Davenal House Surgery Partnership

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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Davenal House Surgery Partnership on 25 November 2014. The practice also has a branch surgery at Stoke Prior which we did not inspect on this occasion. We found Davenal House Surgery Partnership provided a good service to patients in all of the five key areas we looked at. This applied to patients across all age ranges and to patients with varied needs due to their health or social circumstances.

Our key findings were as follows:

- The practice had comprehensive systems for monitoring and maintaining the safety of the practice and the care and treatment they provided to their patients
- The practice was proactive in helping people with long term conditions to manage their health and had arrangements in place to make sure their health was monitored regularly
- The practice was clean and hygienic and had robust arrangements for reducing the risks from healthcare associated infections
- Patients felt that they were treated with dignity and respect. They felt that their GP listened to them and treated them as individuals
- The practice had a well-established and well trained team and had expertise and experience in a wide range of health conditions

We also found the following area of outstanding practice:

- The practice introduced a Friday morning 'drop in' session for babies and children. This was targeted at parents who were not sure if they needed a GP appointment for their child. Appointments were not needed and a GP, practice nurse and health visitor were available.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice provided opportunities for the staff team to learn from significant events and was committed to providing a safe service. Information about safety was recorded, monitored, appropriately reviewed and addressed. The practice assessed risks to patients and managed these well. There were enough staff to keep people safe.

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. Patients' care and treatment took account of guidelines issued by the National Institute for Care and Health Excellence (NICE). Patients' needs were assessed and care was planned and delivered in line with current legislation. The practice was proactive in the care and treatment provided for patients with long term conditions and regularly audited areas of clinical practice. There was evidence that the practice worked in partnership with other health professionals. Staff received training appropriate to their roles and the practice supported and encouraged their continued learning and development.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients told us they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We saw that staff treated patients with kindness and respect and were aware of the importance of confidentiality. The practice provided advice, support and information to patients, particularly those with long term conditions, and to families following bereavement.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice was aware of the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice and said that urgent appointments were available the same day. The practice had good facilities and was well equipped to treat

Summary of findings

patients and meet their needs. There was a clear complaints system with evidence demonstrating that the practice responded quickly to issues raised. The practice had a positive approach to using complaints and concerns to improve the quality of the service.

Are services well-led?

Good

The practice is rated as good for providing well-led services. The practice had an open and supportive leadership and a clear vision to continue to improve the service they provided. There was a clear leadership structure and staff felt supported by management. The practice had well organised management systems and met regularly with staff to review all aspects of the delivery of care and the management of the practice. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this was acted upon. The practice had a patient participation group (PPG). The purpose of the PPG was to act as an advocate on behalf of patients when they wished to raise issues and to comment on the overall quality of the service. There was evidence that the practice had a culture of learning, development and improvement.

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 patients. Patients over the age of 75 had a named GP and were included on the practice's 'avoiding unplanned admissions' list to alert the team to patients who may be more vulnerable. The GPs carried out visits to patients' homes if they were unable to travel to the practice for appointments. The practice was in the process of delivering its 'flu vaccination programme. The practice nurse was arranging to do these at patients' homes if their health prevented them from attending the clinics at the surgery. The practice worked with five local care homes to provide a responsive service to the patients who lived there. A GP is responsible for regularly visiting and providing continuity of care for patients in these homes including regular review and planning.

People with long term conditions

Good

This practice is rated as good for the care of patients with long term conditions, for example asthma and diabetes. The practice had effective arrangements for making sure that patients with long term conditions were invited to the practice for annual and half yearly reviews of their health. Members of the GP and nursing team at the practice ran these clinics.

Patients whose health prevented them from being able to attend the surgery received the same service from one of the practice nurses as home visits were arranged. This included patients in the five care homes the practice supports. Patients told us they were seen regularly to help them manage their health.

Families, children and young people

Good

This practice is rated as good for the care of families, children and young people. The practice held weekly childhood vaccination clinics and offered a weekly 'drop in' session for babies and children which did not require an appointment. Child flu vaccinations were also provided. Staff told us that ante natal and post natal appointments for mothers were usually done by the female GPs. The practice provided a family planning service which was open to patients from other practices.

Working age people (including those recently retired and students)

Good

This practice is rated as good for the care of working age patients, recently retired people and students. The practice was open every week day until 6.30pm, and from 7.30am and until 7.30pm on

Summary of findings

Thursdays for patients unable to visit the practice during the day. There was a Saturday morning clinic approximately two Saturdays every month. The frequency of this varied according to demand. The practice also had arrangements for patients to have telephone consultations with a GP.

People whose circumstances may make them vulnerable

Good

This practice is rated as good for the care of patients living in vulnerable circumstances. One of the GPs was the lead for learning disability (LD) care at the practice and the practice had an LD register. All patients with learning disabilities were invited to attend for an annual health check. Staff told us that the practice did not have many travelling individuals or families currently registered at the practice. We learned that when homeless people came to the practice the team provided appropriate care and treatment and supported them with establishing a correspondence address if possible.

People experiencing poor mental health (including people with dementia)

Good

This practice is rated as good for the care of patients experiencing poor mental health (including people with dementia). The practice employed a mental health worker, had a register of patients at the practice with mental health support and care needs and invited them for annual health checks. Staff described close working relationships with the local mental health team which worked with the practice to identify patients' needs and to provide patients with counselling, support and information.

Summary of findings

What people who use the service say

We gathered the views of patients from the practice by looking at 26 CQC comment cards patients had filled in and by speaking in person with seven patients, one of whom was involved with the Patient Participation Group (PPG). Many patients who gave us their views had been patients at the practice for many years and their comments reflected this long term experience. Data available from the NHS England GP patient survey showed that the practice scored in the middle range nationally for satisfaction with the practice.

All patients were positive about their experience of being patients at Davenal House Surgery Partnership. They told us that they were treated with respect and the GPs, nurses and other staff were kind, sensitive and helpful. Several patients expressed appreciation for the service they had received, some in particularly difficult circumstances. All seven patients we spoke with on the day of our inspection confirmed they were always able to obtain same day appointments when needed.

Outstanding practice

- The practice introduced a Friday morning 'drop in' session for babies and children. This was targeted at parents who were not sure if they needed a GP appointment for their child. A GP, practice nurse and health visitor were available.

Davenal House Surgery Partnership

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector. The inspection team also included two specialist advisors - a GP and a practice manager.

Background to Davenal House Surgery Partnership

Davenal House Surgery Partnership provides primary care services for patients in Bromsgrove and the surrounding area. It has a GMS (General Medical Services) contract with NHS England. The service is responsible for providing primary care for 9,057 patients. It is located in a semi-rural area with a large elderly population.

The practice also provides inpatient care at the local Princess of Wales Community Hospital. As part of this, regular ward rounds and daily care is provided as required at the hospital.

The practice has six GP partners (two male and four female), three salaried GPs (all male), a practice manager, a nurse manager, two practice nurses, a healthcare assistant, along with receptionists and other staff who provide administrative support. Additionally, the practice was also a training practice for doctors.

The practice does not provide an out of hours service to their own patients. Patients are provided with information about the local out of hours service which they can access by using the NHS 111 phone number.

Services are provided from Davenal House Surgery Partnership, 28 Birmingham Rd, Bromsgrove. There is a branch surgery at Stoke Prior which has a dispensary. Patients are free to book appointments at either practice. We did not visit the branch surgery.

The Care Quality Commission (CQC) has had no previous concerns about the practice.

Davenal House Surgery Partnership provides a range of NHS services including blood testing, chiropody, physiotherapy and anti-coagulant testing. Bereavement and mental health counselling sessions are also held there.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

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 CQC at that time.

Detailed findings

How we carried out this inspection

Before this inspection, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. These organisations included Redditch and Bromsgrove Clinical Commissioning Group (CCG), NHS England local area team and Healthwatch. We carried out an announced visit on 25 November 2014. During the inspection we spoke with a range of staff (GPs, nurses, practice manager, reception and administrative staff). We spoke with seven patients who used the service, one of whom was a member of the Patient Participation Group (PPG).

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)

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke to were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, following confusion with a patient's medication following discharge from hospital, discharge summaries were double checked to ensure similar errors were not repeated.

We reviewed safety records, incident reports and minutes of meetings where these had been discussed for the last two years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term. We were shown records that demonstrated information gained from clinical audits and health and safety audits was assessed with patient safety in mind. For example, since the practice introduced telephone consultations, there had been an improvement in the time taken for patients to be referred for secondary care services, such as consultants.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last five years and we were able to review these.

Significant events were a standing item on the practice meeting agenda and discussed at the weekly clinical meetings. An annual review was held to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. We were shown how the practice had discussed an increase in the number of emergency admissions to hospital of patients who were resident in the five care homes it provided medical cover for. The practice organised meetings with the care home management and introduced procedures for the care homes to initially contact the practice in non-emergency cases. This had resulted in the number of emergency admissions to hospital being significantly reduced.

We were shown the system used to manage and monitor incidents. We tracked four incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result of an incorrect medication having been dispensed by a local pharmacy for a patient diagnosed with rheumatoid arthritis. Following this, the practice reviewed all blood test results and medications for all patients with this medical condition to ensure no other patients had been affected. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. For example, changes to the use of aspirin for patients at risk of a stroke. Staff also told us alerts were discussed during meetings held for clinical staff to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were 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.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. We were shown training certificates to demonstrate this. All staff we spoke to were aware who the leads were and who to speak to in the practice if they had a safeguarding concern.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. All nursing staff and health care assistants had been trained to be a chaperone.

Good

Are services safe?

Systems were in place to identify potential areas of concern. For example, to identify children and young people with a high number of accident and emergency attendances and the follow up of children who persistently failed to attend appointments such as for childhood immunisations.

The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the local authority.

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.

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

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic prescribing within the practice.

We saw there were Patient Group Directives (PGD) in place to support the nursing staff in the administration of vaccines. A PGD is a written instruction from a qualified and registered prescriber, such as a doctor, for a nurse or appropriately trained person to administer a medicine to groups of patients without individual prescriptions. We saw the PGDs had been signed by all the nurses who administered the vaccines and authorised by a manager. This meant that staff and managers were informed of any changes to the PGD. There was also a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. No stocks of controlled drugs were held.

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.

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.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy 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 during April 2014 and annually in previous years. Any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed. The most recent infection control audit had identified upholstery damage to some of the waiting room seating. We saw evidence this had been promptly repaired.

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. They included the safe use and disposal of sharps; use of personal protective equipment (PPE); spills of blood and bodily fluid amongst others.

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

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). 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.

There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We saw evidence that their disposal was arranged through a suitable company. The practice employed contract cleaners and their own cleaner for general cleaning of the practice. We were shown the cleaning schedules and checklists for this and saw there was a regular audit of cleaning undertaken.

Good

Are services safe?

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales.

Staffing & Recruitment

We were shown how the practice ensured there were sufficient numbers of suitably qualified, skilled and experienced staff on duty each day. There was a staff rota throughout the week and always a member of clinical staff on duty. Some administrative staff were part time, so staff cover was also available if a staff member was unexpectedly absent.

We saw how the practice had monitored their workforce and reviewed their workforce requirements to ensure sufficient staff were available to meet the needs of the population they served. Management confirmed they had sufficient staff on duty throughout the week. At the time of our inspection, the practice had advertised for a clinical services manager to work alongside the practice manager to provide closer supervision of clinical roles and enable the practice manager to focus on other duties.

We looked to see what guidance was in place for staff about expected and unexpected changing circumstances in respect of staffing. We saw a selection of policies and procedures in place, for example, staff sickness, and planned absences. We saw how the practice would ensure staff absence was managed in a fair and consistent way to ensure the impact on the practice was minimised.

We saw how if a shortfall of doctors ever occurred, for example, as a result of sickness, locum doctors could be used. We were shown the business continuity plan which had been adopted by the practice which advised what to do should there be an shortage of GPs and practice staff. This would help to ensure sufficient availability of doctors to continue the primary care service provision to patients.

The practice had a comprehensive and up-to-date recruitment policy in place which included a full skills assessment. The policy detailed all the pre-employment checks to be undertaken on a successful applicant before that person could start work in the service. This included identification, references and a criminal record check with the Disclosure and Barring Service (DBS). When DBS checks were not required, for example, for administrative staff who did not work alone with patients, a risk assessment had been carried out. We looked at a sample of recruitment files for doctors, administrative staff and nurses. They demonstrated that the recruitment procedure had been followed. All staff were made aware of practice policies and where to locate them.

Additionally, the practice was also a training practice for doctors.

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 annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative who had received appropriate training for the role.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed during staff meetings.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example there were emergency processes in place for patients with long-term conditions, such as asthma and diabetes.

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 all knew the location of this equipment and records confirmed that it was checked regularly. The notes of the practice's significant event meetings showed that staff had discussed a medical emergency concerning a patient and the practice had learned from this appropriately.

Good

Are services safe?

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 and anaphylaxis (an allergic reaction). 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 was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, including flooding, unplanned sickness and access to the building. The practice had carried out a fire risk assessment that included actions required to maintain fire safety.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

Patients' needs were assessed and care and treatment was planned and delivered in line with their individual wishes. All patients we spoke with were very happy with the care they received and any follow-up needed once they obtained an appointment.

Clinical staff managed the care and treatment of patients with long term conditions, such as diabetes, asthma and hypertension (high blood pressure). We found there were appropriate systems in place to ensure patients with long term conditions were seen on a regular basis.

Patients who required palliative care (care for the terminally ill and their families) were regularly reviewed. Their details were passed to the out of hours practice each weekend to ensure care would continue when the practice was closed.

Staff showed us how they used the National Institute for Health and Care Excellence (NICE) templates for processes involving diagnosis and treatments of illnesses. NICE guidance supported the surgery to ensure the care they provided was based on latest evidence and of the best possible quality. Patients received up to date tests and treatments for their disorders. We saw records of meetings that demonstrated revised guidelines were identified and staff trained appropriately.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. Examples of completed clinical audits included stroke diagnosis and treatment before and after the introduction of revised clinical guidelines. Another example was the diagnosis of patients with cancer. The completed audit demonstrated patient referral times to hospital had been reduced by 60% and now averaged nine days, compared with 23.6 days two years ago. Dates had been set to repeat these audits to continue to determine their effectiveness. We found other monitoring the practice had carried out included chronic conditions. Some of this monitoring was carried out as part of the Quality and Outcomes Framework (QOF). This is an annual incentive programme designed to reward doctors for implementing good practice. The practice demonstrated they were meeting the expected targets and were performing well against other practices within the Clinical Commissioning Group (CCG).

The practice was able to identify and take appropriate action on areas of concern. For example, a high number of babies and children had attended the out of hours service and accident and emergency at weekends. At a result, the practice introduced a Friday morning 'drop in' session for babies and children. A GP, practice nurse and health visitor were available. This was targeted at parents who were not sure if they needed a GP appointment for their child. These clinics had been very well attended and the numbers of babies and children who attended the out of hours service and accident and emergency had now reduced by over 50% over the last 18 months.

We also saw evidence that the practice manager attended peer group meetings with other practice managers to identify and discuss best practice. We saw learning was shared in an appropriate way and recorded in the meeting minutes.

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. All GPs were up to date with their yearly continuing professional development requirements and all either 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 NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

All staff had annual appraisals that 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. For example, one receptionist had recently trained and qualified as a Healthcare Assistant and intended to commence their new role at the start of 2015.

As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support.

Good

Are services effective?

(for example, treatment is effective)

Practice nurses were expected to perform defined duties which were outlined in their job description and were able to demonstrate that they were trained to fulfil these duties. For example, administration of vaccines. We were shown certificates to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. 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 a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries that were not followed up appropriately. Any concerns were raised in clinical staff meetings.

The practice held regular multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented. Clinical staff met weekly and the GP partners met every month outside of practice opening times. We saw evidence that clinical updates, difficult cases, significant events and emergency admissions to hospital were discussed and actions identified.

We saw records that confirmed the practice worked closely with the community midwife service, health visitors, community mental health professionals and community drug teams. Clinics were held for blood testing, dermatology, and anti-coagulant testing to which patients were referred.

Within the waiting room there was a large range of information leaflets about local services. Some of this information was available in other languages on request.

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. Electronic systems were also in place for making referrals. For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E.

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. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

There were mechanisms to seek, record and review consent decisions. We saw there were consent forms for patients to sign agreeing to minor surgery procedures. We saw that the need for the surgery and the risks involved had been clearly explained to patients. We also saw evidence audits of minor surgery were also carried out.

We saw signed consent forms for children who had received immunisations. The practice nurse was aware of the need for parental consent and what action to follow if a parent was unavailable. There was information available for parents informing them of potential side effects of the immunisations. The GPs and nurses that we spoke with demonstrated a clear understanding of the importance of determining if a child was Gillick competent especially when providing contraceptive advice and treatment. A Gillick competent child is a child under 16 who has the legal capacity to consent to care and treatment. They are capable of understanding the implications of the proposed treatment, including the risks and alternative options. The practice had access to interpreting services to ensure patients understood procedures if their first language was not English.

Staff we spoke with had an understanding of the Mental Capacity Act 2005 and demonstrated knowledge regarding best interest decisions for patients who lacked capacity. Mental capacity is the ability to make an informed decision

Good

Are services effective?

(for example, treatment is effective)

based on understanding a given situation, the options available and the consequences of the decision. People may lose the capacity to make some decisions through illness or disability.

Health Promotion & Prevention

We saw all new patients were offered a consultation with the practice nurse when they first registered with the practice. If any medical concerns were found, the patient was referred to the GP or another healthcare professional if more appropriate. The practice's performance for cervical smear uptake was similar to others in the Clinical Commissioning Group (CCG) area.

We were shown work the practice had carried out to identify and promote particular health needs within the area. For example, the introduction of the weekly 'drop in' session for babies and children and smoking cessation advice was given.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

All patients we spoke with were very happy with the care they received and any follow-up needed once they obtained an appointment. All patients felt they were consistently treated with dignity and respect by all members of staff. During our inspection we observed, within the reception area, how staff interacted with patients, both in person and over the telephone. Staff were helpful and empathetic, warm and understanding towards patients. Staff we spoke with told us patient care was at the centre of everything they did and their behaviours displayed this at all times.

In December 2013, 250 patients completed a patient survey, issued by the practice. Of those patients who responded, 90% of patients said they found staff at the practice very friendly and helpful. This sample represented 2.75% of the patient list.

We saw that patients' privacy and dignity was respected by staff during examinations. We saw curtains could be drawn around treatment couches in consultation rooms. This would ensure patients' privacy and dignity in the event of anyone else entering the room during treatment.

Care planning and involvement in decisions about care and treatment

We looked at patient choice and involvement. Staff explained how patients were informed before their treatment started and how they determined what support was required for patients' individual needs. Clinical staff told us they discussed any proposed changes to a patient's treatment or medication with them. They described treating patients with consideration and respect and said they kept patients fully informed during their consultations and subsequent investigations. Patients we spoke with confirmed this. Patients had the information and support available to them to enable them to make an informed decision about their care and treatment needs.

Patients told us that their GP listened to them and gave us examples of advice, care and treatment they had received. A number of people confirmed their GP or nurse gave them information, fully discussed their health needs and explained the 'pros and cons' of the options available to them. Some patients indicated that they had long term health conditions and said that they were seen regularly.

GPs recognised the importance of patients understanding their care and treatment needs and gave examples of situations where they had done their best to give patients clear information.

Patient/carer support to cope emotionally with care and treatment

Some of the information we received was from patients who were also carers. In these cases patients described the support and compassion they and their relative had received from the team at the practice. Other patients also described feeling well supported emotionally by the practice.

After bereavement, the practice contacted families to check their well-being and to offer the opportunity to speak with a member of the team. Information was provided about organisations specialising in providing bereavement support.

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 people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, the practice had a register of patients with mental health support and care needs. Each person on the register was invited for an annual review. Staff explained that they had good working relationships with the local mental health team.

The practice planned its services carefully to meet the demand of the local population. We saw minutes of meetings that demonstrated weekly meetings were held to discuss capacity and demand. As a result of this, changes were made to staffing and clinic times when required. Services were also reviewed in the wider context of the local health economy. Review meetings were held with the Clinical Commissioning Group (CCG) and a GP attended these.

The practice provided general practice cover to people living in five local care homes. We spoke with the management at four of these care homes about the service people received from Davenal House Surgery Partnership. All four were positive about the service. They told us that a GP did a routine weekly visit to the homes as well as visits on other days as needed. We were told it was usually the same GP who visited and that this provided welcome continuity. They told us that the GPs were polite, respectful and kind to their patients and listened to them. Care home management confirmed the GPs worked with them and had held meetings with them to review each person's medicines.

The practice had an established Patient Participation Group (PPG) in place. The purpose of the PPG was to act as an advocate on behalf of patients when they wished to raise issues and to comment on the overall quality of the service. This ensured that patients' views were included in the design and delivery of the service. We saw how the PPG played an active role and was a key part of the organisation. Regular meetings were held. We saw how the PPG had been involved with promoting on-line services.

Tackling inequity and promoting equality

Most patients who used Davenal House Surgery Partnership spoke English as their primary language. However, staff explained the telephone interpreting service they used for patients who were unable to converse with ease in English. The system was easy to use and accessible and the reception staff who showed it to us was knowledgeable about how to use it. We noted that information leaflets in the practice were only available in English. However, GPs also had the facility to print up to date NHS patient information leaflets during consultations with patients and it was possible to select other languages for this.

The practice had an induction loop to assist people who used hearing aids and staff could also take patients into a quieter private room to aid the discussion if required. The practice was fully wheelchair accessible.

Access to the service

The practice opened from 8.30am to 6.30pm every weekday. In addition, there were extended opening hours from 7.30-8.00am and until 7.30pm on Thursdays. The practice also had appointments on approximately two Saturday mornings every month. These were arranged according to patient demand. Outside of these times and during the weekend, an out of hours service was provided by another organisation. Patients were advised to telephone the NHS 111 service. This ensured patients had access to medical advice outside of the practice's opening hours.

Appointments could be booked for the same day, for within two weeks time or further ahead. For patients who had an urgent medical condition that could not wait until the next routine appointment, the practice added additional appointments to the end of each surgery slot. Patients could order repeat prescriptions through an on-line service. Home visits were available for patients who were unable to go to the practice.

In March 2014, 250 patients completed a short questionnaire, issued by the practice. Of those patients who responded, 90% said overall the practice was good or very good. 86% said the practice opening times were convenient. This sample represented 2.75% of the patient list.

As part of the national patient survey undertaken for NHS England in October 2014, responses had been received

Good

Are services responsive to people's needs?

(for example, to feedback?)

from 117 patients. This represented 1.3% of the patient list. 68% of patients said they were satisfied with the treatment they had received from a GP at the practice. However, an additional 14% of those who responded said the question did not apply to them as they had not attended the practice within the last six months.

GPs and the practice manager expressed concerns about the quality of the data received following the national patient survey. The previous one had been carried out in September 2013. Of the 124 patients who responded (1.36% of the patient list), 40% had not visited the practice for over six months. During this time, considerable improvements had been made to the appointment system. Staff felt the data was unreliable as a result and had carried out their own patient survey to demonstrate this.

The information from CQC comment cards and patients we spoke with indicated that the service was generally accessible and that patients were able to get an appointment on the same day they phoned if this was needed.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. The 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 were shown how patients' concerns were listened to and acted upon. There was information about how to complain displayed in the waiting area and within the patient information pack. All of the patients we spoke with said they had never had to raise a formal complaint. The complaints procedure identified how complaints would be dealt with. It also identified the timescales for responding to and dealing with complaints. The practice had a complaints summary which summarised the complaints for each year. This was used to identify any trends. Details of the complaints procedure were displayed in the waiting room and within the patient information pack.

We looked to see whether the practice adhered to its complaints policy and we reviewed two patient complaints in detail. We found that the complaints had been dealt with appropriately and within the timescales set out in the practice's complaints policy. One complaint related to practice opening times. The patient had been unaware of the extended opening hours. The other complaint reviewed related to a patient not having been telephoned when promised. As a result of this, the practice issued staff with new guidelines to ensure all calls were recorded as completed at the end of each surgery.

It was also clear that verbal complaints were dealt with in the same way as written complaints. If a patient telephoned the practice to complain, the practice manager would immediately take the call if available.

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 aimed to provide 'monitored, audited and continually improving healthcare services'. This was referred to on the practice website, in literature produced by the practice and by staff during our visit. In discussion with staff, it was evident that the team at the practice shared a desire to provide patients with a safe and caring service where people were treated with dignity and respect. The GP partners held monthly partners' meetings outside of surgery opening times, to discuss important issues such as forward planning, practice objectives and staff morale. The practice regularly reviewed its objectives at staff meetings and they were on target.

We heard that the staff team arranged social activities and that these were also used to celebrate and reward staff achievements.

Governance Arrangements

The GP partners all had lead roles and specific areas of interest and expertise. This included governance with clearly defined lead management roles and responsibilities. During the inspection we found that all members of the team we spoke with understood these roles and responsibilities. There was an atmosphere of teamwork, support and open communication. The practice held a weekly clinical meeting which included clinical discussions about any significant event analyses (SEAs) that had been done. All of the clinical staff attended these meetings and where relevant, other staff also took part in the discussions about SEAs. This helped to make sure that learning was shared with appropriate members of the team. GPs also met every month to discuss clinical and governance issues.

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. . (QOF is a performance management system for GP practices.) We saw examples of completed clinical audit cycles, such as emergency admissions of children to hospital. This demonstrated the practice reviewed and evaluated the care and treatment patients received.

Leadership, openness and transparency

The practice had a team of partners, some of whom had worked together over a number of years to provide stable leadership. They were supported by a practice manager who was described by clinical and other staff as playing a positive and key role in the management of the practice. Staff told us they felt well supported and that all of the partners were approachable. Staff also confirmed that the practice manager had an 'open door' policy. One of the staff we spoke with told us that Davenal House Surgery Partnership was a caring and well led place to work where morale was high.

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

The practice had an established Patient Participation Group (PPG) in place. The purpose of the PPG was to act as an advocate on behalf of patients when they wished to raise issues and to comment on the overall quality of the service. This ensured patients' views were included in the design and delivery of the service. The chair of the PPG told us the group played an active role and was a key part of the practice's organisation. The PPG action plan for 2014 gave examples of activities the PPG was involved with. This included promoting and increasing the use of on-line appointment booking and text message reminders of appointments.

All staff were fully involved in the running of the practice. We saw there were documented regular staff meetings. This included meetings for clinical staff and meetings that included all staff. This ensured staff were given opportunities to discuss practice issues with each other. There was a clear culture of openness and 'no blame' in place. This meant staff could raise concerns without fear of reprisals and the practice's whistleblowing procedure supported this.

The practice asked patients who used the service for their views on their care and treatment and they were acted on. This included the use of surveys to gather views of patients who used the service. We saw that there were systems in place for the practice to analyse the results of the survey for information so that any issues identified were addressed and discussed with all staff members. We saw records of discussions within the minutes of staff meetings. All the

Are services well-led?

Good

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

patients we spoke with on the day of our inspection told us they received a high quality service from the practice. It was clear patients experienced the quality of service that met their needs.

Management lead through learning & improvement

We saw evidence that the practice was focussed on quality, improvement and learning. There was a well-established staff development programme for all staff within the practice, whatever their role.

The whole practice team had sessions each year for 'protected learning'. This was used for training and to give staff the opportunity to spend time together. Topics such as customer service skills and information technology changes had been covered. Cover for the practice was provided by another practice during this time.

The results of significant event analyses and clinical audit cycles were used to monitor performance and contribute to staff learning.