Pool Medical Centre

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?	Outstanding
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Pool Medical Centre on 23 August 2016. Overall the practice is rated as Good.

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

- The system for reporting and recording significant events ensured that these were fully investigated and patients affected were notified and supported.
- Risks to staff and patients were continuously monitored to promote safety, and there were suitable arrangements to deal with emergencies and major incidents.
- Prescription stationery was stored securely but printer forms were not tracked after being removed from their boxes.
- Current evidence based guidelines were monitored and adhered to in the planning and management of patient care.
- The practice held annual staff appraisal meetings to review professional development and identify learning needs. Staff we spoke with during the inspection told us they had access to appropriate training to cover the scope of their work.
- The patients we spoke with told us they felt they were involved when it came to making decisions about the care and treatment they received. They said that clinical staff were good at listening, allowed them enough time and provided information to help them understand their options.
- Information for patients about the services available and how to complain was easy to understand and accessible.

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- The practice had a lead staff member for dealing with complaints and we saw that these were properly managed and lessons were learned. The practice took action to improve the quality of care as a result of concerns raised.
- Results from the national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to or higher than local and national averages.

- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management, and the practice actively sought feedback from staff and patients to improve its offering.

- The provider was aware of and complied with the requirements of the duty of candour.

We saw one area of outstanding practice:

- The practice actively engaged with patients and was responsive to the local community. Needs were assessed and action was taken to improve care and encourage healthier lifestyles. For example the practice had worked with its Patient Participation Group (PPG) to organise activities for local over 75s as a means of reducing social isolation. This had resulted in a one third decrease in appointments made by older people, and their number of hospital admissions had also fallen. The PPG had sent a teenage survey to younger patients asking for their views; and the practice had then offered drop-in sessions for teenagers who were not registered with the practice to allow them to attend anonymously for advice. The practice had also run a men's health evening in a local pub to promote health screening and to educate patients about alcohol intake. As a result of the event the practice identified a small number of patients with previously undiagnosed hypertension who were followed up.

The area where the provider should make improvement is:

- Continue to monitor security in the management of prescription stationery.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

- The system for reporting and recording significant events ensured that these were fully investigated and patients affected were notified and supported.
- Learning from incidents was shared and used to improve safety in the practice.
- There were systems in place to safeguarded patients from abuse.
- The practice used a variety of processes and risk assessments to ensure that the premises met with required infection control and health and safety standards.
- Risks to staff and patients were continuously monitored to promote safety, and there were suitable arrangements to deal with emergencies and major incidents.
- The practice had a system for managing and circulating safety alerts received from external agencies. Prescription stationery was stored securely but printer forms were not tracked after being removed from their boxes.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Quality and Outcomes Framework (QOF) data showed that patient outcomes were in line with or above average compared to local and national averages for the QOF year 2014/15. Following the inspection we also reviewed QOF results subsequently published for 2015/16 and these showed the practice had maintained this performance.
- Current evidence based guidelines were monitored and adhered to in the planning and management of patient care.
- The practice conducted clinical audits and participated in benchmarking. We saw examples that evidenced quality improvement.
- The practice held annual staff appraisal meetings to review professional development and identify learning needs. Staff we spoke with during the inspection told us they had access to appropriate training to cover the scope of their work.
- The practice worked with other services and health and social care professionals to share relevant information and assess and meet the needs of patients.

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- The practice had made arrangements to identify patients who may require additional support. For example patients receiving end of life care, carers, those at risk of developing a long-term condition.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the National GP Patient Survey showed the practice was rated in line with local and national averages for the standard of care provided.
- There was a good return rate of positive comment cards. Of these, 32 were positive about the practice, and of those with negative comments only two related to caring.
- We saw that staff were courteous to patients, offering assistance where appropriate, and treating them with dignity and respect.
- The patients we spoke with told us they felt they were involved when it came to making decisions about the care and treatment they received. They said that clinical staff were good at listening, allowed them enough time and provided information to help them understand their options.
- Information for patients about the services available was easy to understand and accessible.
- Staff told us that if families had suffered bereavement, the practice sent a sympathy card and the last GP they had attended a consultation with offered to make a home visit.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified.
- The practice had run a men's health evening in a local pub to offer health screening educate patients about alcohol intake.
- The practice had worked with a care coordinator and the PPG to organise tea dances at Studley Village Hall for local over 75s, as a means of reducing social isolation. These were ticketed events supported by the practice and had been very successful with over 120 attendees. Since beginning to organise activities for the over 75s there had been a one third decrease in appointments made by older people, and their number of

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hospital admissions had also fallen. The practice continued to work with the PPG to organise activities to support this group. It had also arranged for older people to visit local schools to talk about their lives.

- Results from the national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to or higher than local and national averages.
- The practice had a lead staff member for dealing with complaints and we saw that these were properly managed and lessons were learned. The practice took action to improve the quality of care as a result of concerns raised.

Are services well-led?

Good

The practice is rated as good for being well-led.

- The practice had a clear vision and approached future challenges with purpose. Staff had a common focus on improving the quality of care and people's experiences.
- The practice had implemented a set of core values to guide staff and governance arrangements supported collaboration and the delivery of key aims.
- There were high levels of staff satisfaction. Staff were proud to work for the practice and spoke highly of the culture. The partners encouraged an open, friendly ethos and complied with the duty of candour in dealing with patients.
- Innovative approaches were used to gather feedback from different groups of patients. There were consistently high levels of constructive staff engagement and all staff were encouraged to raise concerns.
- Continuous learning and improvement was embraced at all levels within the practice. GPs proactively participated in research and initiatives.
- There was a systematic approach to working with other organisations to improve care outcomes and obtain best value for money.

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 service provided to older people was proactive, personalised and responsive. For example the practice offered home visits and urgent appointments for those with enhanced needs.
- The practice had worked with a dedicated over 75s care coordinator to identified that 21% of older patients felt lonely. The care coordinator had worked with the practice manager and the PPG to organise activities for the over 75s. This had resulted in a one third decrease in appointments made by older people, and their number of hospital admissions had also fallen. The practice continued to work with the PPG to organise activities to support this group. It had also arranged for older people to visit local schools to talk about their lives.
- The practice participated in events organised by Silver Line charity, and had recently hired coaches to allow patients to attend a celebrity event at Stratford Civic Centre.
- Older patients who may need palliative care were promptly identified and involved in planning and making decisions about their care, including their end of life care.
- The practice monitored older patients discharged from hospital and updated their care plans to reflect their changing needs.
- Staff we spoke with demonstrated that they knew how to recognise and escalate concerns about signs of abuse in older patients.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.

- The practice maintained registers of patients with long-term conditions and used these to monitor their health and ensure they were offered appropriate services.
- The nursing team had lead roles in chronic disease management.
- Performance for diabetes related indicators was similar to CCG and national averages. For example, 80% of the practices patients with diabetes had a blood glucose level within the target range in the preceding 12 months compared with the

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CCG average of 82% and the national average of 78%. 95% of patients with diabetes had a record of a foot examination in the preceding 12 months compared with the CCG average of 92% and national average of 88%.
- The practice ran specialist clinics and offered longer appointments for patients with long term conditions. Review appointments were coordinated for those with multiple long term conditions.
- Clinical staff engaged with healthcare professionals to provide a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of people with long-term conditions.

- The practice maintained registers of patients with long-term conditions and used these to monitor their health and ensure they were offered appropriate services.
- The nursing team had lead roles in chronic disease management.
- Performance for diabetes related indicators was similar to CCG and national averages. For example, 80% of the practices patients with diabetes had a blood glucose level within the target range in the preceding 12 months compared with the CCG average of 82% and the national average of 78%. 95% of patients with diabetes had a record of a foot examination in the preceding 12 months compared with the CCG average of 92% and national average of 88%.
- The practice ran specialist clinics and offered longer appointments for patients with long term conditions. Review appointments were coordinated for those with multiple long term conditions.
- Clinical staff engaged with healthcare professionals to provide a multidisciplinary package of care.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students).

- The practice offered extended opening hours on Monday evenings from 6.30pm until 8pm, and Wednesday mornings from 7.30am until 8am for working patients who could not attend during normal opening hours.
- Patients could access online services such as repeat prescription ordering and appointment booking.

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- Telephone consultations were available for patients who did not feel they required a physical consultation or who had difficulty in attending the practice during opening hours. There was also a triage nurse who worked on Mondays and Tuesdays to advise patients whether a physical consultation was necessary.
- A full range of health promotion and screening was available, including NHS health checks for those aged 40 to 74.

People whose circumstances may make them vulnerable

Good

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

- Longer appointments were offered for patients who needed them, including learning disability patients. There were 16 patients on the practice's learning disability register at the time of the inspection, ten of whom had received a health check during the previous year.
- The practice was a member of the Safe Place Scheme for people with a learning disability. This meant there was a logo displayed identifying the practice building to those with a learning disability as a safe place to come if they needed assistance or were experiencing fear. Longer appointments were also available for patients with a learning disability.
- The practice worked with a multidisciplinary team of other health care professionals in the case management of vulnerable patients.
- Staff we spoke with during the inspection knew how to recognise signs of abuse in vulnerable adults and children and were aware of their responsibilities. All staff had additionally completed IRIS (Identification and Referral to Improve Safety) training in domestic violence and the practice had made individual arrangements to support patients as necessary.
- The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 131 patients as carers (2% of the practice list). A member of non-clinical staff had a lead role in managing the carers register and monitoring their uptake of relevant services. For example, carers were able to receive the flu vaccine. There was a board in the patient waiting area providing information for carers about avenues of support available.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

Summary of findings

- Quality Outcomes Framework (QOF) data showed that the practice was performing above local and national averages in its care of patients with dementia. For example, 90% of patients diagnosed with dementia had a face to face care review in the past 12 months, compared with an average 85% in the CCG area 84% nationally.
- Performance for mental health related indicators was also similar to the CCG and national averages. For instance, 91% of patients with a form of psychoses had a comprehensive, agreed care plan documented in the preceding 12 months, compared to the CCG average of 93% and the national average of 88%. 91% of the same group had also had their alcohol consumption recorded in the previous 12 months, similar to the CCG average of 94% and the national average of 90%.
- The practice liaised with multidisciplinary teams in the management of patients experiencing poor mental health and we saw that care plans were in place for those with dementia.
- The practice worked jointly with the local parish council to promote dementia friendly allotments to patients.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 7 July 2016. The results showed the practice was performing in line with or above local and national averages. 226 survey forms were distributed and 113 were returned. This represented 2% of the practice's patient list and a 50% completion rate.

- 96% of patients found it easy to get through to this practice by phone compared to the CCG average of 78% and the national average of 73%.
- 91% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 91% and the national average of 85%.
- 93% of patients described the overall experience of this GP practice as good compared to the CCG average of 90% and the national average of 85%.
- 86% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 85% and the national average of 78%.

As part of our inspection we asked patients to complete Care Quality Commission comment cards. Of the 43 patient comment cards we received, 32 were positive about the service experienced. Positive comments included that staff were caring and helpful, and used words such as 'excellent' and 'brilliant'. 11 patients made negative comments about the practice; two of these related to a member of reception staff being curt and the rest related to appointment access.

We also spoke with ten patients who we met in the waiting area during the inspection. All ten patients told us they were satisfied with the overall standard of care they received.

We spoke with one member of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said they felt valued and appreciated.

Areas for improvement

Action the service SHOULD take to improve

- Continue to monitor security in the management of prescription stationery.

Outstanding practice

- The practice actively engaged with patients and was responsive to the local community. Needs were assessed and action was taken to improve care and encourage healthier lifestyles. For example the practice had worked with its Patient Participation Group (PPG) to organise activities for local over 75s as a means of reducing social isolation. This had resulted in a one third decrease in appointments made by older people, and their number of hospital admissions had also fallen. The PPG had sent a teenage survey to younger patients asking for their views; and the practice had then offered drop-in sessions for teenagers who were not registered with the practice to allow them to attend anonymously for advice. The practice had also run a men's health evening in a local pub to promote health screening and to educate patients about alcohol intake. As a result of the event the practice identified a small number of patients with previously undiagnosed hypertension who were followed up.

Pool Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Pool Medical Centre

Pool Medical Centre is a practice in the village of Studley with a catchment area also including the neighbourhoods of Mappleborough Green, Marton Bagot, Outhill, Sambourne, and Coughton. The practice operates under a Personal Medical Services (PMS) contract with NHS England. A PMS contract is one type of contract between general practices and NHS England for delivering primary care services to local communities. The practice operates from premises which were purpose built in 1991. The building has accessible facilities for patients with additional needs, such as wheelchair access and disabled parking. There is also a pharmacy on the premises although this is not run by the practice. Pool Medical Centre has a patient list size of 6,286. Pool Medical Centre is a training practice which has qualified junior doctors working under the supervision of the GPs.

Pool Medical Centre's patient list has lower than average levels of social deprivation. There are a higher than average number of patients aged 45 and above, and a lower than average number aged 44 and below. The practice has expanded its contracted obligations to provide enhanced services to patients. An enhanced service is above the contractual requirement of the practice and is commissioned to improve the range of services available to patients. For example, the practice offers minor surgery, unplanned admissions, rotavirus and shingles immunisation and risk profiling and case management.

The clinical team includes three male GP partners, one female salaried GP, two trainee GPs, one triage nurse, two practice nurses and one healthcare assistant. The team is supported by a practice manager, an IT coordinator, two medical secretaries, one administrator, eight reception staff and one apprentice.

Pool Medical Centre is open from 8.30am to 6pm from Monday to Friday. The practice is closed between 1pm and 2pm daily and from 2pm until 4pm on Thursdays. Extended opening hours are on Monday evenings from 6.30pm until 8pm, and Wednesday mornings from 7.30am until 8am. The practice reception team is available to answer the phones during the core hours of 8am until 6.30pm from Monday to Friday, during which time a GP is always available in the event of an emergency. Outside of these hours there are arrangements in place to direct patients to out-of-hours services provided by NHS 111.

Why we carried out this inspection

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. The 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.

Detailed findings

How we carried out this inspection

Before the inspection we reviewed a range of information we hold about the practice and asked other relevant organisations to share their information. We carried out an announced inspection on 23 August 2016, during which we:

- Spoke with clinical and non-clinical staff.
- Spoke with patients who were attending the practice on the day of the inspection.
- Made observations of staff interactions with patients.
- Reviewed CQC comment cards completed by patients in the two weeks prior to the inspection.

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia).

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.

Good

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- We interviewed staff members who told us they would inform the senior receptionist or practice manager of any incidents. There was a suitable incident recording form and this supported the recording of notifiable incidents under the duty of candour. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.
- There was evidence demonstrating that when things went wrong with care and treatment patients were informed of the incident and offered reasonable support and a written apology.
- The practice discussed significant events during the relevant staff meeting (there was a receptionist meeting every two weeks, a nurse meeting every month, clinical meetings every week and a whole practice meeting every six weeks) to ensure that learning was cascaded.

We reviewed details of significant events the practice had recorded in the previous 12 months and saw that these had been dealt with appropriately and measures implemented as a result of lessons learned. For example, following an incident where a GP issued a death certificate for a patient at a care home unaware they were subject to the Mental Capacity Act's Deprivation of Liberty Safeguards (DoLS). The DoLS are checks carried out to ensure any person deprived of their liberty is protected, and that the action is appropriate and in the person's best interests. In some circumstances the deaths of people subject to DoLS need to be investigated by the Coroner before a death certificate is produced. As a result of this incident the practice implemented a new End of Life policy for dealing with DoLS. The practice also contacted the care home to confirm that all patients with DoLS were known to the practice.

The practice received safety alerts issued by external agencies, for example from MHRA (Medicines and Healthcare products Regulatory Agency). These were received by the practice manager who circulated these to the relevant staff members. Alerts were discussed at clinical governance meetings to ensure appropriate action was taken as a result. We looked at recent alerts and saw that action had been taken as a result.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.

- There were appropriate arrangements to safeguard children and vulnerable adults from abuse. These reflected relevant legislation and local requirements. There were practice safeguarding policies and all staff we spoke with knew how to access these. The policies identified who to contact for further guidance if staff had concerns about a patient's welfare. One of the GPs was the practice lead for safeguarding. The GPs liaised with other agencies regarding safeguarding as required. Staff understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. All staff had additionally completed IRIS (Identification and Referral to Improve Safety) training in domestic violence, which included both adult safeguarding and child protection training to level 3.
- There was a notice in the waiting room which advised patients of how to request a chaperone, as well as in all clinical rooms. It was the practice policy for nurses and the healthcare assistant to act as chaperones and they had received training and a Disclosure and Barring Service (DBS) check. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. Several members of reception staff were additionally trained to allow them to act as chaperones if a member of the nurse team was not available. Non-clinical staff that had been employed for a significant amount of time were risk assessed by the practice and reviewed annually, but only newly recruited staff had received a DBS check. The practice also provided information that they had decided to conduct DBS checks for all remaining non-clinical staff who acted as chaperones and these had been applied for. Following the inspection the practice confirmed that these had been received.

Good

Are services safe?

- Appropriate standards of cleanliness and hygiene were observed by the practice, and we observed the premises to be clean and tidy during the inspection. One of the practice nurses was the infection control lead and all staff had received up to date training in June 2016. Annual infection control audits were also undertaken and we saw evidence that action was taken to address improvements identified as a result of recent audits, for example wipe-clean chairs had been purchased to replace those with absorbent fabrics. There was also a policy for the cleaning of children's toys in the reception area.
- There were systems in place for dealing with repeat prescriptions. Where a patient had reached their maximum number of repeat prescriptions and were overdue for a review, they were provided with a prescription for a small supply of medicine and asked to make an appointment. The practice also reviewed prescriptions that had not been collected by patients.
- Clinical rooms were locked when they were not in use and staff removed computer access cards when they left their computers unattended. Paper patient records were securely stored in locking cabinets. Prescription stationery was stored securely but printer forms were not tracked after being removed from their boxes. The practice confirmed following the inspection that measures had been put in place to manage this.
- The practice had a number of patients who were prescribed high risk medicines. The practice had shared care agreements in place for these patients, who also received treatment from specialists in their particular illness. Any patients who did not attend for secondary care monitoring such as blood testing were followed up to ensure that they were prescribed medicines safely.
- The practice had implemented measures to monitor fridge temperatures and take action if cold storage medicines deviated from the recommended range. We saw evidence that a temperature log was maintained and medicines were rotated frequently. Two nurses at the practice were responsible for monitoring these and ordering medicines.
- One of the practice nurses was a qualified Independent Prescriber and could therefore prescribe medicines for specific clinical conditions. She received support from the GPs and attended annual chronic disease management updates to maintain her professional knowledge. The practice used Patient Group Directions to allow the practice nurses to administer medicines in line with legislation. The healthcare assistant was trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.
- During our inspection we reviewed five personnel files which contained documentation evidencing appropriate recruitment checks prior to employment. For example files contained references, proof of identity, qualifications, registration with the appropriate professional body and DBS checks for clinical members of staff.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- The practice had implemented procedures to monitor and manage risks to patient and staff safety. There was a fire risk assessment dated July 2016 and we saw evidence that fire alarm tests and drills had been carried out. The last annual portable appliance test had been carried out in October 2015 for all electrical equipment to ensure it was safe to use. Clinical equipment was calibrated every year to ensure it was working properly and records showed that the last checks had been carried out in June 2016. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella. Legionella is a term for a particular bacterium which can contaminate water systems in buildings.
- The practice carried out workforce planning to ensure a suitable number and mix of staff were available to meet patients' needs at all times. For example, the practice nurse team and non-clinical staff provided holiday cover for one another and could not take annual leave at the same time where this would leave the practice understaffed. The practice increased its use of telephone appointments when GPs were on annual leave to help manage appointment demand and there was a triage nurse who directed patients appropriately.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

Good

Are services safe?

- There were panic buttons in all clinical rooms and there was also an instant messaging system available on all computers which staff could use to alert one another in the event of an emergency.
- Staff were up to date with basic life support training. Staff we spoke to were able to tell us how they would respond to a variety of emergencies.
- Emergency medicines were available and staff knew how to access these. There was also a defibrillator with adults and children's pads, and oxygen with adult and children's masks. A first aid kit and an accident book were available. All of the medicines and equipment we checked were in date.
- The practice had a disaster handling and recovery plan which was regularly updated and could be used in the event of major incidents such as power failure or building damage. The plan included emergency contact telephone numbers for key staff and local suppliers. Copies were kept off site for use in the event that the premises could not be accessed.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practices clinical staff assessed needs and delivered care in line with relevant and current evidence based guidance and standards. This included National Institute for Health and Care Excellence (NICE) best practice guidelines. There were systems in place to keep all clinical staff up to date by email. Staff knew how to access guidelines to inform the care they delivered. The practice monitored that these guidelines were followed, for example using clinical audits. We saw examples of recent guidance received and audits undertaken which demonstrated that the system was effective.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. QOF is a system intended to improve the quality of general practice and reward good practice. The most recent published results were 99% of the total number of points available.

Exception reporting was significantly higher than the Clinical Commissioning Group (CCG) or national averages for osteoporosis, contraception and cardiovascular disease. Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects. The practice was aware that exception reporting was high in these areas for the previous year but felt that there may have been errors with the data published, as they had successfully achieved 0% exception reporting in these areas the following year. For example, exception reporting was 14% for contraception, compared with the CCG average of 2% and the national average of 3%. The practice had since improved this, and we saw published evidence that during the following QOF year exception reporting for this indicator had reduced to 0%. Osteoporosis exception reporting was high at 40%, compared with the CCG and national averages which were both 12%, although it should be noted that the small number of patients involved made this indicator appear inflated. We saw that during the following year this had reduced to 0%. For cardiovascular disease, the practice exception reported 67% of patients, compared with the CCG average of 35% and the national average of 30%. Again, we saw evidence that during the following QOF year this had been reduced to 0%.

This practice was not an outlier for any QOF (or other national) clinical targets. We also checked QOF data published following the inspection and this confirmed that the practice had maintained its performance. Data from 2014/2015 showed:

- Performance for diabetes related indicators was similar to CCG and national averages. For example, 80% of the practices patients with diabetes had a blood glucose level within the target range in the preceding 12 months compared with the CCG average of 82% and the national average of 78%. Exception reporting was 9% for this indicator, lower than the CCG average of 10% and the national average of 12%. 95% of patients with diabetes had a record of a foot examination in the preceding 12 months compared with the CCG average of 92% and national average of 88%. Exception reporting was 8%, compared with the CCG average of 5% and the national average of 8%.
- Performance for mental health related indicators was also similar to the CCG and national averages. For instance, 91% of patients with a form of psychoses had a comprehensive, agreed care plan documented in the preceding 12 months, compared to the CCG average of 93% and the national average of 88%. Exception reporting was 3%, significantly lower than the CCG average of 11% and the national average of 13%. 91% of the same group had also had their alcohol consumption recorded in the previous 12 months, similar to the CCG average of 94% and the national average of 90%. The practice had not exception reported any patients for this indicator, whereas the CCG average was 9% and the national average 10%.

There was evidence of quality improvement including clinical audit.

- The practice was able to provide examples of quality improvement activity, but during the inspection we only saw evidence of three clinical audits which had been completed in the last two years. Two of these were completed audits where the improvements made were implemented and monitored. Following the inspection the practice informed us that a quarterly controlled drug prescribing audit had also been implemented.

Good

Are services effective?

(for example, treatment is effective)

- The practice participated in benchmarking to monitor its performance against other practices and identify areas for improvement.
- Findings were used by the practice to improve services. For example, recent action taken as a result included an audit to evaluate and improve antibiotic prescribing for patients with sore throat symptoms against NICE clinical guidance.

Effective staffing

The practice used a number of measures to ensure that staff had the skills, knowledge and experience to deliver effective care and treatment.

- An induction programme was used to orientate all newly appointed staff to the practice. This covered such topics as confidentiality, infection control, health and safety and fire safety.
- Staff had completed specific training relevant to their role and competency updates if required. The practice used a training log and annual appraisals to identify training needs. For example, those reviewing patients with long-term conditions attended annual chronic disease update courses.
- The nursing team administered vaccines and took samples for the cervical screening programme. Staff carrying out these roles had completed specific training and an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, such by accessing online resources and making a record of updates for ease of reference.
- The practice held annual staff appraisals meetings to review professional development and identify learning needs. Staff we spoke with during the inspection told us they had access to appropriate training to cover the scope of their work. The practice supported GPs and nurses in the revalidation of their skills in order to maintain their professional registrations.
- All staff received training that included safeguarding, fire safety awareness, basic life support and information governance. Staff were trained using e-learning as well as in-house training.

Coordinating patient care and information sharing

Staff could review the information they required to plan and deliver care and treatment through the practice's patient record system. This included risk assessments, care plans, medical records and investigation and test results.

The practice worked with other services and health and social care professionals to share relevant information and assess and meet the needs of patients. This included when patients were referred or moved between services.

Multidisciplinary meetings were held every month. We saw minutes and these included discussions about vulnerable patients, those at risk of hospital admission and those approaching the end of life. The practice worked with Macmillan nurses and followed the Gold Standards Framework guidance in end of life care.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Clinicians demonstrated their understanding of the relevant consent and decision-making requirements of legislation and guidance. This included the Mental Capacity Act 2005, Gillick competence and Fraser guidelines. Staff understood why these needed to be considered when providing care and treatment to young patients under 16. The Gillick test is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions. Fraser guidelines related specifically to contraception and sexual health advice and treatment.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- There was a consent recording form for minor surgery procedures and written consent was stored in patient notes.

Supporting patients to live healthier lives

The practice had made arrangements to identify patients who may require additional support. For example patients receiving end of life care, carers, those at risk of developing a long-term condition. Patients who required dietary or smoking cessation advice were signposted to the relevant service.

The practice's uptake for the cervical screening programme was 84%, which was in line with the CCG average of 83%

Good

Are services effective?

(for example, treatment is effective)

and the national average which was 82%. Exception reporting was lower than average at 4%, compared with the CCG average 5% and the national average of 6%. There was a female sample taker available to encourage patient uptake, and failsafe systems were used to verify that results had been received for all samples and ensure any abnormal results were followed up. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. Data from the National Cancer Intelligence Network published in March 2015 showed that the practice was in line with averages. For example, 78% of women aged 50 to 70 had been screened for breast cancer within the target period, similar to the CCG average of 75% and the national average of 72%. 66% of patients aged 60 to 69 had been screened for bowel cancer within the target period, compared with the CCG average of 64% and the national average of 58%.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 90% to 98%, which was comparable to the CCG average of 84% to 99%. Rates for five year olds from 90% to 95%, which was slightly higher than the CCG average of 93% to 98%.

Appropriate health assessments and checks were available to patients, including NHS health checks for patients aged 40–74 and enhanced health checks for the over 75s.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During the inspection we saw that staff were courteous to patients, offering assistance where appropriate, and treating them with dignity and respect.

- Clinician's consulting rooms had curtains to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Doors were closed during consultations and this prevented conversations being overheard.
- Reception staff told us that if a patient appeared upset or asked to discuss something of a sensitive nature they offered to take them to a private room to discuss their needs.

Thirty-two of the 43 patient Care Quality Commission comment cards we received were positive about the service experienced. Positive comments included that staff were caring and helpful, and used words such as 'excellent' and 'brilliant'. Eleven patients made negative comments about the practice, and two of these related to a member of reception staff being curt. Following the inspection we were informed that customer service update training had been arranged for reception staff as a result of these comments and would be completed on 21 September 2016.

We spoke with one member of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said they felt valued and appreciated.

We also spoke with 10 patients who we met in the waiting area during the inspection. All 10 patients felt their privacy and dignity was respected by staff at the practice. All were satisfied with the overall standard of care they received. One patient stated that one member of reception staff was difficult to communicate with. The other patients we asked said they were happy with staff attitudes.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was in line with averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 91% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 83% and the national average of 89%.
- 91% of patients said the GP gave them enough time compared to the CCG average of 91% and the national average of 87%.
- 97% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 98% and the national average of 95%.
- 84% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 89% and the national average of 85%.
- 92% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% national average of 91%.
- 95% of patients said they found the receptionists at the practice helpful compared to the CCG average of 89% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

The patients we spoke with told us they felt they were involved when it came to making decisions about the care and treatment they received. They said that clinical staff were good at listening, allowed them enough time and provided information to help them understand their options.

Results from the national GP patient survey showed patients responses to questions about their involvement in planning and making decisions about their care and treatment were in line with national averages. For example:

- 88% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 91% and the national average of 86%.
- 87% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 87% and the national average of 82%.
- 82% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 88% and the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care, for example:

- Staff told us that language barriers were identified at the time of patient registration, and that leaflets were

printed in the relevant language for those who needed them. The practice offered an interpreter service to assist patients whose first language was not English during consultations. Translation software on the practice website allowed users to view it in any of 65 different languages.

- The practice provided pictorial leaflets to assist patients with a learning disability.
- There was a hearing loop to assist patients with a hearing difficulty, and the practice was considering how to offer improved services to these patients by using more email communication.
- A wide range of information leaflets were available for patients to aid their understanding of illnesses and explain what support they could access. GPs referred patients to guidance relevant to their conditions.
- Information was displayed on the walls in the patient waiting areas to raise awareness of various health issues.

Patient and carer support to cope emotionally with care and treatment

There were also patient information leaflets and notices about support groups and organisations on display in the patient waiting area and on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 131 patients as carers (2% of the practice list). A member of non-clinical staff had a lead role in managing the carers register and monitoring their uptake of relevant services. For example, carers were able to receive the flu vaccine free of charge. There was a board in the patient waiting area providing information for carers about avenues of support available.

Staff told us that if families had suffered bereavement, the practice sent a sympathy card and the last GP they had attended a consultation with offered to make a home visit. The GP signposted bereavement services to the patient and asked the patient questions to assess their state of health.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Services were tailored to meet the needs of individual people and delivered in a way that ensured flexibility, choice and continuity of care. The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. There was a proactive approach to understanding the needs of different groups of people and delivering care in a way that met their needs and promoted equality. This included people who were in vulnerable circumstances or who had complex needs. The involvement of other organisations and the local community was integral and ensured that services meet people's needs.

- The practice offered extended opening hours on Monday evenings from 6.30pm until 8pm, and Wednesday mornings from 7.30am until 8am for working patients who could not attend during normal opening hours.
- Patients could access online services such as repeat prescription ordering and appointment booking.
- The involvement of other organisations and the local community is integral to how services were planned and ensured that services met people's needs.
- There were large schools in the area and the practice recognised that adolescents were a key group. The PPG had sent a teenage survey to younger patients asking for their views. The practice had then offered drop-in sessions for teenagers who were not registered with the practice to allow them to attend anonymously for advice, but found there was little demand. The practice continued to offer a school nurse service.
- The practice had also held a men's health evening in a local pub to offer health screening and to educate patients about alcohol intake. The practice had invited all men aged 18 to 75 who were not otherwise attending for health monitoring. Approximately 50 men attended the event. Members of clinical and non-clinical staff ran the event by setting up several stations for patients to visit, at which checks such as weight and blood pressure were carried out. As a result of the event the practice identified a small number of patients with previously undiagnosed hypertension who were followed up.
- The practice had worked with a dedicated over 75s care coordinator provided by Prime GP who had retired shortly before the inspection. The care coordinator saw patients at the practice as well as in their own homes, and after speaking with over 690 older patients to discuss their needs she identified that 21% felt lonely. The practice had worked with the PPG to organise tea dances at Studley Village Hall for local over 75s, as a means of reducing social isolation. These were ticketed events supported by the practice and had been very successful with over 120 attendees. Since beginning to organise activities for the over 75s there had been a one third decrease in appointments made by older people, and their number of hospital admissions had also fallen. The practice continued to work with the PPG to organise activities to support this group. It had also arranged for older people to visit local schools to talk about their lives.
- The practice participated in events organised by Silver Line charity, and had recently hired coaches to allow patients to attend a celebrity event at Stratford Civic Centre.
- The practice worked jointly with the local parish council to promote dementia friendly allotments to patients. The PPG had also organised a memory walk to encourage people with dementia to socialise and remain active.
- The practice was a member of the Safe Place Scheme for people with a learning disability. This meant there was a logo displayed identifying the practice building to those with a learning disability as a safe place to come if they need assistance or are experiencing fear. Longer appointments were also available for patients with a learning disability.
- Older patients and patients who had clinical needs which resulted in difficulty attending the practice could access home visits.
- Appointments were available on the same day for children and patients with medical problems that required same day consultation.
- The PPG liaised with the practice to create a monthly newsletter and made this available in the patient waiting area. This informed patients of changes to staffing and shared practice news, provided information about the practice website and the PPG, and notified patients of events such as flu vaccination clinic dates. There was also a TV screen in the waiting area displaying information for patients.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

Patients could access appointments and services in a way and at a time that suited them. The practice was open from 8.30am to 6pm from Monday to Friday and appointments were available between these times. The practice closed between 1pm and 2pm daily and from 2pm until 4pm on Thursdays. The practice reception team were available to answer the phones during the core hours of 8am until 6.30pm from Monday to Friday, during which time a GP was always available in the event of an emergency. Extended opening hours were on Monday evenings from 6.30pm until 8pm, and Wednesday mornings from 7.30am until 8am. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them. On Mondays and Tuesdays the triage nurse filtered and prioritised appointment requests by speaking to patients over the telephone and establishing the nature of the appointment and the urgency of need.

Results from the national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to or higher than local and national averages.

- 79% of patients were satisfied with the practice's opening hours compared to the CCG average of 77% and the national average of 76%.
- 96% of patients said they could get through easily to the practice by phone compared to the CCG average of 78% and the national average of 73%.

Of the ten patients we spoke with on the day of the inspection, six said that they were always able to get appointments when they needed them, and four said they could usually but not always get appointments when they needed them.

The practice had a home visit request policy outlining how to deal with these. The system allowed the practice to assess whether a home visit was clinically necessary and the urgency of the need for medical attention. Patients requesting a home visit asked patients if they were willing to provide brief details of the issue and whether they could wait until 1pm for the GP to telephone. Any patients who felt their need was so urgent they could not wait were telephoned by the duty GP immediately, and the remainder were phoned at 1pm. The GP assessed the level of need during the telephone discussion with the patient and prioritised their visit accordingly. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Both clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- One of the GPs was the lead for managing complaints in the practice and the GP was assisted by the practice manager in handling these.
- The practice displayed its complaints procedure in the patient waiting area, and this was in line with recognised guidance and contractual obligations for GPs in England.

We looked at five complaints received in the last 12 months and found that these had been properly managed and lessons were learned. The practice took action to improve the quality of care as a result of concerns raised. For example, a patient had complained when their appointment with the duty GP had to be re-arranged. The patient had taken time off work to attend the appointment and was told on arrival that the appointment had been moved to the afternoon due to the GP attending an emergency home visit. The patient was unhappy as they then had to arrange further time off work the same day. The practice acknowledged that while the emergency visit had to be prioritised the patient's circumstances ought to have been taken into account, and staff should have attempted to find another appointment that morning. As a result of this complaint reception staff were provided with training to assist them in dealing with similar situations in future, to help minimise the inconvenience to patients whose appointments had to be changed.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision for patients to have greater control of their health and wellbeing, and support to live longer through high quality health and care services that are compassionate, inclusive and constantly improving. The practice had also implemented a set of core values for staff to follow, these were: innovation; caring; encouragement; resilience; flexibility; courage; ambition and adaptability. Staff we spoke with during the inspection were aware of the vision and values of the practice and had a common focus on improving quality of care and people's experiences.

The practice also recognised the challenges it faced and took a proactive approach to dealing with problems. For example, the practice had found it difficult to recruit new GPs to plan for succession when the partners chose to retire. The planned closure of another local practice would add a large influx of new patients, and the partners were considering how to cope with the demands of a larger patient list. Also, the restructuring of a local hospital meant that a number of secondary care services would no longer be available to patients, and the practice was planning how to ensure patients received the care they needed.

Governance arrangements

Governance arrangements supported collaboration between staff and the delivery of the practice's aims.

- The practice had successfully participated in a bespoke leadership programme for General Practice. This was a leadership course designed to strengthen and improve practices through the shared leadership of GPs, practice managers and practice nurses. The practice told us this experience had improved their way of working.
- Staff we spoke with understood their roles and responsibilities and were able to tell us who clinical and non-clinical leads were.
- Practice specific policies were used and staff could easily access these.
- The practice monitored its performance and used this information to implement improvements.
- There were processes in place for managing risks and protecting staff and patients, but electronic prescription stationery was not monitored during use and not all members of non-clinical staff had received a DBS check before conducting chaperone duties.

Leadership and culture

The inspection team met with the partners in the practice who assured them they had the capability and experience to provide a high quality of care and ensure the effective running of the practice. They were committed to achieving a comprehensive and efficient health service and improving patients' quality of life.

There were high levels of staff satisfaction. Staff were proud to work for the practice and spoke highly of the culture. Staff told us they were on first name terms with the partners and practice manager, and found them approachable and helpful.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. There was an open and friendly culture in the practice, and there were systems in place to ensure that when things went wrong with care and treatment affected patients received reasonable support and sufficient information to help them understand. There was evidence demonstrating that when things went wrong with care and treatment patients were informed of the incident and offered reasonable support and a written apology.

There was a clear leadership structure in place and staff felt supported by management.

- The practice held a range of meetings to support communication between staff. For example the reception team held a morning briefing as well as a weekly team meeting. There were also monthly whole practice meetings and weekly clinical meetings.
- Staff told us they felt like part of a family working at the practice, and that they felt supported in dealing with problems.
- Staff said they were respected and their contribution to the practice was valued.

Are services well-led?

Good

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

- Staff were involved in extracurricular activities organised by the practice, such as charity fundraising events and social activities. For example staff had raised money for charity by fasting for Ramadan for a day in support of a Muslim staff member.

Seeking and acting on feedback from patients, the public and staff

Innovative approaches were used to gather feedback from different groups of patients. There were consistently high levels of constructive staff engagement and all staff were encouraged to raise concerns.

- The practice gathered feedback from patients through the patient participation group (PPG) as well as through surveys and complaints received. The PPG met formally with the practice every three months, and carried out patient surveys and submitted proposals for improvements to the practice management team. For example, the PPG had carried out a teenagers' survey to assess whether they found services accessible. The PPG had also submitted proposals which the practice had put into action such as installing a waiting room TV to display information for patients. The practice had also worked with an over 75s care coordinator to engage with over 690 older people and discuss their needs.
- Staff provided feedback to the practice in a variety of ways, including informally by discussion, through appraisal meetings and at monthly staff meetings. Staff we spoke with during the inspection told us they felt able to give feedback and discuss any concerns or ideas for improvements with colleagues and management.

Continuous improvement

As a training practice Pool Medical Centre had two qualified junior doctors working under the supervision of its senior GPs at the time of our inspection. There was also a strong focus on continuous learning and improvement at all levels within the practice.

For example, two of the practice's GPs were participating in the Health Education England Urgent Care Fellowship pilot which involved rotating between the practice and a local Accident and Emergency department. This was done in conjunction with Warwick University with the aim of improving the GPs skillset and bridging the gap between primary and secondary care.

One of the practice nurses was a mentor for pre-registration nurses, and the practice was participating in the national apprenticeship scheme.

The practice showed us a SWOT analysis it had carried out. A SWOT analysis is a study carried out by an organisation to identify its internal strengths and weaknesses, as well as external opportunities and threats. This had helped the practice to create a strategy for the future, for example the practice had recognised the potential to expand its pharmacy and extend the role of their pharmacist in primary care in order to subsidise its income and cope with increasing demands.

There was a systematic approach to working with other organisations to improve care outcomes and obtain best value for money. The practice was part of a GP Federation with 35 other practices in South Warwickshire. This allowed the practice to benefit from economies of scale whilst retaining their independence and providing a local service. This also meant that the practice was part of a buddy group with several other practices with which it could share best practice ideas and discuss challenges.