Woodville Surgery

Quality Report

Burton Road
Woodville
Swadlincote
Derbyshire
DE11 7JG
Tel: 01283 217036
www.woodvillesurgery.co.uk

Date of inspection visit: 20 May 2015
Date of publication: 06/08/2015

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 Woodville Surgery on 20 May 2015. Overall the practice is rated as good.

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

Our key findings were as follows:

- Systems were in place for the learning and improvement from safety incidents. Staff understood and fulfilled their responsibilities to raise concerns and report incidents. Learning from incidents was shared internally and externally.
- Risks to patients were assessed and well managed.
- A multi-disciplinary approach to patient care was evident; the practice worked well with other agencies to ensure care and support was coordinated.
- Patients' needs were generally assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Annual health checks had not been undertaken for patients with a learning disability in the last 12 months, however, the majority of these patients had been seen by a doctor in this time.
- Feedback we received from patients during the inspection, and through comment cards, was overwhelmingly positive. Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about how to make a complaint was available and easy to understand. Complaints were dealt with appropriately and in a timely manner.

Summary of findings

- 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.

We saw an area of outstanding practice:

- The practice employed a pharmacist on a contract basis to provide a consultation and advice service. The pharmacist's role involved carrying out medicines audits, reviews of patients' medicines, and checks on patients to determine whether they had had any negative side effects from medicines or from being prescribed several medicines. The pharmacist sent out a monthly newsletter updating all clinicians on any changes to medicines guidelines or medicines alerts which highlighted any actions which were necessary to ensure patients received appropriate treatment. The pharmacist also did a patient search and identify affected patients to ensure action was taken as needed.

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

The provider should:

- Strengthen systems to assess and demonstrate the competence of healthcare assistants for specific tasks.
- Ensure routine checks undertaken on equipment are documented.
- Review policies and procedures to ensure these are robust, for example ensuring recruitment policy includes pre-employment checks required by legislation.
- Ensure governance systems are strengthened to include more detailed recording of meetings and information disseminated.
- Ensure staff have had appropriate training to undertake annual health checks for patients with a learning disability and undertake these checks as soon as possible

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. The practice had a system in place for reporting, recording and monitoring significant events. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated internally and externally to support improvement. There were enough staff to keep patients safe.

The practice had some systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. The practice's performance for antibiotic prescribing was better than the CCG average in respect of all antibiotics.

Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patients' needs were generally assessed and care was planned and delivered in line with current legislation. However, the practice had not carried out annual health checks for any of its registered patients with a learning disability. The practice had seen the majority of these patients for other reasons over the last year and told us that some aspects of the health checks were carried out opportunistically.

Staff worked with other health care professionals to improve patient outcomes. Regular multi-disciplinary meetings were held and actions identified. In general staff had received relevant training, appropriate to their roles and training needs were regularly reviewed. There was evidence of appraisals and personal development plans for staff. Staff had not received training in undertaking annual health checks for patients with a learning disability; however this has been completed since the inspection.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients spoken with on the day of the inspection said they were always treated with dignity and respect and they felt involved in their care and treatment. 94% of respondents said the last GP they saw or spoke to was good at explaining tests and treatment (the CCG

Summary of findings

average was 87%). We received 17 completed comment cards which were all positive. Patients described staff as being friendly and helpful. Views of external stakeholders such as care home managers were generally positive and aligned with our findings.

The practice had systems in place to identify and support carers, including a Carers' Champion.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice reviewed the needs of its local population and planned services in accordance with this. For example, the practice had engaged with the CCG and the NHS England area team to secure approval for new premises.

Patients we spoke with told us they found it easy to make an appointment with a named GP and that urgent appointments were available on the same day. 69% of respondents said they usually got an appointment with their preferred GP (compared to a CCG average of 60%). Comment cards, which had been completed by patients, reflected this view.

The practice had an active patient participation group (PPG) who told us about improvements the practice had made in response to identified priorities. The PPG are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them. Information about how to complain was available and easy to understand and evidence showed that the practice responded appropriately to issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were aware of the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt well supported by management.

The practice had a number of policies and procedures to govern activity and held regular meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) worked with the practice to identify areas for further improvement. Staff had received inductions, regular performance reviews and attended staff meetings and events. Staff had access to appropriate training.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

All patients over 75 had a named GP for continuity of care. The practice was responsive to the needs of older people, and offered homes visits for those with enhanced needs. Some services were offered in house to minimise travel for older patients, such as phlebotomy (collecting blood samples for testing). The practice had an enhanced care register.

The practice had recently implemented a system of planned visits to the five local care homes it served on a monthly basis to prevent unplanned hospital admissions. The practice had a Carers' Champion who identified and met with carers to signpost them to local support services. The practice had an attached care coordinator who organised monthly multidisciplinary meetings and provided the practice with a link to social services which the GPs told us was timesaving for them.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The practice had GP leads for long term conditions as well as practice nurse leads for some conditions, including diabetes and chronic obstructive pulmonary disease (COPD).

We found that practice nursing staff had the skills and knowledge to respond to the needs of patients with diabetes, asthma, COPD and cardiovascular disease. Patients diagnosed with diabetes were recalled in the month of their birthday and this system was being rolled out across other long term conditions as well as inviting patients with multiple long term conditions to one annual review. The practice had improved their monitoring of patients with diabetes through the use of this system. For example, the percentage of patients with diabetes receiving an influenza immunisation had increased from 76.3% to 98.2%.

If patients were unable to attend the surgery, practice nurses and GPs undertook home visits. For those who attended the surgery for appointments, these were offered with flexible times and days.

The practice was aware of patients at risk of an unplanned admission to hospital and demonstrated a multi-disciplinary team approach to care planning.

Summary of findings

Families, children and young people

Good

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

There was a named safeguarding lead at the practice. The staff we spoke with demonstrated knowledge and understanding in relation to safeguarding children and were aware of their responsibilities to report concerns. The practice held regular meetings with health visitors and school nurses to discuss children at risk.

Two of the practice GPs fitted contraceptive implants. Antenatal clinics were run twice per week from the practice by the midwife. The practice operated a call and recall system for baby checks and immunisations and flagged issues of concern to the health visitor.

Flexible appointment times were offered for mothers at the beginning and end of the day to avoid long waiting times. Babies and young children were seen on the same day in the practice's sit and wait clinic.

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, for example, the practice had recently started piloting 8:00am appointments. Pre-bookable appointments were available up to four weeks in advance and the practice offered telephone consultations.

The practice was proactive in offering online services as well as a range of health promotion and screening that reflected the needs of this age group. The practice used technology and IT to communicate with this population group. For example, the practice sent out appointment reminders via text message and was trialling using text messaging to communicate normal blood test results. The practice had a presence on social media with a profile on Facebook and Twitter.

The practice had an active patient participation group (PPG), a number of whose members were of a working age. The PPG are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them.

People whose circumstances may make them vulnerable

Requires improvement

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

Summary of findings

We saw evidence of support for people whose circumstances may make them vulnerable such as working closely with social care colleagues to enable patients to remain living at home. The practice held regular multi-disciplinary community support team meetings at which vulnerable people were discussed. Details of how to access support groups and voluntary organisations were available via the practice website and in the reception area.

The practice recognised patients whose circumstances may make them vulnerable, for example those who were homeless and those who had experienced drug and alcohol misuse. Staff gave an example of having registered a patient with no fixed abode.

The practice offered longer appointments where these were necessary, for example due to communication difficulties. The practice had access to interpretation services if necessary and a practice nurse was able to communicate using basic sign language. The practice had a wide range of easy read information available.

The practice had not undertaken any annual health checks for patients on its register with a learning disability in the last 12 months due to not having any staff trained to undertake these. However, the majority of patients on the register had seen a doctor in that time and general health had been reviewed opportunistically.

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). 92.5% of patients with a mental condition had a comprehensive, agreed care plan in place.

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

The practice had a lead GP for mental health. The practice healthcare assistants were trained to undertake mini mental tests for patients who had been experiencing memory problems which facilitated early diagnosis of dementia. The practice manager had recently attended dementia awareness training and was planning to involve Alzheimer's Society in planning for their new surgery building to ensure this was dementia friendly.

The practice offered longer appointments for patients experiencing poor mental health as required and offered home visits for those patients unable to attend the surgery.

Summary of findings

What people who use the service say

We looked at the results of the national patient survey from July 2014. Questionnaires were sent to 305 patients and 124 people responded. This was a 41% response rate. The practice performed well when compared with others in the CCG respect of the following areas;

- 69% of respondents said they usually got an appointment with their preferred GP (compared to a CCG average of 60%),
- 94% of respondents said the last GP they saw or spoke to was good at explaining tests and treatment (the CCG average was 87%) and
- 92% of patients said they found the reception staff helpful.

The practice did not perform as well in the following areas;

- 43% of patients said they waited 15 minutes or less to be seen (compared with a CCG average of 69%),
- 74% said the last nurse they saw was good at involving them in decisions about care (the CCG average was 86%) and
- 62% found it easy to get through by telephone (the CCG average was 74%).

The practice was aware of areas for improvement and had worked with the patient participation group (PPG) when considering the new telephone system. A PPG is a group of practice patients who work together with the staff to improve the care to patients. They told us they had also tried a number of initiatives to improve patient access including using a sit and wait service which may reduce delays in being seen.

We received 17 completed comment cards. These were all overwhelmingly positive with no negative comments. Common themes from the comment cards were patients felt they were treated with dignity, respect and care by all of the practice staff. Some patients singled out particular GPs, or particular designations of staff, for praise and provided examples of compassionate care.

We spoke with eight patients on the day of our inspection. Patients we spoke with were extremely positive about the service they received. Patients told us they could book appointments at convenient times and were treated with dignity and respect. Some patients commented that they did not mind having to wait.

We spoke with the chair of the PPG and the PPG secretary. They told us the practice was engaged with the PPG and representatives from the practice attended the PPG meetings. They found the practice responded to suggestions for improvements.

Healthwatch Derbyshire provided us with six comments from patients of the practice. These were largely positive and provided examples of ease of access. Two comments contained negative references to coordination of services and involvement in care.

Areas for improvement

Action the service SHOULD take to improve

- Strengthen systems to assess and demonstrate the competence of healthcare assistants for specific tasks.
- Ensure routine checks undertaken on equipment are documented.
- Review policies and procedures to ensure these are robust, for example detailing pre-employment checks required by legislation within recruitment policy.
- Ensure governance systems are strengthened to include more detailed recording of meetings and information disseminated.
- Ensure staff have had appropriate training to undertake annual health checks for patients with a learning disability and undertake these checks as soon as possible.

Summary of findings

Outstanding practice

- The practice employed a pharmacist on a contract basis to provide a consultation and advice service. The pharmacist's role involved carrying out medicines audits, reviews of patients' medicines, and checks on patients to determine whether they had had any negative side effects from medicines or from being prescribed several medicines. The pharmacist sent out a monthly newsletter updating all clinicians on any changes to medicines guidelines or medicines alerts which highlighted any actions which were necessary to ensure patients received appropriate treatment. The pharmacist also did a patient search and identify affected patients to ensure action was taken as needed.

Woodville 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, a specialist practice nurse, a specialist practice manager and an inspection manager.

Background to Woodville Surgery

The Woodville Surgery provides primary medical services to approximately 9,120 patients through a general medical services (GMS) contract. The services are provided from a single purpose built practice.

The practice is situated in a former mining community. The practice population live in one of the less deprived areas of the country, yet the number of children and older people affected by income deprivation is above average.

The practice team comprises four GP partners (two male and two female) providing 32 sessions per week. They are supported by two part time practice nurses and two part time healthcare assistants (who are all female). The practice employs a practice manager, an assistant practice manager and eight administrative and reception staff.

The practice is not currently designated as a training practice but they are a teaching practice with a medical student on placement.

The practice is open between 8.00am to 6.30pm Monday to Friday. Appointments are available from 9.00am to 12.00pm every morning and 4.00pm to 6.00pm each afternoon. The practice has opted out of providing out-of-hours services to their own patients. This service is provided by Derbyshire Health United when the practice is closed.

The practice declared non-compliance with Outcome 8 (Cleanliness and Infection Control) at the point of registration with CQC. This was due to not having lead within the practice for infection control and not having flexibility with their arrangements for cleaning. The practice has since appointed a lead for infection control and appointed a contract cleaning firm.

Why we carried out this inspection

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

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

Detailed findings

How we carried out this inspection

We carried out an announced inspection of Woodville Surgery on 20 May 2015. As part of this inspection we received and considered pre-inspection information from the provider and had contact with the five care homes the practice provided a service to.

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)

Before carrying out our inspection, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We received feedback from Healthwatch, NHS England and the clinical commissioning group (CCG). We spoke with staff from five care homes served by the practice. We carried out an announced inspection on 20 May 2015. During our inspection we spoke with a range of staff (including three GPs, the practice manager and assistant practice manager, four nurses and healthcare assistants as well as reception and administrative staff). We also spoke with eight patients who used the service. We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed 17 comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents, as well as comments and complaints received from patients were shared internally with all staff at the practice meeting. Learning was also shared externally with other practice managers in the locality to improve safety across all local services.

The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example we saw evidence of action taken as a result of an inappropriate administration of a vaccine including new notices displayed on vaccine fridges.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed the records of seven significant events which had been recorded in 2014. Significant events were discussed at the weekly partners' meetings and at the clinical meetings held monthly. Actions and learning from significant events were shared with the whole practice team at an annual complaints and significant event review meeting. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

The GP partners told us they reviewed all significant events and complaints annually in order to identify any patterns and to assure themselves that the action they had taken in response to events had prevented re-occurrence. The records demonstrated the practice had identified learning from these events. Staff told us they were encouraged to report any incidents or near misses.

Where patients had been affected by something that had gone wrong, the practice invited them in to discuss the incident and they were given an apology and informed of the actions taken.

There was a system in place for reviewing national patient safety alerts (NPSA). The practice management team received all alerts electronically and disseminated these to the most appropriate person. For example, an alert was received from the Clinical Commissioning Group (CCG) about a patient trying to access controlled drugs. Records reviewed showed this information was disseminated to the whole practice team to ensure all staff were aware of the concerns and the appropriate action they needed to take.

If there are any alerts on medicines the pharmacist prepared a report for the partners highlighting changes needed and patients affected to enable the GPs to undertake reviews.

Reliable safety systems and processes including safeguarding

The practice had a higher than average number of children and older people affected by income deprivation and had a number of ways of identifying children and adults who may be at risk. This included reception and administrative staff using their knowledge and observations of patients which the GPs would follow up in their direct contact with patients. The GPs told us they were not always able to attend child protection conferences but confirmed they would prioritise this in situations of high risk. They all confirmed that they would send reports if they were unable to attend and would ensure records of the meetings and any actions were followed up to protect those at risk of harm. We saw records which demonstrated there was formal liaison with health visitors and school nurses where vulnerable children were discussed and actions agreed to keep patients safe.

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

The practice had appointed a nurse as the lead for child safeguarding and a GP as the lead for adult safeguarding.

Good

Are services safe?

They had been trained to an appropriate level and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak within the practice if they had a safeguarding concern. The practice held regular meetings with the health visitor, practice nurse, school nurse and GP (if available) to discuss children who were at risk and looked after children. We saw there were comprehensive notes available which highlighted any action needed.

There was a system to highlight vulnerable patients on the practice's electronic records. We saw an example of children at risk being flagged on the system. This ensured staff were aware of any relevant issues when patients attended appointments; for example patients who regularly attended out of hours services.

There was a chaperone policy, which was visible in the waiting room and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Some members of the reception staff acted as a chaperone if nursing staff were not available. Receptionists had undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy but confirmed there had not been any incidents where fridge temperatures went outside of their recommended range.

Robust processes were in place to check medicines were within their expiry date and suitable for use and we saw written evidence of this. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistants had received appropriate training to administer vaccines. However, the systems to assess the competence of healthcare assistants could be strengthened with documented evidence to demonstrate a clinician had signed them off as able to undertake this role.

There was a system in place for the management of high risk medicines, which included regular monitoring and checks in line with national guidance before any repeat prescription was issued. Appropriate action was taken based on the results.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. There were extra checks and balances in place for patients who were prescribed controlled drugs. (Controlled drugs are those medicines that require extra checks and special storage arrangements because of their potential for misuse.) Patients prescribed controlled drugs had this highlighted on the front page of their notes and where possible only their named GP prescribed that particular drug.

The clinical commissioning group (CCG) employed a pharmacist who was attached to the practice two days a week. The practice also held a contract with this pharmacist to provide a consultation and advice service. The pharmacist's role involved carrying out medicines audits, reviews of patients' medicines, and checks on patients to determine whether they had had any negative side effects from medicines or from being prescribed several medicines. We saw an example of a medicines newsletter prepared by the pharmacist to keep clinical staff up to date with developments and changes.

Cleanliness and infection control

Good

Are services safe?

We observed the premises to be clean and tidy in most areas. We saw there were cleaning schedules in place and cleaning records were kept. Four patients who completed comment cards and all of those interviewed told us they found the practice clean and had no concerns about cleanliness or infection control.

The practice had a nurse as the lead for infection control and they had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates.

We saw evidence that the lead had carried out an audit in the last year and that changes had been implemented. For example chairs with ripped fabric had been removed from the waiting area. An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy.

There was also a policy for needle stick injury which was on display in the treatment room and staff could explain the procedure to follow in the event of an injury. The healthcare assistant described the actions they had taken following an injury which were in line with the policy and they had recorded the incident as a significant event. 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 and in the reception area.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

The practice declared itself non-compliant at the point of registration with CQC in respect of Outcome 8 – Cleanliness and Infection Control. We were informed that this was due to not having an infection control lead and not having flexibility in respect of their arrangements for cleaning. We found the practice had appointed an infection control lead and made arrangements to have contract cleaners. The practice also conducted a thorough infection control audit in December 2014 and implemented a number of changes as a result of this.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. Staff told us equipment was checked regularly to make sure it was in working order and fit for use and they confirmed that they had a process in place for doing this. However, they did not document that they undertook these checks. For example the defibrillator was checked daily but there was no record to show this check had been undertaken.

Most of the portable electrical equipment was routinely tested and displayed stickers indicating the last testing date, the remaining two items to be tested were a fax machine and a foetal monitor, however these items were not in use. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example blood pressure measuring devices and the fridge thermometer to make sure they were providing readings which were correct.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice undertook registration checks annually at the time of appraisal.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough people on duty to keep patients safe. The practice staff told us they planned to recruit additional staff in advance of their move to new premises.

Good

Are services safe?

Monitoring safety and responding to risk

There were systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment and equipment.

The practice had a health and safety policy and a health and safety folder. Health and safety information was displayed for staff to see and the practice manager was the identified health and safety representative.

The practice had a number of risk assessments in place, and we saw evidence that these had been reviewed and updated regularly. Risks were assessed and mitigating actions recorded to reduce and manage the risk.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. Staff told us that reception staff and healthcare assistants monitored the waiting area to identify any deterioration in patients' conditions. Patients who became unwell could be moved to a room off the waiting area used by the healthcare assistant where a doctor attended to them.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). When we asked members of staff, they all knew the location of this equipment. When we inspected the equipment it was in working order.

There were robust systems in place to monitor patients waiting to be seen and staff gave us an example of a patient whose health deteriorated and they were seen immediately.

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, hypoglycaemia (low blood glucose), anaphylaxis (a severe allergic reaction), and asthma. Doctors did not carry emergency medication in their bags. The reason for this was they could obtain any drug from the local pharmacy if this was indicated and this had been risk assessed. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk had mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of the telephone company to contact should the telephone system have failed.

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

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Staff we spoke with told us these were discussed at weekly partners' meetings and clinical meetings and templates were changed when needed.

The GPs and nurses used standardised electronic templates to ensure they completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as diabetes, joint injections, minor surgery and contraceptive implants. One GP was a Section 12 approved doctor (this is a doctor who has received extra training to enable them to assess whether patients need to be detained under the Mental Health Act) and also brought this expertise to the practice team.

The practice nurses assumed lead roles in respect of chronic obstructive pulmonary disease (COPD – a lung disease); diabetes and cervical cytology. We saw records which demonstrated they had received appropriate training and guidance in these areas.

All clinical staff we spoke with were open about asking for and providing colleagues with advice and support and they gave us examples of who they would go to with their queries. The practice staff were committed to shared learning within the practice and more widely with local practices so as to improve patient outcomes within the practice and the wider locality.

The practice was performing better than the CCG average in respect of antibiotic prescribing in respect of all antibiotics. They were aware of their prescribing overspend and were looking at strategies to support patients without them resorting to medicines, for example by referral to the pain clinic. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. The practice had developed care plans for 3.2% of patients at high risk of hospital admission and had met their contractual target in this respect. As part of their enhanced contract (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract) they ensured that patients were followed up, though this was reported to be an informal system.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions with the exception of ophthalmology referrals. All GPs we spoke with used national standards for the referral of patients with suspected cancers to be seen within two weeks.

The practice had ways of identifying patients who needed additional support. For example the practice kept registers of the number of patients with a learning disability, dementia and a mental health condition. 84% of patients on the mental health register had received a review in the last year. However, there were 88 patients on the learning disability register and none of these had received an annual physical health check in the last 12 months. The practice manager told us this was due to staff having left the practice and therefore not having appropriately trained staff. The practice reported that 71of the patients on the learning disability register had seen a GP in the last 12 months and that opportunistic checks on general health had been undertaken. The practice has informed us that training on conducting annual health checks has now been completed.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients and leading in clinical areas specified in the quality and outcomes framework (QOF). QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures.

The practice showed us 17 clinical audits which had been undertaken in the last three years. We saw that an audit had been undertaken to try and improve the diagnosis of diabetes in patients with a diagnosis of hypertension. The initial audit in 2013 demonstrated that only 20% of patients with a diagnosis of hypertension had been screened for diabetes. In response to this, the practice introduced testing patients with hypertension for symptoms of diabetes. A re-audit was completed in 2014 and the

Good

Are services effective?

(for example, treatment is effective)

practice was able to demonstrate this screening had increased the diagnosis rate of diabetes significantly as 67% of patients with a diagnosis of hypertension had been found to also have diabetes. One GP undertook minor surgical procedures at the practice and had undertaken comprehensive audits looking at the patient outcomes over the past four years. During this period the GP had carried out 228 minor surgical procedures. The audits had considered infection rates and the number of excisions which had identified a malignant lesion had been removed. The rates of infection following surgery were 0.877% which was significantly lower than the national average of between 1 and 2%. The rate of excisions of lesions which were malignant was 2% which is line with national average. The GP had also been able to demonstrate that by offering the minor surgical procedures on site the practice referral rate to dermatologists had reduced. This resulted in a more local service being provided to patients.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF) and we saw this was the case in the majority of the examples we reviewed.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example 92.5% of patients with a mental health condition had a comprehensive, agreed care plan in place which was better than the national average of 86.1%. The practice demonstrated significant improvements had been made in the care of patients with diabetes. For example, 98.2% had received their annual flu vaccination compared with 76.3% the previous year.

The GPs provided clinical supervision to the nursing staff through appraisal and they reported the GPs were very open and approachable. Staff spoke positively about the culture in the practice around audit and quality improvement. They told us all issues were discussed at clinical meetings and there was a high level of professional engagement.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP and there were flags on the electronic system which prevented GPs from issuing certain prescriptions without them seeing and reviewing the patient. For example controlled drugs which are medicines which require extra checks and special storage arrangements because of their potential for misuse. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

The pharmacist sent out a monthly newsletter updating all clinicians on any changes to medicines guidelines or medicines alerts. The newsletter highlighted any actions which were necessary to ensure patients received appropriate treatment. The staff we spoke with and the evidence we reviewed confirmed that they took action in respect of this guidance. The pharmacist would also do a patient search and identify affected patients to ensure action could be taken as needed.

The practice worked to provide good quality care for patients nearing the end of their life. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. The GPs and nurses worked together with other professionals to ensure care was co-ordinated and that patients were able to end their life in their preferred place.

The practice had conducted an audit which demonstrated that 16 out of 17 patients had died at home in line with their preference in the past twelve months. The practice shared RightCare care plans in respect of patients nearing the end of their life with the out of hours service to ensure co-ordinated care. RightCare is a scheme designed by Derbyshire Health United (DHU) to ensure patient care takes place out of hours, when GP practices are closed.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable or better than other services in the area. For example the data showed the practice was performing better than others in the local area in respect of the number of patients attending A&E.

The GPs held a partners' meeting each week, covering all issues including patients, business issues, complaints and significant events. We saw records of these meetings and

Good

Are services effective?

(for example, treatment is effective)

the issues discussed although detailed minutes were not taken. The clinical staff including health care assistants met every other month to discuss clinical issues across the practice.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending courses such as annual basic life support and fire safety. We noted a good skill mix among the doctors with one having a personal interest in diabetes, one in joint injections and one in minor surgery and contraceptive implants.

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

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses and staff we spoke with told us they had never been refused funding for any training course they requested. For example the healthcare assistants had both undertaken a diploma and received training in phlebotomy and flu vaccinations. Further training was also planned for ear irrigation. Practice nurses had also recently undergone a new, more comprehensive appraisal process designed with the input of the local medical committee (LMC). LMCs are local representative committees of NHS GPs and represent their interests in their localities to the NHS health authorities

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, administration of vaccines, cervical cytology and phlebotomy. Those with extended roles such diabetes care had received appropriate training. The nurse who led in this area had achieved the diploma in diabetes and was formerly a respiratory nurse. At the time of the inspection the practice did not have nursing staff trained to undertake annual health checks for patients with a learning disability but training has now been undertaken.

Working with colleagues and other services

The practice provided a GP service to seven local care homes. Most of the care home staff we spoke to felt they had a very good relationship with the practice. The practice GPs had recently started to undertake monthly visits to the homes to review patients and their medicines.

A community health trust employed care coordinator worked for the practice two days per week and they reported a good relationship with practice staff. Clinical and administrative staff could make referrals to the care coordinator. The care coordinator's role involved acting as a single named contact for patients and carers considered to be at risk of hospital or care home admission. We were told about an example of a patient who did not attend an appointment being referred and assisted to remain at home. The care coordinator held monthly community support team meetings with relevant professionals from the local health services; including a physiotherapist, community matron, district nurse, community psychiatric nurse, assistant practice manager and social services, as well as a GP from the practice. The practice felt that working with the care coordinator saved time and led to a reduced need for appointments. Copies of minutes of these meetings were circulated to relevant staff.

The practice worked with other service providers to meet patients' 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 robust systems to scan all paper communications and allocated these to the appropriate clinician (which was usually the person who requested the test). The clinical and reception staff confirmed these were allocated as tasks and when we looked at the tasks awaiting completion by clinicians we saw they were efficient at reading and responding to these.

The practice was commissioned for the new enhanced service and had a process in place to try and prevent unplanned admissions into hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract).

The practice held multidisciplinary team meetings monthly to discuss the needs of complex patients including those approaching the end of their life. These meetings were attended by palliative care teams, the community matron

(if they were available) and district nurses. The practice used a traffic light system at this meeting to highlight and prioritise patients' needs. This system was used to highlight those most at risk or patients needing high priority services. The records we saw demonstrated good working relationships existed between these professionals and the practice. There was clear evidence of a collective discussion and agreement of a care pathway to support each individual's need.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local community trust. However the system used by the GP out-of-hours provider was not compatible and the practice had systems in place to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

All staff used electronic tasks as a prompt to enable them to ensure all work was completed and actioned appropriately. We looked at the tasks allocated to GPs and saw they were on track with these. Therefore we were assured that this system worked well in practice. The person who ordered any tests reviewed the results. There was also a system in place to enable GPs to cover each other if they were absent which the practice manager told us worked well in practice.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. There was a specific policy in place to guide staff in making decisions where patients may lack capacity.

Feedback from care home staff confirmed that staff had a good understanding of patients lacking capacity in respect of specific areas of their care and treatment. The practice also demonstrated learning from issues regarding consent, with a GP telling us he now carries a consent form when going on home visits to ensure consent is recorded where possible.

RightCare care plans specifically directed staff to complete an assessment of whether a do not attempt cardio pulmonary resuscitation order (DNACPR) should be put in place.

Patients with a mental health condition and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. For example; 79% of patients dementia had received a face to face review in the last year.

All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. We were shown evidence of completed written consent forms. Doctors carried consent forms in their medical bags should they need these on a home visit.

Health promotion and prevention

The practice website had general health and signposting information including a section on common ailments and medications. The practice reception had a wide range of information regarding various health conditions and healthy living.

New patients completed a health questionnaire when they registered with the practice. If any new patients were

Good

Are services effective?

(for example, treatment is effective)

receiving repeat prescriptions they automatically received an appointment and a health check. All other patients were invited to take up an annual health check as needed. The GPs used their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, the GP who provided contraceptive implants also offered opportunistic chlamydia screening to patients aged 18 to 25 years and signposted them to a local sexual health clinic.

The healthcare assistants had responsibility for running lifestyle advice clinics which included education about diet and exercise. They told us they also made referrals for patients to join gyms. Patients at the practice with a new diagnosis of diabetes were referred to the "Diabetes and You," sessions which were available locally. Diabetes and You is a group education programme for people with Type 2 diabetes.

All clinical staff told us they used their contacts with patients to help maintain or improve mental, physical health and wellbeing. Staff told us they discussed promoting a healthy lifestyle with patients when they carried out reviews for patients with long term conditions.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. The practice told us that 77 health checks have been performed since the beginning of the year.

The practice had also identified the smoking status of patients where possible and 44% of patients who smoked had been given smoking cessation advice in the last year. The practice's performance for cervical smear uptake was 82.9%, which was better than the national average of 80%. There was a policy to send a letter out to patients who did not attend for cervical screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG, and again there was a clear policy for following up non-attenders by the named practice nurse.

Good

Are services caring?

Our findings

espect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey from July 2014. Questionnaires were sent to 305 patients and 124 people responded. This was a 41% response rate. We also considered a survey of patients undertaken by the practice's patient participation group (PPG). The patient participation group are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them.

The evidence from these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed that 94% of respondents said the last GP they saw or spoke to was good at explaining tests and treatments. The survey showed that 96% of respondents felt that the doctor was good at listening to them and gave them enough time. Both of these results were above the local Clinical Commissioning Group (CCG) averages. Eighty-five percent of patients rated their overall experience of using the practice as good. Seventy-four percent of respondents said the last nurse they saw or spoke to was good at involving them in decisions about their care which was below the local CCG average of 86%.

We received comment cards from patients to tell us what they thought about the practice. The 17 completed cards were all positive about the service they experienced. Patients said they felt the practice offered an excellent service and commented that the staff were professional, helpful and understanding. We also spoke with eight patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

We spoke with staff from all five of the care homes served by the practice. They told us the practice staff treated their patients with dignity and respect and said that the GPs took time with the patients.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The telephone was located away from the reception desk and was shielded by glass partitions which helped keep patient information private.

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

New mothers were offered early appointments for their eight week health check to avoid them having to wait in a crowded room. The practice staff were also aware of patients who had visual impairment and would collect them in person for their appointments. The practice had an electronic board announcing appointments.

Staff took the circumstances of people who may be vulnerable into consideration when they were waiting for appointments. For example, a patient with autism waited in a room off reception rather than in the main waiting area.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 94% of respondents said the last GP they saw was good at explaining tests and treatment and this was above the CCG average. 88% of practice respondents said the GP involved them in care decisions.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Good

Are services caring?

The GPs and nurses told us that the practice developed RightCare comprehensive care plans for patients at risk of unplanned admission, those on the palliative care register and those with long term conditions. RightCare is a scheme designed by Derbyshire Health United (DHU) to ensure patient care takes place out of hours, when GP practices are closed. Care plans we reviewed were clear and comprehensive. The practice had completed 3.2% of these plans and this was in line with national guidelines. The GPs showed us the system they had in place to flag when reviews of these plans were due.

Staff told us that English was the first language for the majority of patients registered at the practice. Staff told us they had access to language line to help with consultations with patients where English wasn't their first language.

The practice held regular multidisciplinary meetings to discuss patients on the palliative care register. We saw comprehensive minutes of these meetings, including evidence of discussions and reviews of patient deaths. Of those patients who had expressed a preference to die at home, a recent audit had showed 16 out of 17 of these patients died at home.

Patient/carer support to cope emotionally with care and treatment

The national patient survey information we reviewed showed patients were positive about the emotional support provided by the practice. For example, 93% of patients surveyed said that the last GP they saw or spoke with was good at treating them with care and concern with a score of 84% for nurses. The majority of patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information.

Leaflets and posters in the patient waiting room told people how to access a number of support groups and organisations. The practice's computer system alerted staff if a patient was also a carer. The practice recognised the importance of maintaining a carer's health to enable them to continue to provide care and support to the people they provided cared for. The practice also had a carers' champion and had displayed a notice asking carers to identify themselves. The healthcare assistants also sought to identify carers and record this on the computer system.

Patients we spoke with told us the practice communicated with them well as carers and considered their needs. We received 17 completed patient comment cards which were all positive. These all highlighted that practice staff were kind, patient, caring and listened to them.

The GPs were aware of the need to support patients who had recently been bereaved and told us about their learning from an incident involving a bereaved patient. GPs told us they made contact with bereaved patients by telephone and this call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to access support services. A patient we spoke with told us about the support they received after the death of their parents, including telephone contact from the GP and signposting to support groups.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The practice offered a range of enhanced services, for example minor surgery, implant fitting and warfarin management. The practice also provided a range of clinics for the management of long term conditions, such as asthma, chronic obstructive airways disease (COPD), heart disease and diabetes. The nurses did not run set times for clinics and devised these around the needs of the patient population. This was especially helpful for working patients who constituted the majority of the patient population.

The needs of the practice population were understood and systems were in place to address identified needs. As part of an enhanced service the practice had identified patients most at risk of unplanned admissions and had developed individual care plans for patients. The practice pharmacist also undertook medication reviews to ensure patients were taking the correct medication.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices in the local area to discuss local needs and service improvements that needed to be prioritised. There was an open culture and a willingness to share learning with other practices. For example, learning from complaints and significant events was shared at practice manager meetings. The practice told us about sharing details of the learning from a significant event involving a contraindicated vaccination at a recent practice managers' meeting to avoid other practices making the same error.

The practice had adapted their services in response to the patient demographic, for example they offered on line services, text messaging and communicated with patients using social media to reach their working age patients. The practice had realised that they needed to improve their monitoring of patients with diabetes and had taken proactive action to address this. As a result they had improved the number of patients receiving foot examinations from 70% to 92.4%.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example improving the practice telephone services and installing a new door. The PPG also identified three areas for improvement which the practice had acted upon:

- Improving electronic prescribing
- Reduction in waiting times – through the introduction of 'sit and wait' surgery and catch up time being built in appointment schedules
- Improved online access for patients.

We spoke with representatives from five local care homes. The majority told us they worked in partnership with the practice to meet the needs of the patients and spoke highly of the GPs. They told us the practice was very responsive and the GPs always visited on request. They said that the GPs involved the patients and families in decision making about care and treatment.

The GPs told us they had started to use a text messaging system to communicate blood test results when these were normal, meaning people found out the their results sooner and did not have to telephone the practice during the working day.

Tackling inequity and promoting equality

The practice covered the first and second floors of the building, with all of the services for patients being provided on the ground floor to facilitate access. We observed that space within the practice, including the waiting areas, was limited. The GP partners recognised the practice premises had limitations and had plans in place to address this by securing new and more appropriate facilities nearby which would allow for expansion to meet the increasing patient demand for services. The practice told us that the move was being planned for November 2016. The PPG told us that, in response to feedback from them, the practice had fitted a new entrance door to the surgery. This improved access for parents with prams and for those using wheelchairs.

The majority of the practice population was made up of English speaking patients though it could cater for other different languages through translation services, available via telephone and online. Staff told us they were aware of how to access this service but had not had experience of using it. The practice had a nurse who could communicate using sign language if required. The practice website directed deaf patients to use the text phone or text line.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice had a system in place for flagging vulnerable patients through their individual records. The practice had arrangements in place to enable patients to register with the practice easily, for example they recently registered a new patient who had no fixed abode.

Access to the service

The practice opened from 8:00am to 6:30pm on weekdays. Appointments with doctors were available from 8:00am to 12:00pm and 3:00pm to 6:00pm. Appointment lines were open from 8:00am to 1:00pm and 2:00pm to 6:30pm. The practice offered same day appointments, pre-bookable appointments and telephone consultations.

The practice offered appointments with GPs in situations of medical emergency and would give an appointment with the nurse if no GP was available. Appointments could be booked via the telephone, online and in person. GPs told us they had started a recent pilot where 8:00am appointment slots are offered. They reported that this had been popular with patients.

Comprehensive information was available to patients about appointments on the practice website and in the practice leaflet. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. The website provided guidance as to the type of information NHS 111 service would need. During lunch times a recorded message informed the caller that the surgery was closed but offered a mobile number to contact a doctor should the situation be urgent.

The practice offered ten minute appointments and advised patients to book a longer appointment if needed. The reception staff automatically booked longer appointments for certain patients as needed. Home visits were made to five local care homes as requested by care home staff. Care home staff reported that GPs always attended without question, in a timely manner. The practice had recently implemented a system whereby there were undertaking monthly visits to each of the care homes where patients were registered.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had generally been able to make appointments on the same day of contacting the practice. Patients we spoke with felt that access to appointments had greatly improved. For example, one patient said it was now relatively easy to get an appointment.90% of patients were able to get an appointment to see of speak to someone the last time they tried which was better than the CCG average (87%) and the national average (85%).

The practice had provided sit and wait sessions for patients to try and respond to emerging need. Patients were invited to attend the practice at staggered times after morning surgery, appointments were limited to five minutes and patients would be seen by the next available doctor. The practice had introduced flexible nurse clinics to provide services at convenient times. The practice also worked with a care coordinator and as a result their admissions to A&E were lower than other local practices.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system including a patient leaflet and links to the forms on the website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at 15 complaints received in the last 12 months and found these were responded to in a timely way and were fully investigated.

The records we saw and comments from staff assured us that the practice responded positively to complaints and had an open and transparent approach when responding to these. For example, two complaints received impacted on patient care and the practice had also undertaken a significant event analysis on those incidents and made changes to practice as a result of their findings.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The GP partners told us the practice reviewed complaints annually to detect themes or trends and the findings and lessons learned were discussed as a whole practice team. We saw records which confirmed this and showed learning was shared with the whole practice team. We looked at the report for the last review of complaints and no themes had been identified, although the practice themselves identified that there had been an increase in complaints within the past year.

Staff we spoke with were aware of the complaints process and how to support patients to make a complaint.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's future plan. The aims of the practice were outlined in the statement of purpose. These included providing personalised care, working in partnership with their patients and professionals, and taking care of their staff. It was clear when speaking with the GPs and the practice staff that they shared these aims and were committed to providing high quality care. Patients commented that they felt they received personalised care and support, and were involved in their care.

The partners had communicated their future plans with all members of the staff team and shared their vision for the relocation and expansion of the practice. Staff we spoke with were engaged with the practice plans for the future.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the intranet and hard copy. Staff we spoke with knew where the policies were located. Some of the policies and procedures we reviewed had a completed cover sheet to confirm that they had been read and when. Some of the policies we reviewed had issue dates but did not have dates for review. The practice had arrangements for recording and managing risks and a system for the management of complaints.

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 child safeguarding and a GP partner was the lead for adult safeguarding. Members of staff we spoke with were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns. Staff told us that the GPs had an open door policy and that they would not hesitate to speak to them.

The practice held a weekly partners' meeting also attended by practice management. We looked at the minutes which covered significant events, compliments and complaints, patient participation group (PPG) input, staffing issues and follow up clinics. The minutes were not specific on actions but there was evidence that things were followed up and decisions were highlighted. The PPG are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them.

Clinical meetings were held monthly and attended by GPs, practice nurses and healthcare assistants, as well as practice management. The practice did not hold frequent whole practice meetings due to staffing but did hold annual meetings to discuss complaints and significant events with all staff.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. The practice had taken action to improve their performance as a result of QOF from the previous year. For example, they had implemented a new recall system for patients with diabetes which they had now rolled out across other chronic conditions.

Monthly locality meetings were attended by the practice manager and a GP. These involved six local practices and afforded the practice with an opportunity to share learning and best practice. This also provided the practice with the opportunity to measure its service against others and identify areas for improvement. For example, the practice shared learning from a significant event regarding a vaccination at a recent meeting.

The practice had arrangements for identifying, recording and managing risks. The practice had a number of risk assessments, which addressed a wide range of potential issues, such as lone working.

The practice did not hold regular governance meetings although performance, quality and risk was discussed at partners' meetings regularly.

Leadership, openness and transparency

All staff we spoke with told us there was a culture of openness within the practice. Staff we spoke with told us that the GPs and the practice management were friendly and approachable. The healthcare assistants and practice nurses told us they felt able to approach any of the GPs for advice or support at any time of the day.

Are services well-led?

Good

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

There was a culture of learning within the practice, with staff having regular appraisals and access to a range of training. The practice had also recently taken on an apprentice within the administration team as a permanent member of staff following the end of their apprenticeship.

The PPG told us the practice were open and honest with them about challenges they faced and shared learning from complaints and significant events where appropriate.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had an active PPG, with 18 members. The PPG had carried out an annual survey for the last three years and identified priority areas for the practice. The practice made changes as a result of all the identified priorities. The results of the survey and the priority areas had been made available on the practice website. In addition to the changes made as a result of the priorities identified in the survey, the PPG told us how they had been involved in other areas of improvement outside of the annual survey. For example, they were involved in getting a new door fitted to the practice to improve access.

The practice demonstrated that it had a robust system for dealing with complaints from patients and had implemented learning from these.

Staff told us they felt confident to raise issues and make suggestions for improvements. They told us they would do this informally, through management or in a meeting.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff had regular appraisals and personal development was discussed during these. GPs told us they attended educational meetings.

The practice told us that they plan to become a training practice for doctors who are training to become qualified GPs. Two of the GPs partners are GP trainers. The practice currently has a medical student on placement.

The practice completed reviews of significant events and other incidents and shared these with staff at meetings to ensure the practice improved outcomes for patients. The practice also shared learning within the locality.