Windsor Surgery

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Outstanding
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

Windsor Surgery was inspected on the 1st October 2014. The inspection was a comprehensive inspection under our new approach methodology.

Windsor Surgery provides services that include access to GPs and nursing staff for diagnosis and treatment of conditions and illness, minor surgical procedures and ante and post natal health care for mothers and their babies.

The practice worked effectively to reach good outcomes for patients, improve the quality of the patients' lives and worked within the most up to date guidance including developing some innovative approaches to better meet the needs of the patients using the practice.

Our key findings were as follows

- The practice had improved year on year on the things that are important to patients including
    - Patient access to a range of appointment types
    - Patients receiving an appointment in an emergency situation on the same day.
    - Patients getting through on the phone
    - The practice had an ever growing Patient Participation Group that took an active role in developing and improving patient services.
    - The practice had systems in place to protect patients from infection and maintain a clean environment.
    - The practice staff received training in excellent customer care and we witnessed staff being respectful and polite to patients at all times.

We saw areas of outstanding practice including:

- The practice adopting the principles of the 'Better Care Together' strategy and working in a cohesive way with community services to better meet the needs of the patients.

Summary of findings

- A number of meetings took place weekly to continuously improve how the practice delivered services to the patients. Many of these meetings included external professionals and invited patients as appropriate.
- A GP mentoring programme was in place to support GPs returning from long term leave of absence. The programme worked around the needs of the GP and lasted for as long as they wanted the additional support.

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 was safe. The practice had specific systems and protocols to identify and respond to risk and potential unsafe practice. Risk management plans identified actions taken that improved delivery within the practice. The practice took action to ensure staff understood risks and issues and steps were taken to ensure risks were reduced and the practice improved.

Are services effective?

Outstanding

The practice was effective. The GPs and practice management took lead areas to develop the practice and meet patients' needs. Locally agreed multi-disciplinary protocols incorporated best practice guidelines and resulted in positive outcomes for patients. Staff and patients were involved in local forums to drive up standards. Changes in national best practice or locality procedures were shared and agreed amongst all staff and supporting community teams. Data we reviewed confirmed the practice to be continually improving and performing highly when compared to neighbouring practices in the Clinical Commissioning Group (CCG). Patient needs were met by the practice or by referral to specialist services. Practice staff were well qualified to meet patient needs with additional training provided for their lead area.

Are services caring?

Good

The practice was caring. Patients whose views we sought spoke highly of the practice and its staff. Patients told us they were treated with respect and involved with their care and treatment. Patients who could no longer give informed consent were supported by best interest decisions and appropriate assessment and referral.

Are services responsive to people's needs?

Good

The practice was responsive. Steps had been taken to understand the patients whom the practice served and enhanced services supported work with patient groups as required. The practice worked with the Patient Participation Group (PPG) in developing and improving the practice. A clear complaints procedure was available.

Are services well-led?

Good

The practice was well-led. Quality and safety were priorities for development of risk management systems. Staff were committed to maintaining and improving high standards of care. The practice had developed systems that supported learning and promoted an open and fair culture.

Summary of findings

Staff and patients demonstrated a high level of satisfaction with working in and using the practice and were actively involved with the on-going development and improvement agenda.

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 The practice offered a health check for patients over the age of 75 years and every patient over this age had a named GP.

A member of the Patient Participation Group had presented a case to the Clinical Commissioning Group to ensure a more comprehensive system remained in place to support patients at risk of falls. This meant that comprehensive risk assessments were completed with patients and community support was available for those that needed it.

The practice worked within the Gold Standards Framework for end of life care and worked with the palliative care and Macmillan nurse to develop and deliver this.

People with long term conditions

Outstanding

The practice is rated as outstanding for the population group of people with long term conditions The practice ran a number of clinics for patients with long term conditions. Appointment times varied dependent on the needs of the patient The practice nurse team led on management of long term conditions including reviews and follow ups. The practice nurses visited patients in nursing homes for their reviews if it was required.

The practice worked with community teams to avoid hospital admissions and could access intermediate care services by referral. The practice worked with nursing homes in the vicinity and had a dedicated prescription collection protocol.

The practice had completed a number of audits on care delivery and outcomes for patients with long term conditions with an aim to improve services. The community team worked with the practice to meet the needs of patients at home. Community teams and practice staff developed care plans for patients with long term conditions to ensure a holistic service was provided.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. The nurse practitioner was the lead for women's sexual health and family planning. Clinics were delivered flexibly to meet the needs of mothers.

The practice health visitor held a weekly well baby clinic and midwives held a weekly antenatal clinic; GPs were available during

Summary of findings

clinics to discuss any concerns. The practice worked with community teams to identify and safeguard children and young people who may be at risk. Multi-disciplinary monthly meetings were held to support this group.

The practice had less than the Clinical Commissioning Group (CCG) average for under 18 year olds and less than average A&E attendees. Patients under 18 had their conditions managed in a planned way with the number of hospital admissions being planned rather than attending hospital as an emergency.

The practice undertook a number of enhanced services with mothers, children and young people including hepatitis B vaccinations for new born babies and meningitis C vaccinations for students There was a range of health promotion and sexual health information within the waiting room

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age people (including those recently retired and students). The practice had available information for patients to better manage their own conditions. On line services were available for ordering prescriptions and making appointments up to two weeks in advance. The practice were planning to offer extended practice opening times to meet the needs of this group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. A local home for people with people with complex physical disabilties was supported by the practice and community teams and an enhanced service was undertaken to better meet the needs of these patients. There were 32 patients registered with the practice who were living with learning disabilities. Health assessments were completed annually and GPs visited patients at home when required

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). The practice worked with 71 patients who were experiencing poor mental health this included patients living with dementia. The GPs worked within shared care protocols with local community teams to support patients with poor mental health.

The practice had regular meetings with the local community teams to develop better procedures and access to services for patients

Summary of findings

experiencing poor mental health. The practice had information available for advance care planning and understood the principles of the Mental Capacity Act 2005. A lead GP had developed a capacity assessment and included other professionals and family members as required to make best interest decisions for patients who lacked capacity to make them themselves.

The practice had information on support groups for patients and family members in the waiting room.

Summary of findings

What people who use the service say

We spoke with eight members of the Patient Participation Group (PPG) on the day of the inspection, eight patients on the phone following the inspection and reviewed five completed CQC comment cards. We spoke with patients from different backgrounds and with different health needs. Everyone we spoke with was positive about their experience at the GP practice. PPG members were confident they could speak with the practice management and influence change.

We were told all staff treated patients well and were good at their jobs. All but one patient was satisfied with the service received at the practice with one patient describing the counselling provision as inconsistent. Patients felt they could influence their care and were involved with treatment and referral decisions.

Areas for improvement

Action the service MUST take to improve

Action the service SHOULD take to improve

The fridge was not hard wired in line with latest recommendations.

The system for monitoring the resuscitation trolley was not easy to follow, the details of all the medicines, their quantities and expiry dates were not in one concise document. There was not a clear rationale as to why some medicines were locked away and some were not.

The practice pharmacist team responsible for the medicines within the doctor's bag did not have the bag in their possession or on their premises it was held within the practice reception with staff that had no responsibility for its contents or security.

Non clinical staff training records did not show they received any training in infection prevention control or hand washing techniques.

Risk assessments were not undertaken on all practice staff to determine the need for a Disclosure and Barring Service (DBS) check.

Outstanding practice

The practice was a pilot practice for the 'better care together' strategy. The strategy was looking to develop care closer to where patients live, develop seamless services for patients across health and social care providers and develop, where needed, specialist services to meet patient needs. The practice had adopted the principles of the strategy and embedded it into everyday practice. The practice team worked in a cohesive way with community services to better meet the needs of the patients.

A number of meetings took place weekly to continuously improve how the practice delivered services to the patients. Many of these meetings included external professionals and invited patients as appropriate.

GP mentoring was available to GPs when returning from long term leave of absence. This included: a named GP mentor, mentor reviews and consultations around any issues or concerns, regular meetings to discuss progress and additional breaks in the returning GPs schedule to ensure everything that needed to be done could get done in a timely manner. The programme was not time limited and was developed and implemented around the needs of the GP. Work resumed as normal when the GP felt ready to undertake duties as before their period of leave.

A regular locum doctor was available to work at the practice. They were paid a fixed fee and guaranteed a number of hours work each month. This was a valuable safety net for unexpected pressures to the business.

Windsor Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector who was accompanied by a GP.

Background to Windsor Surgery

Windsor Surgery is based at Garstang Medical Centre. The practice shares the site with a second GP practice who both take responsibility for the onsite dispensary. The site is also utilised by various community teams including the district nursing team, health visitors, audiologists and physiotherapists.

Windsor surgery is situated close to the centre of Garstang. The practice is managed by six partners. Five partners are GPs and one partner who oversees the practice is the practice manager. The practice clinical team includes the GP partners, one full time and two part time salaried GPs. The practice has regular trainee doctors under tuition at the practice. The GPs are supported by two nurse practitioners, four practice nurses and a health care assistant. GP staff consist of five females and three males. The practice manager is supported by a deputy, an office manager and a team of secretarial, administration and reception staff.

The practice is open for consultations Monday to Friday from 8.30am to 10.30am and 3.30pm to 5.30pm with the exception of Thursday where consultations are available from 8.30am to 10.00am. The practice closes at 6pm every weekday except Thursday when it closes at 1pm. Treatment advice outside of this time is available from the website and from the national '111' number. Access to appointments is available out of hours from Preston Primary Care Centre at the Royal Preston Hospital. The practice has opted out of North Lancashire Clinical Commissioning Group out of hours provision due to the practice population being closer to Preston provision.

The practice serves Garstang and surrounding rural areas. The patient list at the time of the inspection was 11233. The patient population comprises of less than the England average of patients aged 40 years and under and greater than the England average for patient aged 45 years and over. The population area is within the second least deprived population group and includes patients mostly from higher socio/economic backgrounds. The area has a low ethnic minority population. The practice was based in a relatively affluent area. There were less than 1% of the practice population who were unemployed and just over 4% who were claiming disability benefit.

The practice has a General Medical Services (GMS) contract, this is the contract between general practices and NHS England for delivering primary care services to local communities.

The practice is part of the pilot for better care together and within this develops formal arrangements to work across professional teams to better support and protect patients.

The practice is registered to provide the following regulated activities: treatment of disease, disorder or injury; diagnostic and screening services; maternity and midwifery services; and surgical procedures.

Detailed findings

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme to test our approach going forward. This provider has been inspected before but had not received a quality rating from CQC and that was why we included them.

How we carried out this inspection

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

- 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
- Mothers, babies, children and young people
- The working-age population and those recently retired (including students)
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Before our inspection we reviewed information we hold about the practice and asked other organisations and key stakeholders to share what they knew about the practice. We analysed information received through our intelligence monitoring system and reviewed policies, procedures and other information the practice provided before the inspection. We carried out an announced inspection on 1st of October 2014.

During our inspection we spoke with a range of staff including; GPs and nurse practitioners, practice nurses and a health care assistant, the practice manager and reception and administration staff. We spoke with eight members of the Patient Participation Group (PPG) on the day of the inspection and eight patients on the telephone the following day. We reviewed five CQC comment cards available for patients to complete on the day where patients and members of the public shared their views and experiences of the service. We observed how patients were being cared for and reviewed documentation as required. We looked at the cleanliness and management of the building and verified practice procedures were being followed by the practice staff.

Good

Are services safe?

Our findings

Safe Track Record

The practice took steps to ensure events that could impact on patient safety were recorded. Records were reviewed regularly and information on improvements shared with the team at practice meetings. There were systems in place to monitor areas of risk including health and safety.

Records were easy to follow and actions taken were recorded. Dates were kept of the meetings where events were discussed and changes made to protocols were shared. There was a clear audit trail from event to the associated change in systems and protocols to reduce risk of reoccurrence.

The practice was within or above expected parameters for data related to safety for example the practice had well developed documented incident management and reporting procedures.

Learning and improvement from safety incidents

The Practice had a system in place for reporting, recording and monitoring significant events. When incidents occurred details were recorded and discussed to ensure practice staff understood the circumstances under which the incident occurred. Action was agreed to reduce the risk of reoccurrence. Annual reports were completed on complaints, significant events and practice audits to identify any trends where improvement action could be taken. These were formally shared with the team within weekly and monthly meetings and minuted for future reference.

Reliable safety systems and processes including safeguarding

Different members of the practice clinical team, pharmacist and community team members based within the practice building took responsibility to share information of concern with the practice. Team meetings were inclusive of team members not directly employed by the practice as and when required or requested. The teams who used the practice building shared information of concern including safeguarding concerns. Patients were then coded within the patient record system and as a team all staff would work to promote their safety.

The practice had a safeguarding lead who attended local forums to share and gather information. This information would be shared with the team at meetings as appropriate.

The practice safeguarding register was reviewed weekly with all staff involved. All staff attended basic safeguarding training as part of their induction and attended refresher training intermittently. Clinical staff received more comprehensive training and GPs were trained to level three.

There were leaflets displayed in the waiting room on recognising and reporting safeguarding concerns. All staff had the reporting procedure on their computer desktop. Clinicians had received some training in the Mental Capacity Act 2005 and were shortly to attend further local training on the Act and its implementation.

Clinical staff were all trained to undertake chaperone duties if requested. There were posters and information in the waiting room about the role of a chaperone and how patients could request one. When we spoke to patients they were aware the service was offered.

Medicines Management

The management of the process and its on-going effectiveness was the responsibility of the practice manager. GPs and nurse practitioners were responsible for prescribing and reviewing medication at given points in time and the repeat prescription administration officer was responsible for checking and distributing prescriptions as required including for collection by the patient. Some prescriptions were collected from the reception; others were dispensed by the attached pharmacy.

The practice pharmacist regularly attended practice meetings and shared any issues, concerns and alerts around medicines. They were responsible for reviewing all discharge summaries and updating systems and GPs as required.

Processes for medication reviews were consistently evaluated to ensure they met the needs of patient groups. General reviews were arranged around patient birthdays and other more comprehensive reviews were condition and medication specific. Patients were alerted to the need of a medicine's review on their collected prescription note. If patients failed to attend for their reviews the GPs and practice staff followed this up. Depending on the medicine the practice may suspend collection until a review had taken place.

We reviewed the system for logging in and out prescriptions to both local pharmacies and nursing and

care homes. Signatures were required to collect any controlled drug prescriptions and prescriptions were made up in dossed boxes for patients who required additional support to take their medication.

Repeat prescriptions could be booked online through the website, via telephone and in person. Prescriptions were usually ready within 48 hours. Patients told us their medicines were always ready when they came to collect them.

The practice had a fridge within which vaccines were stored. The temperature of the fridge was recorded daily and a digital readout was constantly visible. Vaccines were rotated to ensure they were used before expired.

The practice had a well-stocked resuscitation trolley with emergency medicines. A system was in place to ensure new medicines were ordered before medicines reached their expiry date. However the resuscitation trolley did not have a list of all the medicines held on it and it was stored in an area accessible to patients. We fed this back to the practice manager who assured us the trolley had now moved to an area accessible only by staff. The system for monitoring the trolley was not easy to follow and some medicines were kept in a locked cupboard. There was not a clear rationale as to why some medicines were locked away and some were not.

An emergency doctor's bag was also kept in the reception area. This bag was not the responsibility of the practice staff as was monitored by the pharmacy staff. Practice staff could not tell us where the list of medicines for the bag were or when it had last been checked. Pharmacy staff checked the bag and its contents on a monthly basis from a list of medicines held in a zipped pocket of the bag.

Cleanliness & Infection Control

The practice completed bi annual infection control audits. Actions were identified for improvement and completed in a timely way. The lead infection control nurse was responsible for ensuring actions were completed and any changes to procedures were shared with practice staff at practice meetings.

There were hand sanitizers throughout the practice for use by staff and patients. There were hand hygiene posters displayed at hand washing sinks to reinforce a good technique.

Specialist contract cleaners were used to clean the practice. Procedures were in place to ensure the contractors had any updated information on guidelines they used to fulfil their role. These included the colour coding of cleaning equipment to reduce the risk of cross infection and the latest COSHH guidance for storing and handling substances and chemicals.

Cleaning schedules were in use for the cleaning of the environment and equipment. Procedures were overseen by the deputy manager. Planned programmes for replacement of furniture that could not be wiped down were in place.

Sharps bins, elbow taps and foot operated clinical waste bins were in use in the consulting and treatment rooms. Spill kits were available for staff to clean up any bodily fluids.

Clinical staff had received infection control training in 2013. Non clinical staff training records did not show they received any training in infection prevention control or hand washing techniques.

There were good supplies of Personal Protective Equipment (PPE). Disposable gloves, aprons and other necessary PPE was available in all treatment rooms. The infection control lead was responsible for ensuring stocks were kept as needed by clinical staff.

The practice had last carried out tests for legionella in May 2014.

Equipment

Emergency equipment including the oxygen and the defibrillator were checked monthly. Nebulisers (machines used to get medicines into the lungs to improve breathing), weighing scales and other equipment were calibrated to ensure they were accurate.

The vaccines fridge had an electronic monitoring system installed. In the event the cold chain was broken the practice staff would be able to see the fluctuations in temperature and any timeframes the temperature was out of the recommended range for storing vaccines. The fridge was not hard wired in line with latest recommendations.

All the equipment held on site had a certificate to evidence it had been checked or calibrated by a suitably qualified professional to ensure it was fit for purpose.

Good

Are services safe?

Staffing & Recruitment

The practice kept records of registration details for the nurses employed by the practice. All nurses had an up to date registration with the Nursing and Midwifery Council (NMC). The practice had not routinely kept records of Disclosure and Barring Service (DBS) checks but had started to collate these on the day of the inspection. Risk assessments were not undertaken on all practice staff to determine the need for a DBS check. We were assured the non-clinical staff did not undertake the role of chaperone with patients during sensitive or personal examinations.

The practice had a recruitment policy that had been recently been reviewed. The practice manager informed us of how the process would become more formalised including the seeking of written references at all times. We did not see any evidence that photographic identification had been requested at the point of recruitment or after staff started in posts. Photographic identification was required for distribution of practice IT security cards. The practice assured us they were to keep photographic ID on all personnel files going forward.

The practice worked with trainee doctors and students. Any clinical professional who was training at the practice received a comprehensive induction to the role and support from the permanent clinical team.

Monitoring Safety & Responding to Risk

Meetings took place every day at the practice to ensure the on-going safety of patients. Monday morning meetings discussed any admissions, discharges or emergencies over the weekend. Lunchtime meetings discussed wound care and home visits and clinical teams discussed issues as they arose. Clinical and non-clinical meetings took place weekly and monthly within the different staff groups where all information of any concern and any significant events were shared.

Analysis was undertaken of risks and issues to identify remedial action wherever possible. Recently this had led to agreement of a specific storage area for equipment used when reviewing and testing patients with eye problems.

Health and safety risk assessments were completed and reviewed at specific points in time. The practice regularly monitored fire equipment and held a weekly fire alarm test. Gas and electric installations were professionally tested in line with guidelines.

Many practice staff did not work full time so there was added flexibility within the team to cover sickness and holiday when required

Arrangements to deal with emergencies and major incidents

The practice had plans in place in case of emergencies. A business continuity plan included risk assessment and management plans for foreseen events including loss of electric, fire and flood. We spoke with staff that were fire marshals who understood their role in clearing the building in the event of a fire.

A regular locum doctor was available to work at the practice. They were paid a fixed fee and guaranteed a number of hours work each month. This was a valuable safety net for unexpected pressures to the business.

A physical and electronic panic button system was in place. Staff knew how to use the system to alert other staff if required in the event of an emergency. We were told of more than one emergency where staff had both had to use the resuscitation trolley and call an ambulance for patients who had required emergency medical treatment. All clinical staff were trained in emergency life support annually.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice had volunteered to take part in the Better Care Together (BGT) pilot. The BGT pilot involved community and practice staff working together to better meet the needs of patients. Models of care had been developed which aimed to make sure all patients got the right care in the right place at the right time. The principles of the pilot were around how primary, community and social care services work together to provide the best possible care for patients.

The practice had a web based advice and guidance page set up for approximately two years. Recent increased publicity about this service had reduced unnecessary hospital referrals.

The practice had a number of enhanced services working with community and population groups where patients may need additional support. Each service, along with each long term condition had a designated named clinical lead. The lead had developed templates for care plans and was contributing into community care plans to promote delivery of a holistic service.

Clinical staff took responsibility for areas of the Quality Outcomes Framework (QOF), an annual self-assessment against a national set of targets for quality healthcare provision. As lead for any given area they ensured all policies, protocols and Standard Operating Procedures (SOP) were in line with current best practice guidelines. Any updates were shared via practice meetings, emails and were available to all staff electronically

Management, monitoring and improving outcomes for people

The practice manager and most of the clinical staff attended meetings externally to promote patient care. These included meetings with the Clinical Commissioning Group (CCG) and forums dedicated to locally managing enhanced and specialist services including the BCT pilot. Meetings focused on developments in practice regimes and monitoring the quality of service provision. Good practice examples were shared and discussed to develop better ways of meeting patients' needs.

Each practice completed an annual QOF self-assessment. Data collected from the 2013 QOF showed the practice had improved year on year for many of the data items. The practice was not an outlier for any QOF clinical items.

Clinical and non-clinical staff completed audits on practice held information. We were sent a review of the 10 audits completed in the last 20 months. Three of the audits had completed an audit cycle and clinical or process improvements had been noted when the re-audit had been completed. An initial audit into records of exacerbations (worsening) of Chronic Obstructive Pulmonary Disease (COPD) showed that an improvement in how the data was collected would be beneficial to ensure consistent results. The issues and actions were discussed at the monthly in house respiratory meeting and the re audit showed better use of the COPD template and patient conditions were RAG (Red, Amber, Green) rated to show severity.

Clinical and non-clinical staff were aware of their responsibilities as leads for certain areas of practice. Practice meetings had agenda items set for feedback of areas such as Long Term Conditions (LTC). Meetings were attended by community teams and the practice pharmacist. Weekly clinics were held by the lead practitioners and community staff supported patients outside of appointments. Patients were invited in for a review of their condition or medication at the recommended intervals.

The practice did not work in isolation. Working with the community based services the practice was able to use resources including intermediate care services to avoid admission and readmission to hospital. We were told GPs were available through an outreach clinic agreed with the community teams to support them out of hours. The practice and community team met weekly to discuss admissions and discharges.

Effective staffing

The practice had a very low turnover of staff across both clinical and non-clinical teams. Newer staff had completed a comprehensive induction and told us support was on-going throughout the year. All staff felt supported by both their direct line managers but also by their peers. The atmosphere in the practice was positive and friendly.

Revalidation was introduced in 2012 to protect, promote and maintain the health & safety of the public by ensuring proper standards in the practice of medicine. Revalidation

Are services effective?

(for example, treatment is effective)

requires GPs to provide evidence that they work within robust local systems that support high quality care. Three of the five GP partners had been revalidated in the last two years with the remaining two due to be revalidated in the next two years. All GPs working at the practice had revalidation scheduled and each GP had been receiving annual appraisals.

The practice had a whistle blowing policy and staff were aware of how to use the procedure if it was required. All staff knew who to speak with for specific advice.

Training records indicated clinical staff received annual emergency CPR training and attended many other relevant and specific courses in their lead area. Each staff member had a list of training courses attended in the last four years.

We saw some evidence of annual appraisals but most were due. All staff we spoke with told us support was always available and they could request and agree additional training outside of the appraisal review process. Staff were clear about their accountabilities and their line manager responsibilities. Nurses told us clinical supervision was available as and when they requested it.

Working with colleagues and other services

Community teams were based in the practice building and shared staff room facilities. Professional relationships had developed across the teams to better provide holistic treatment to the patients of the practice. Community matrons, health visitor and district nurses were invited to and attended practice meetings.

The community matron and their team were working with the practice to prevent avoidable hospital admissions. The practice and community matron team liaised with each other and agreed the best team to visit patients based on their current need. This helped support inappropriate GP visits and develop self-management plans for patients with Long Term Conditions (LTC).

The practice had access to a number of services on site including chiropody, physiotherapy and sight and hearing tests. Services were accessible via referral to in house teams or delivered by trained practice staff.

The practice was part of the pilot for the 'Better Care Together' strategy. Through the development of local strategic partnerships, integration of services with shared objectives the pilot aimed to better meet the needs of the local population.

A core team had been developed to deliver the working better together programme. Access to systems had been shared so staff were able to locate up to date information about patients. Person centred care plans were developed and community teams visited patients with LTC daily. The core team of practice and community staff received joint training and attended joint meetings to deliver and develop the programme.

The practice had a number of visiting clinics to support patient needs. Visiting professionals included Help Direct. Help Direct was a generic support service offering services to help people live independently; services included learning and leisure, mobility and transport and health and fitness.

A monthly palliative care meeting took place attended by local nursing and residential home managers and the relevant community team including the local hospice staff. Palliative care and end of life information including preferred priorities of care were shared with the out of hours service as required. Sharing information of this type helped ensure patients received the care they wanted at the end of their life.

Each morning the practice pharmacist updated records with any discharge or admissions changes to patient information. The pharmacist sent information to relevant teams as tasks on the system if anything needed following up. The practice pharmacist visited local nursing and residential homes to undertake medication reviews.

GPs requested patients to have tests undertaken through the appointment system. Appointments were booked as urgent or routine dependent on the GP's request. Patients were informed of test results via letter. If results came back of concern the GP set up a task for administration staff to arrange an appointment with the patient to discuss the results.

The practice was located centrally to three NHS trusts. The GPs knew areas of special interest and good working practice within the trusts. As such there were more options available to patients for referrals. Patients were confident in

Outstanding ☆

Are services effective?

(for example, treatment is effective)

the practice and how it worked with other partner NHS services. We were told GPs acted in a timely manner to make referrals to secondary services (hospitals) when required.

Information Sharing

Information was available in the reception about the patient summary care records and who else may access the information within them. Sharing some specific patient information with other services allowed external services to work with patients as soon as possible. Patients were given details of how to opt out of the service and restrict access to their summary care record.

Consent to care and treatment

The consent policy considered when it would be appropriate to act on a patient's implied, written or verbal consent to treatment, immunisation or investigation. The Gillick competencies were explained when asking younger patients to give their consent and understanding of diagnosis, treatment, risks and issues and consequences. Procedures were also available for patients to agree to students sitting in on consultations.

We spoke with staff about working with patients with limited capacity to make decisions and give consent.

The practice had a mental capacity lead clinician. The lead had developed an assessment in line with current understanding for testing if patients may lack the capacity to make specific decisions. Reception and administration staff were made aware of patients with limited capacity and they had received training around working and supporting patients through a customer care and equality and diversity course. Staff we spoke with explained how they would support patients if they were distressed or frustrated or could not be understood.

Health Promotion & Prevention

The practice had one large waiting room with a selection of different seating. A number of health promotion posters and leaflets were available on display and to take away. Leaflet displays were accessible posters were displayed in a way for each to have the desired impact.

There was information for patients around managing their own conditions and support offered for changing lifestyle choices including smoking cessation. There were posters identifying the availability of the flu vaccine and encouraging eligible patients to make appointments.

All new patients whether temporary or permanent on regular medication had a health check at their first appointment. The secretary updating the patient record identified if the patient required an immediate appointment. The check identified any immediate health care or social care needs and included details of lifestyle choices that could be detrimental to patients health including smoking and drinking.

A display bar helped patients understand when they had been called for their appointment and where they needed to go. A notice board in the reception informed patients what visiting professionals were on site.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We spoke with eight patients by telephone and received five CQC comment cards. All the information we received was positive about practice staff. One concern was identified with counselling services and delays in appointments. All grades of staff were praised from reception and administrative staff through to the GPs. Everyone said they were treated well and spoken to respectfully at all time. One patient suggested an evening surgery would be beneficial to better support patients who worked.

The practice had a patients' charter available in reception. The charter outlined the expectations patients should have from their GP including access to treatment and for their privacy to be consistently upheld. We saw a number of staff patient interactions on the day and found the staff to be pleasant at all times. It was evident good relationships were formed with patients at the practice.

Consultation rooms were private and there was an available confidential space for discussion or to wait if patients were distressed for whatever reason. Posters advertising chaperones were visible throughout the practice and patients we spoke with were aware of the service.

We saw from staff training records that reception, administration and secretarial staff were trained in equality and diversity, excellent customer care, information governance and triage and appointments. Training of this kind helped ensure staff had the appropriate skills to undertake their role.

Care planning and involvement in decisions about care and treatment

Patients told us their opinion was considered when discussing treatment and medication. Appointments at the practice were 15 minutes as opposed to the usual 10 minutes and patients confirmed they found this beneficial to fully discuss their needs. Patients we spoke with said they understood their condition and their diagnosis had been discussed with them in a way they understood. Patients were accessing support for their condition from the website and were referred to self-help programmes including the DAFNE (Dose Adjustment For Normal Eating) programme to support patients with type one diabetes.

Patients who had taken someone into an appointment with them for support or had supported someone else in their appointment, told us this had been beneficial and encouraged by staff. GPs told us they involved carers and family members when explaining specific treatments if they were at the appointment with the patient.

Patient/carer support to cope emotionally with care and treatment

The waiting area had available information for dealing with bereavement. From practical steps to take to managing grief. Staff we spoke with showed an understanding and empathy when discussing bereavement and were confident in how to deal with patients faced with this type of loss.

Support group information for health conditions was available in reception and the practice referred to Help Direct for more practical support with general living including housing and benefits.

The practice had a carers' notice board offering support and advice. A carers' register was kept both for patients who were carers and for patients who were cared for.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice offered a number of enhanced services to meet local needs. These included working more comprehensively with patients with learning disabilities, patients with dementia and services to avoid and reduce unplanned admissions to hospital. Each enhanced service was led by a clinician. The lead shared learning and improvements through practice meetings. Each enhanced service had templates or care plans to support the work undertaken by staff at the practice and other professionals involved with the patient's care and treatment.

Patients told us the practice were quick to diagnose and make referrals to secondary (hospital) services if required. Patients spoke highly of the choice of local hospitals and the GP knowledge of the specialist services available in each one.

The practice saw patients in clinics for reviews and check-ups specific to conditions. Reviews were where possible requested around the patient's birthday. Patients were sent letters for reviews or they would be reminded on their repeat prescription a review was due. Patients who did not attend for reviews were coded on the system and when they came for any future appointment, a task for the review would be sent through to the clinician completing the patient consultation.

The practice updated the website monthly and included in the surgery news section anything that had recently happened or was on the agenda for GPs in that month. The website currently had information on the flu vaccination and identified eligible patient groups to receive it.

The practice held registers of patients with differing needs and conditions. The current patient registers for patients with learning disabilities was 32 and 79 patients were in receipt of palliative care. The practice had both male and female GPs and patients told us they could see a GP of choice in non-emergency situations.

The Patient Participation Group (PPG) had been set up for approximately six months. In that time they had become active in making suggestions for improvements. The practice had acted on these requests and change had been implemented. This included the development of a 'how we can help' leaflet which helped patients identify whether they needed to be seen by a GP or if a practice nurse could be just as effective. This had been developed following feedback that patients did not like discussing their condition with the reception staff. Whilst all reception staff were trained in basic triage the development of the leaflet had led to more patients requesting to see a practice nurse for simpler conditions such as sore throats or tummy bugs.

Tackling inequity and promoting equality

The practice had a large glass sliding front door. The door could be opened via a waist height disabled access button. The reception desk had a lowered section to speak to patients using a wheelchair. All doorways to treatment and consultation rooms were of adequate width for patients using a wheelchair. Hallways had handrails to support patients with difficulty mobilising. The practice had disabled parking available and access to disabled facilities.

Practice staff told us they knew the patient list well and patients requiring longer appointments could be accommodated. One of the practice staff was trained in British Sign Language if patients using the practice communicated in this way.

The practice had an electronic check in system which was available for use in eight different languages. Written information including the practice leaflet could be requested in different languages if required.

Access to the service

The practice did not book appointments for Mondays. All Monday appointments were used for same day appointments. This helped patients see a GP following the weekend if required. Each day, one GP kept a free list for on the day appointments. Patients told us they could always get an appointment on the day if it was needed. If all the same day appointments were booked then the GP would phone the patient and either add them to be seen at the end of the day or make an appointment at a later time if required.

The practice leaflet identified available appointments and how to book them. These included routine appointments that could be booked two weeks in advance, emergency same day appointments, telephone consultations and home visits where patients were unable to get to the practice. Each routine appointment was 15 minutes long and double appointments could be booked if needed.

The practice had a referral procedure with details of how to refer to third party agencies including local hospital and community services.

Good

Are services responsive to people's needs?

(for example, to feedback?)

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.

The complaints procedure was displayed in the practice waiting room and was referred to on the practice leaflet. Patients we spoke with told us they knew how to complain but none had felt they needed to. The practice annually reviewed all complaints received and discussed them in practice meetings. Any areas identified for improvement were agreed and implemented. An annual synopsis was completed of all complaints for the Clinical Commissioning Group (CCG) detailing numbers and types of complaint.

The practice also regularly reviewed the NHS choices website and provided responses where applicable to do so. We saw a number of thank you cards displayed in the reception area. A feedback and suggestion box was available in the waiting room and on the day of the inspection a survey was being run on whether to have music in the waiting room. We did not speak to anyone who had needed to raise a complaint but patients told us they would be comfortable raising concerns with any of the practice staff.

The practice responded to patient feedback. The emergency appointment line had been difficult to get through on in the mornings. The practice extended the lines availability to 10am and increased the staff available to answer the calls. Patient satisfaction in accessing the practice had improved in the 12 months.

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 took steps to identify potential problems or issues. They then identified solutions. This way of identifying issues or concerns, producing potential solutions and then evaluating if the solution had worked and making further changes if required was evident throughout the practice. Practice staff attempted to remedy problems or issues at the earliest possible point but were always open for suggestion and continued improvement.

Practice management and senior staff were visible around the building. Practice and community staff told us they could ask for clarity on anything or discuss issues or concerns at any time with the practice leadership team.

Governance Arrangements

The practice had administrative leads for clinical and non-clinical areas including infection control and medicines management. Protocols and procedures were available to staff to manage the day to day business. Policies were held centrally on a shared drive and were updated at least annually. When policies were changed as a consequence of an event it was shared with the team within practice meetings. Non clinical staff had annual refresher training on practice policies and procedures to ensure they understood protocols the clinical team worked to.

The practice had a partnership agreement detailing the responsibilities and accountabilities of all of the practice partners. The agreement was due to be reviewed due to some staff changes.

The practice had completed four clinical audits to date in 2014. Two were complete audit cycles. One was used to identify if women diagnosed with gestational diabetes were being reviewed in line best practice guidance. The initial audit identified the number of patients diagnosed and those followed up in line with guidance. Some patients had not attended appointments and others had not had appointments made. Changes made included practice staff chasing patients to make follow up appointments and then the same audit was completed again showing an improvement in the numbers of patient followed up.

The practice had a number of potential risks identified and risk assessments had been completed or issues had been discussed at practice meetings. Recent concerns included the development of over 200 homes around the practice. The practice had written to their local area team outlining their concerns with regards to access, resources and transport during and after the homes were built.

Leadership, openness and transparency

There was a clear clinical and non-clinical line of accountability up to the lead GP and practice manager. Staff we spoke with knew who to go to for specific advice and were confident they would be supported with any issues they raised.

As part of the 'Better Care Together' initiative the practice identified that patient care and treatment needs could be better met by professionals working in an integrated way to identify the best teams to work with patients on specific concerns and at specific times during treatment.

We spoke formally with 10 members of staff from the practice and two staff members from the community team. We spoke with staff across management, clinical and non-clinical teams. It was clear from talking to staff that each was proud of the practice, the work that they did and their role within it. Staff were relaxed, open and friendly with the inspection team and displayed integrity and passion for their job. The impact the practice had on patients' lives was clear, with many chatting freely with practice staff.

Staff we spoke with described the team as cohesive, supportive and flexible. Everyone we spoke with was confident in their role and said they would be happy to discuss anything with their manager. Staff felt valued as a team member and supported to develop. Regular staff meetings showed an open dialogue and questioning to aid understanding.

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

The practice had an active Patient Participation Group (PPG). The group produced its first annual report in 2013/2014. The PPG met bi monthly and influenced changes within the practice. The PPG agreed priorities for improvement and suggestions and opinions were canvassed from the practice population through both on line and paper surveys and a suggestion box in the waiting room. The PPG members were representative of the practice population and new members were continuously invited through posters in the waiting room.

Are services well-led?

Good

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

We met with eight members of the PPG on the day of the inspection. We were told of a number of improvements made to the practice. Improvements included more staff answering the phones at busy times, a leaflet being developed to better explain what practice nurses and nurse practitioners can offer during patient consultation. This in turn had led to better and more effective use of the both GP and nurse led appointments. On the day of the inspection a survey was being held on whether to have music played in the waiting room. We saw a number of patients completing the survey.

Patient Participation Group (PPG) members were encouraged to attend Clinical Commissioning Group (CCG) meetings in support of initiatives to support the patient group. A recent falls initiative was expected to lose funding and a PPG member attended a commissioners' meeting to share how the initiative had supported patients at the practice and the funding was continued.

The practice envisaged patients may not like to be asked questions about their condition or illness by reception staff. The practice developed a telephone signpost protocol for reception staff to follow when making appointments and deciding what appointment was most suitable. The practice received feedback from the Patient Participation Group (PPG) that patients do not like talking over the phone about specific illnesses or conditions. The practice developed a 'how can we help you' leaflet to enable the patient to be more aware of their own most suitable required appointment and therefore request it when speaking to reception staff.

The practice had a number of weekly meetings. Clinical and non-clinical staff could discuss and influence changes within the practice and how it worked. All staff were confident to share ideas for improvement. All staff we spoke with had any requested additional training authorised. Staff felt part of the bigger team and were all proud of where they worked and their colleagues.

The practice had a whistle blowing policy and all staff were aware of it and confident to use it if they felt necessary.

Management lead through learning & improvement

The practice had regular meetings to discuss performance against the Quality and Outcomes Framework (QOF). Monthly Continued Professional Development (CPD) meetings would invite external professional speakers to talk on developments as they occurred in specific fields for example managing prescribing and hypertension. Lead clinicians updated on changes made to improve performance and the responsible administrator updated systems and templates if required. Changes made were minuted and agreed. More formal training was offered to practice nurses if required.

The practice engaged with external peer review managed by the local Clinical Commissioning Group (CCG). Performance against enhanced services and contractual obligations were discussed and solutions agreed for improved area wide performance. Practices took anonymous case examples as required to highlight difficulties or successes.

The practice was a training practice and had regular trainees at different stages of their learning. The practice trained both GPs and practice nurses. As a training practice staff were supported through mentorship and guided learning.

Staff were supported to develop through annual appraisals, team meetings and daily mentoring. The practice clinical team mentored staff to develop their lead areas and had even mentored the community matron and a physiotherapist through the non-medical prescribing diploma

Significant events were discussed and lessons learnt agreed and shared within the team. We were told by all staff that the ethos of the practice was one of continued development and it strived to be the best it could. Regular training was provided in house and externally to all staff. Annual reports were made on significant events, complaints and audits undertaken to identify themes and trends to action as required.