem they were always seen the same day. The National GP Patient Survey 2013-2014 showed patients at the practice scored them better than average nationally when asked how easy is it to get through to someone at your GP surgery on the phone.

Information about how to complain was available and easy to understand and evidence showed that the practice investigated and responded quickly and appropriately to any issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear statement of purpose and staff knew what their responsibilities were in relation to this. There was a clear leadership structure and staff told us they felt supported by management. The practice had a number of policies and procedures to govern activity and there was a procedure in place to monitor and improve the quality of service provision and to identify any risks to staff or patients. The practice proactively sought feedback from staff and patients, and we saw evidence of actions taken in response to feedback.

Summary of findings

The six population groups and what we found

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

Older people

Good

This practice is rated as good for the care of older people. Patients over the age of 75 had a named GP to ensure they were offered proactive, personalised care to meet their individual needs. Longer appointments were available for this population group.

The practice provided home visits to frail or housebound patients. Each month they held a fragility meeting; these involved the wider practice team including the Community Matron, District Nurses, and social workers.

Data the CQC held showed the uptake of flu vaccination for this population group at the practice was slightly above average compared with other practices nationally.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The nurse at the practice provided health promotion, asthma, diabetes and chronic obstructive pulmonary disease clinics for patients in this population group. Longer nurse and GP appointments and home visits were also available when needed. The practice maintained disease registers for patients with long-term conditions to ensure management and review of patients was optimal. Patients in this population group had a named GP, care plan, and many were also on the fragility register. All these patients had a structured review to check their health and medication needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a more multidisciplinary package of care.

The practice had specific emergency processes and referrals in place for patients with long-term conditions who experienced a sudden deterioration in their condition.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were processes in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were extremely high for all standard childhood immunisations in comparable data for the local practices. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice had baby changing facilities and offered full

antenatal and postnatal care. They had weekly appointments available in the surgery with the midwife and had developed a good working relationship with them. Baby checks and all childhood immunisations were provided.

Information and advice on sexual health and contraception was provided during GP and nurse appointments.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. Appointments could be booked in person, by telephone or online. Appointments could be booked up to eight weeks in advance and on alternating weeks from 7am to 8am on Wednesdays and until 7.30pm on Fridays. These appointments were particularly useful to patients who were unable to attend during the working day.

The practice was proactive in offering a range of health promotion and screening that reflected the needs for this age group. For example there were nurse clinics held for general health checks, and travel vaccination and advice.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability and they had received a follow-up when needed. They also offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice signposted and provided support to patients to access support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. The practice told us they knew their patients within this population group well.

Staff were aware of their responsibilities regarding information sharing and documentation of safeguarding concerns. They knew who to contact in normal working hours and how to contact relevant agencies when out of hours.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). People experiencing poor mental health at the practice had received an annual physical health check. The practice regularly worked with multi-disciplinary teams to implement new care pathways and share care. They worked with specialist teams in the case management of people experiencing poor mental health, including those with dementia.

The practice maintained a register of people experiencing poor mental health. The register supported clinical staff to offer patients an annual appointment for a health check and a medication review. The practice referred patients to appropriate services such as psychiatry and counselling services and improving access to psychological therapies (IAPT). IAPT is a programme to improve access to talking therapies in the NHS by providing more local services and psychological therapists. Referrals were made to Child and Adolescent Mental Health Services (CAHMS) to support younger patients.

The GPs worked closely with the Community Mental Health Team (CMHT) nurse and made combined visits to patients when necessary. CMHT support people living in the community who have complex or serious mental health problems.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

We spoke with four patients visiting the practice on the day of inspection. Patients told us the practice manager and reception staff were very polite and caring. They praised the care they received from the staff in particular from the clinical team. One patient told us how the GP was responsive and patient in responding to their individual needs. They said the GP was caring and always found time to address their concerns.

Prior to the inspection we invited patients to complete Care Quality Commission comment cards on their experiences of the practice. We received eight completed cards. The comments on all the cards were positive regarding the practice. Many of the cards commented on the courteous staff both clinical and administrative and the welcoming environment. Some of the cards in particular expressed their satisfaction with their ability to always book an appointment when they needed.

We spoke with a visiting healthcare professional working at the practice on the day of inspection. They told us they found both GPs very approachable and communication with the staff at the practice was excellent.

We reviewed the results of the patient surveys conducted by the GPs towards their appraisals (2015). These included comments written by patients; these were also complimentary and expressed sentiments regarding the caring, sympathetic, and understanding attitude to their patients.

Areas for improvement

Action the service SHOULD take to improve

- Implement formal risk assessment procedures to assess which staff may require a criminal records check.

Collingwood Road Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission Inspector and a GP specialist advisor.

Background to Collingwood Road Surgery

Collingwood Road Surgery is located on Collingwood Road close to the centre of Witham. The practice provides services for approximately 1,725 patients living in and around the Witham area of Essex. The practice holds a GMS contract.

Staff members at the practice include one male and one female GP partner, a practice nurse, a phlebotomist/ receptionist, a medical secretary, two reception staff, and a practice manager who supports the practice GPs. A phlebotomist is a specialist clinical support worker who takes blood samples from patients for testing in laboratories.

Patients may contact the practice reception by telephone from 8:30am and 6pm Mondays, Tuesdays, Wednesdays and Fridays. Additionally the practice reception is open from 7am to 8am Wednesdays, and 6.30pm to 7.30pm Fridays, on alternate weeks. The practice is closed on Thursdays from 1pm; however on Thursday afternoons patients may telephone the GP directly. Appointments are available between 9am to 12pm and from 4.30pm to 6pm on Mondays, Tuesdays, Wednesdays, and Fridays. It is open for appointments from 9am to 12pm on Thursdays and is closed Thursday afternoon from 1pm after which time patients may contact the GP directly. The practice has extended opening hours for appointments on Wednesday mornings between 7am to 8am and on Friday evenings between 6.30pm to 7.30pm on alternate weeks.

The Collingwood Road Surgery has opted out of providing out-of-hours services weekends, bank holidays, and after 6.30pm weekdays (when out-of-hours service takes over patient care). These services are provided by a local out-of-hours service provider 'Primecare' and details of how to contact the services were available within the practice and in the recorded telephone message when patients rang the surgery outside normal working hours.

Why we carried out this inspection

We inspected Collingwood Road Surgery as part of our comprehensive inspection programme.

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

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

Detailed findings

How we carried out this inspection

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

Is it safe?

Is it effective?

Is it caring?

Is it responsive to people's needs?

Is it well-led?

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

Older people

People with long-term conditions

Families, children and young people

Working age people (including those recently retired and students)

People living in vulnerable circumstances

People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 18th March 2015. During our visit we spoke with a range of staff including two GP's, a practice nurse, the practice manager, receptionists a medical secretary and the practice manager. We spoke with patients who use the service, observed how staff interacted with and welcomed patients to the practice, and reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety including incidents, comments, complaints, friends and family test, thank you cards, and national patient safety alerts. The practice had policies and procedures for reporting and responding to accidents, incidents and near misses. Staff members told us they were aware of the procedures for reporting and dealing with risks to patients and concerns and pointed to a diagram for the staff to follow, explaining what to do in response to different circumstances. Records we viewed showed incidents and near misses were reported, assessed and used to consider safety within the practice.

There were systems for dealing with the alerts received from the Medicines and Healthcare products Regulatory Agency (MHRA). The alerts had safety and risk information regarding medication and equipment, often resulting in the withdrawal of medicines from use and return to the manufacturer. We saw that all MHRA alerts received by the practice had been actioned and completed. There were also arrangements in place for reviewing and acting on National Patient Safety Agency (NPSA) alerts. These are alerts that are issued to help reduce risks to patients who receive NHS care and to improve safety. The practice manager told us that information was shared through email notifications and during meetings.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. Through discussions with the practice manager and a review of records we saw that significant events were fully investigated to establish where improvements could be made and to identify learning opportunities to avoid any reoccurrences. We looked at the records in relation to the four significant events reported within the previous 36 months. We found that these had been investigated, and acted upon. Learning outcomes arising from the investigation of these events were shared with staff during practice meetings and periodically reviewed and analysed to help prevent any recurrence. Incidents were a standard agenda item discussed within the monthly clinical and administrative meetings. Staff members confirmed these discussions took place.

Staff, including receptionists, administrators and nursing staff, told us the practice had an open and transparent culture for dealing with incidents when things went wrong. They told us that they were supported and encouraged to raise concerns and to report any areas where they felt patient care or safety could be improved.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable families, children, young people and adults. Safeguarding policies and procedures were available to staff which included details of how, and to whom, concerns should be reported. Practice training records made available to us showed clinical staff had received role specific training on safeguarding adults and children. The practice had a designated lead for safeguarding vulnerable adults and children who acted as a resource for the practice. Staff we spoke with were aware who the lead was and who they could speak with if they had any safeguarding concerns.

Staff we spoke with were able to show that they understood their responsibilities to keep patients safe and they knew the correct procedures for reporting concerns.

There was a method to identify vulnerable patients on the practice electronic records system. This included information for staff regarding any relevant issues when patients attended or failed to attend appointments; for example looked after children (children under the care of the local authority / in foster care) or those children who were subject to child protection plans, elderly patients and those who had learning disabilities. Vulnerable families, adults and children were discussed during weekly GP meetings and at monthly multidisciplinary team meetings, which were attended by health visitors, and other health and social care professionals as required.

A chaperone policy was in place and 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). The chaperone policy described situations and occasions when a chaperone would be required and requested.

Chaperone duties were undertaken by the nurse and members of reception staff that had undertaken in-house chaperone training given by the GP. Training was confirmed by the staff members. Staff we spoke with were aware of their roles and responsibilities when acting as a chaperone during patient consultations. We were told reception staff, when acting as chaperones, were never left alone with a patient. The practice did not have a formal process by which these staff were risk assessed as to whether they required a criminal records check. Patients were aware they could request a chaperone during their consultation.

Patients' records were written and kept in a way to keep them safe. The practice electronic system recorded all communications about the patient including scanned copies of communications from hospitals and including results from laboratories and x-rays.

Medicines management

We checked the arrangements for the storage of medicines, including vaccines, emergency medicines and medical oxygen. We found medicines were stored at the appropriate temperature to ensure they remained effective. The temperature of fridges used to store medicines were checked daily to ensure they did not exceed that recommended by the medicine manufacturer. We checked a sample of medicines, including those used in a medical emergency and found they were stored, and checked appropriately.

The practice nurse administered immunisations and vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of directions and evidence that nurses had received appropriate training to administer vaccines.

The practice followed national guidelines around medicine prescribing and repeat prescriptions. We reviewed information we held about the practice in respect of medicines prescribing. We found that the practice prescribing for antibiotics and sedatives medicines were similar to the national average and in line with prescribing guidelines demonstrating that the practice was following local and national guidelines. The practice prescribing for non-steroidal anti-inflammatory medicines had shown lower prescribing percentages against local and national guidelines in the 2013-2014 data we held. This was also lower than other practices in the local area and nationally. The GP told us the practice had been working to improve these findings and had initiated a change in their prescribing behaviours to change this.

All prescriptions were reviewed and signed by a GP before they were given to the patient. The practice had arrangements for reviewing patients with long term conditions on a six to 12 month basis to ensure the medicines they were prescribed were appropriate and risks were identified and managed. When talking with the GPs we were told the arrangements for checking that patients' therapeutic blood levels were checked and medicines were prescribed safely and effectively. The practice manager told us they followed up patients and encouraged patients to contact the practice for blood test results. Blank prescription forms were handled in accordance with national guidance, tracked through the practice and kept securely at all times.

Information about the arrangements for obtaining repeat prescriptions was made available to patients in practice leaflets and posters in the waiting room. Patients could order repeat prescriptions in person, by post, or online via the electronic medical record system.

Patients we spoke with told us they were given information about any prescribed medicines such as side-effects and any contra-indications. They told us the repeat prescription service, worked well and they were able to receive their medicines in good time.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. We also reviewed the completed Care Quality Commission patient comment cards, patients told us they found the practice clean, tidy, and a pleasant environment.

The practice had a lead for infection control who had undertaken training to enable them to provide advice on the practice infection control policy and carry out staff

training. All staff received induction training about infection control specific to their role. We saw evidence the lead carried out audits periodically to identify any corrective actions if needed to practice procedures.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff were able to describe how they would use these to comply with the practice's infection control policy such as, when changing and treating wound dressings. Within the infection control policy there was procedures for handling needle stick injury and staff knew the process to follow if a needle stick injury occurred.

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

Equipment

Staff we spoke with said they had sufficient equipment to carry out the diagnostic examinations, assessments and treatments required at the practice. They told us the equipment was tested and maintained regularly and we were shown equipment maintenance logs and other records that confirmed this. The portable electrical equipment displayed stickers indicating the last testing date, which we noted were within the last year.

Staffing and recruitment

Staff records we looked at held evidence that suitable employment checks had been undertaken before starting work at the practice. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Criminal Record Bureau (CRB) now known as Disclosure and Barring Service (DBS) for those staff members that required these for their roles. The practice had a recruitment procedure that set out the standards it followed when recruiting clinical and non-clinical staff.

The practice manager told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for the practice to ensure that enough staff were on duty to keep patients safe. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. The practice manager showed us the annual leave planner that demonstrated staff booked their annual leave in advance enabling the practice to ensure sufficient staff cover.

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

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included periodic checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice had a health and safety policy which and health and safety information was displayed in the reception area for staff and patient to see. The practice manager and the GP were appointed as the practice health and safety representatives.

Identified risks were included on a risk record. Each risk was identified, evaluated and necessary actions recorded to reduce and manage the risk. We saw that risks were discussed at meetings.

Arrangements to deal with emergencies and major incidents

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

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. (Anaphylaxis

is a sudden allergic reaction that can result in rapid collapse and death if not treated. Hypoglycaemia is low

Good

Are services safe?

blood sugar.) Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

The practice was in the process of developing their business continuity plan to deal with a range of emergencies that may impact on the daily operation of the practice when we inspected.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. The staff handbook held information for staff members regarding fire safety at the practice.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could summarise the basis for their delivery of patient care and treatment. Staff were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence and from local commissioners. Information and new guidance were available in recent publications and via their computers. We were told practice staff shared new information during meetings to ensure they were aligned with current guidelines to deliver safe patient care and treatments.

We saw that assessments of patients took place in accordance with NICE guidelines. Where an assessment revealed a more complex diagnosis, patients were referred to associated health care specialists or secondary care services in a timely manner where urgent, often on the same day. We found the GPs and nurse were utilising clinical templates within the electronic medical records system to provide thorough and consistent assessments of patient needs. Information we held about the practice showed us that the practice's performance in assessing and treating patients with long term conditions such as diabetes, heart disease, asthma and chronic obstructive pulmonary disease (COPD) were in line and in some cases above the national averages.

The GPs and nurse specialised in a number of clinical areas such as diabetes, heart disease and asthma. This supported the needs of patients who were able to receive appropriate monitoring, along with advice and guidance regarding how best to manage their conditions and maintain a healthy lifestyle.

The practice computerised patient record system was used to identify those patients whose needs required more regular monitoring. This included those with long-term conditions, complex needs or those patients nearing the end of their lives. The records were coded so that patients needing additional support such as periodic reviews could easily be identified.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race were not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Staff at the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scanning documents onto the electronic medical records system, scheduling clinical reviews, managing child protection alerts and repeat prescriptions. The information staff collected was then used to support the practice to carry out clinical audits, long-term condition management, and patient follow-up and review.

The practice showed us two clinical audits that had been undertaken in the last 18 months. One audit had been undertaken throughout the whole of 2014 to look at the attendances of the practice patients at Accident and Emergency (A&E) within core practice working hours and outside core practice working hours. The audit was intended to determine if patients at the practice used the A&E service for the correct conditions/injuries and at the correct times. Analysis of their findings showed the majority of patients were using the services correctly, and therefore the practice was meeting the patients' needs in relation to providing minor injuries care during core working hours.

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

The practice also used the information collected for the QOF and performance against national screening programmes such as immunisation, or cervical screening, to monitor outcomes for patients. For example, ensuring patients with diabetes had an annual medication review. The practice met all the minimum standards of review for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease), physical and/or mental health conditions and chronic kidney disease. The practice was also above the average range for some QOF (or other national) clinical quality standards of care when reviewing and treating patients with long term conditions.

There was a protocol for repeat prescribing which was consistent with national guidance. Staff told us they checked that patients receiving repeat prescriptions had

been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. Through discussion with the GPs we were assured that the clinicians had oversight and a good understanding of best treatment for each patient's needs.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients, their carers and families.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We saw evidence that clinical staff were appropriately qualified and trained, and where appropriate, had current professional registration with the Nursing and Midwifery Council (NMC) and General Medical Council (GMC). We saw clinical staff undertook relevant training and reflective practice to enable them to maintain continuous professional development to meet the revalidation requirements for their professional registration. We reviewed staff training records and saw that all staff were up to date with relevant training courses to support their role. We noted the nurse had a certificate in asthma, cytology and family planning, and both GPs provided joint injections. The GPs were up to date with their yearly continuing professional development requirements and they had dates this year for their revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

We looked at three staff files and found appraisals and training records. The staff appraisals included reference to learning needs identified and any planned training to address these were documented. Staff told us the practice were proactive regarding training for staff members and offered relevant courses, for example infection control update course.

The practice had dedicated leads for supervising areas such as safeguarding, infection control, family planning and female reproductive health. The practice nurse provided services including review of asthma, diabetes, cervical screening, general health checks, blood pressure checks, removal of sutures and wound dressings. Patients welcomed the provision of a phlebotomist at the practice as they could have their blood taken locally and not attend the hospital for this service. A phlebotomist is a specialist clinical support worker who takes blood samples from patients for testing in laboratories.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs including those with more complex needs. There was a clear procedure for receiving and managing written and electronic communications in relation to a patient's care and treatment. Correspondence including tests and X ray results, letters, including hospital discharge, out of hour's providers, and summaries were all reviewed by a GP before being actioned on the day they were received.

The practice held monthly multidisciplinary team meetings to discuss patients with complex needs including those with end of life care needs, vulnerable families and children on the at risk register. These meetings were attended by district nurses, social workers and palliative care nurses where decisions about care planning were documented in the patients' care plan. We saw that records were maintained in respect of these meetings, which demonstrated the practice worked collaboratively with other agencies to ensure that patients received appropriate and coordinated care and treatment.

The practice had implemented proactive case management for all patients on their 2% most vulnerable patients register. The practice monitored the emergency admissions, readmissions, unplanned admissions and discharges from hospital for patients with long term conditions, older people, those living in care homes and vulnerable at risk patients. Through this they identified patients for the vulnerable patient register and those most likely to have an unplanned admission to hospital. Those patients deemed most vulnerable were provided a written and electronic personalised care plan developed in partnership with them and their carer (if applicable). This was jointly owned by the patient, carer (if applicable) and named accountable GP. The plans when finalised were signed by the patient and kept at their home to inform visiting healthcare professionals of the agreed care and treatment wishes of the patient, and a copy of the recorded

Good

Are services effective?

(for example, treatment is effective)

plan was on the patient's records at the practice. The practice told us they had identified a reduction in their unplanned admissions since the plans had been implemented.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. The practice made information available to the 'out of hours' service about patients with complex care needs, or those receiving end of life care.

There was also a local central referral system in place for making secondary care referrals; staff told us this was easy to use. The practice also printed out for emergency patients, a copy of their summary medical patient record to take with them to A&E.

Staff used an electronic patient medical record to coordinate, document and manage patients' care. All staff were fully trained on the patient medical record system, and were positive about the system's safety and ease of use. The system enabled scanned paper communications, for example letters from the hospital, to be saved in the system for future reference. Staff were aware of the importance of patient confidentiality and the need to obtain consent before sharing any information with a third party.

The practice maintained registers of patients who were identified as vulnerable, such as those who had life limiting illnesses, were receiving palliative care and treatments and patients with learning disabilities. GPs and the nurse at the practice worked with Macmillan nurses and other agencies that support people with life limiting illnesses, through their quarterly palliative care multidisciplinary meetings. These meetings co-ordinated services for those patients with life limiting illnesses to ensure their care and treatment met their changing needs.

Consent to care and treatment

The practice had a procedure in place for obtaining patient's' consent to care and treatment. GPs and the nurse we spoke with had an understanding of the practice consent procedure and told us they obtained patients' verbal consent before carrying out physical examinations or providing treatments. Clinical staff we spoke with were aware of parental responsibilities for children and said they obtained parental consent before administering child immunisations and vaccines. One patient commented that the GP always asked them for consent before examining them and made sure their hands were warm. They regarded these actions as exceptionally considerate.

The clinicians demonstrated an understanding of legal requirements when treating children. They understood Gillick competency. This is used to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. Staff we spoke with were aware of the Mental Capacity Act 2005, this related to the treatment of people who lack capacity to make certain decisions. The Mental Capacity Act is designed to protect people who cannot make decisions for themselves or lack the mental capacity to do so, by ensuring that any decisions made on their behalf are in the person's best interests. The GPs told us how they supported patients with a learning disabilities and those with dementia to make decisions through their care plans which were reviewed annually or more frequently if clinically indicated.

Health promotion and prevention

Newly registered patients were offered a medical health check with the GP and we were told any health concerns detected would be followed up in a timely way. Patients who had not attended the practice for a period of 12 months were encouraged to book an appointment for a general health check-up. Nurse led appointments were available for health promotion and disease prevention these included blood pressure checks, family planning, diabetes, asthma, and cervical screening.

The practice kept a register of all patients with a learning disability and offered them an annual physical health check. Similar mechanisms for identifying 'at risk' groups were used for patients who experienced poor mental health. These patients were offered further support in line with their needs. For example, patients experiencing poor mental health may be referred to Improving Access to Psychological Therapies (IAPT) for Cognitive behavioural therapy (CBT) or to the Dove Centre for counselling services. IAPT is implementing National Institute for Health and Clinical Excellence (NICE) guidelines for people

Good

Are services effective?

(for example, treatment is effective)

suffering from depression and anxiety disorders. Cognitive Behavioural Therapy (CBT) is a talking therapy that can help you manage your problems by changing the way you think and behave.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Public health data available for the public to view collected during 2013-2014 that can be accessed via the internet showed the practice was performing above average in the area for the uptake up of childhood immunisations. The practice manager told us they followed up non-attenders.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the eight Care Quality Commission comment cards that patients had completed prior to our inspection and spoke in person with four patients. The response from patients was overwhelmingly positive with them all reporting that staff at the practice were helpful and good at listening to them. Some patients who gave us their views had been patients at the practice for many years and their comments reflected this experience. The majority of patients said they felt the practice provided excellent care and treatment.

We reviewed the most recent information available from the National GP Patient Survey, which was carried out in 2013/2014, this showed patients were generally satisfied with how they were treated. The practice scored 95.95% for, the proportion of respondents to the GP patient survey who described the overall experience of their GP surgery as fairly good or very good.

Staff were aware of the practice policy for respecting patients' confidentiality, privacy and dignity. Reception staff told us that when patients wished to speak privately in reception, they were offered the opportunity to be seen in a private room. During the inspection we spent time in the practice reception area to give us the opportunity to see and hear how staff interacted with patients. We saw there was a friendly atmosphere and that the reception staff were polite, friendly and respectful to patients.

There were signs in the waiting room explaining that patients could request a chaperone during consultations. 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. Patients we spoke with told us they knew that they could have a chaperone during their consultation should they wish it. Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation/ treatment room doors were closed during consultations.

The practice staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected they would raise these with the practice manager.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

The National GP Patient Survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the 2013/2014 showed the practice was about average for the GPs involving them in care decisions and slightly above average for nurse consultations.

Patients we spoke with on the day of our inspection told us they were listened to and supported by staff. They also told us they had been given sufficient time during consultations to make an informed decisions about the choice of treatment they wished to receive. They told us the GPs were exceptionally caring and spent time explaining information and treatment in relation to their health and care in a way that they could understand

Staff told us that translation services were available for patients who did not have English as a first language. Although the practice manager could not recall any patients currently registered that could not speak English.

Patient/carer support to cope emotionally with care and treatment

The practice supported patients who were unpaid carers for friends, relatives, partners or others, who needed help to live at home due to illness or disability. Patients who were carers for others were identified as part of the new patient registration and carers were provided with information and support to access local services and benefits designed to assist carers.

The practice had arrangements for obtaining patients' wishes for the care and treatment they received as they approached the end of their lives. Patient wishes in respect of their preferred place to receive end of life care was

Good

Are services caring?

discussed with doctors other health care professionals and organisations to help ensure that patients' wishes were acted upon. Information about the support was provided to patients who were terminally ill, their carers and families.

Staff told us families who had experienced bereavement were sent a card and called by the GP. An appointment or home a visit was arranged as appropriate. There was a variety of written information available to advise patients and direct them locally and nationally to organisations that provide help and support dealing with emotional issues such as bereavement. Notices in the waiting room, explained to patients how to access a number of support groups and organisations. The practice computer system alerted GPs if a patient was also a carer. We were saw written information available for carers to ensure they understood the various avenues of support available to them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood and was responsive to the different needs of their population it served and acted on these to plan and deliver services. The practice kept registers of patients who had specific needs; among them were those with dementia, mental health conditions, learning disabilities and those with life limiting conditions who were receiving palliative care and treatment. These registers were used to monitor and respond to the changing needs of patients. The practice utilised an electronic medical records system to record and collect information regarding their patients.

The practice told us they accommodated and saw children if they were sick at any time, regardless of any lack of appointment availability. They also benefited from a central booking system for making referrals to secondary care which gave patients a choice of location for their appointments.

The practice manager also told us they engaged with other practices in the local area to discuss local needs and service improvements that needed to be prioritised.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example those with a learning disability, people who were unemployed, and carers for example. The practice had access to the NHS telephone interpreting services and one of the GPs spoke Tamil.

The ground floor of the premises and services had been adapted to meet the needs of patient with disabilities. For example the rear door entrance to the reception area had a slope and hand rail with a door bell to alert reception staff to help open the door for those patients using a wheelchair or mobility scooter. The practice had a disabled accessible toilet and facilities for baby nappy changing. The ground floor consulting and treatment rooms were accessible to patients with restricted mobility.

The practice waiting room and accessible consultation rooms had door openings wide enough for patients with wheelchairs. This helped to maintain patients' independence.

Access to the service

Patients may contact the practice reception by telephone from 8:30am and 6pm Mondays, Tuesdays, Wednesdays and Fridays. Additionally the practice reception is open from 7am to 8am Wednesdays, and 6.30pm to 7.30pm Fridays, on alternate weeks. The practice is closed on Thursdays from 1pm; however on Thursday afternoons patients may telephone the GP directly. Appointments are available between 9am to 12pm and from 4.30pm to 6pm on Mondays, Tuesdays, Wednesdays, and Fridays. It is open for appointments from 9am to 12pm on Thursdays and is closed Thursday afternoon from 1pm after which time patients may contact the GP directly. The practice has extended opening hours for appointments on Wednesday mornings between 7am to 8am and on Friday evenings between 6.30pm to 7.30pm on alternate weeks.

The Collingwood Road Surgery had opted out of providing out-of-hours services (evenings, Thursday afternoons and weekends). These services were provided by a local out-of-hours service provider 'Primecare' and details of how to contact the service were available within the practice and in the recorded telephone message when patients rang the surgery outside normal working hours. The practice's extended opening hours were particularly useful to patients unable to attend during the working day.

The Collingwood Road Surgery has opted out of providing out-of-hours services weekends, bank holidays, and after 6.30pm weekdays (when out-of-hours service takes over patient care). These services are provided by a local out-of-hours service provider 'Primecare' and details of how to contact the services were available within the practice and in the recorded telephone message when patients rang the surgery outside normal working hours.

Longer appointments were also available for patients who needed them for those with long-term conditions. This also included appointments with a named GP or nurse.

Patients we spoke with and the comments from patients received told us they were satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to. They also said they could see another GP if there was a wait to see the GP of their choice. Comments received from patients showed that patients in urgent need of treatment had been able to make

Good

Are services responsive to people's needs?

(for example, to feedback?)

appointments on the same day of contacting the practice. Patient feedback on the eight comment cards we received told us they were pleased they could get an appointment so easily.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system; there was a poster in the waiting room and information on the practice leaflet. Patients we spoke with were not aware of the process to follow if they wished to make a complaint. However, they told us they would speak to the GP or the practice manage and were confident their concerns would be appropriately responded to. None of the patients we spoke with had ever needed to make a complaint about the practice.

The practice had not received any complaint in the last 12 months but the process they had in place to handle complaints showed they would be conducted, in a timely way, and with openness and transparency.

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 statement of purpose to deliver high quality care and promote good outcomes for patients. We found details of their practice values displayed in the waiting areas. The practice's stated aim was to ensure friendly, high quality and effective services were provided. Staff members were aware of the practice values.

The practice was committed to improving their outcomes in primary care. We saw that the practice recognised where they could improve outcomes for patients and had made changes through listening to staff and patients and responding. For example, the practice used donated funds to provide baby changing facilities at the request of patients.

Governance arrangements

There were arrangements in place to ensure the continuous improvement of the service and the standards of care. The policies and procedures were clear, up to date and accessible to staff. Staff told us that they were aware of their roles and responsibilities within the team. A number of key staff had lead roles, these included infection control, and safeguarding. During the inspection we found that all members of the team we spoke with understood their roles and responsibilities. There was an atmosphere of teamwork, support and open communication.

The practice used information from a range of sources including their Quality and Outcomes Framework (QOF) results and the Clinical Commissioning Group to help them assess and monitor their performance. The practice had a strong commitment to make improvements and secure high quality outcomes for patients. The practice used the Quality and Outcomes Framework (QOF) to measure its clinical performance. The QOF data for this practice showed it was performing in line with national standards. We were told that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a GP lead for safeguarding. We spoke with three members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported by management and knew who to go to in the practice with any concerns.

The practice manager told us about a local peer group that they took part in with neighbouring GP practices. The practice manager told us this group gave the practice the opportunity to measure its service against others and identify areas for improvement.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, the practice reviewed their A&E admissions and the appropriateness of their arrangements for identifying, assessing and managing risks to patients. The practice manager showed us the practice risk record, risks were identified, assessments were carried out and action plans produced and implemented.

Leadership, openness and transparency

All staff we spoke with told us that the GPs and the practice management team were most amenable. They told us they were encouraged to share new ideas around improving practice services and they felt the practice was well managed. They told us that there was an open culture within the practice and that both staff and patients were encouraged to make comments and leave suggestions about how the practice was managed, what worked well and where improvements could be made.

We saw staff valued their open relationship with the clinical and non-clinical staff on the day of our inspection. This was formalised through the regular practice meetings and additional meetings when required to discuss any issues or changes within the practice.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. They also told us they felt involved in improving outcomes for both staff and patients. The practice had a whistleblowing policy which was available to all staff in the staff handbook.

Are services well-led?

Good

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

The GPs had surveyed their patients this year, 2015, to gain their opinions and invite them to comment regarding the services provided by the practice. Comments received had been positive and had not shown any gaps in the service provided by the GPs.

Management lead through learning and improvement

The practice had management procedures in place which supported learning and improved performance. During discussions with staff they confirmed they had received annual appraisals and their learning and development needs had been identified and planned. Staff told us the practice strived to learn and to improve patient's' experience and deliver high quality patient care. Records showed various clinical audits had been carried out and there was on-going audit when we inspected the practice. This showed the practice quality improvement process to enhance the service and patient care.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at three staff files and saw that regular appraisals took place which identified role specific training and development needs. These staff members were also supported to achieve their learning objectives, and encouraged to engage in improvement discussions to benefit patients and staff at the practice.