The Clays Practice

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?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We undertook a planned, comprehensive inspection of The Clays Practice on 11February 2015. The practice provided primary medical services to people living in the village of Roche and surrounding villages in Cornwall. The practice also had two other branch surgeries in St Dennis and Bugle that were open every weekday morning.

The practice comprised of a team of five GP partners (four male and one female) who held managerial and financial responsibility for running the business. In addition there were one and a half salaried GPs, four registered nurses, six qualified dispensers and three health care assistants. There was also a comprehensive administrative team that consisted of a full time practice manager, a deputy practice manager, receptionists and administration staff.

Patients who used the practice had access to community staff including district nurses, community psychiatric nurses, health visitors, physiotherapists, mental health staff, counsellors, chiropodist and midwives.

The practice had a dispensary attached. A dispensing practice is where GPs are able to prescribe and dispense medicines directly to patients who live in a rural setting. The Clays practice dispensed to patients who did not have a pharmacy within a mile radius of where they lived.

The practice is rated as good. A safe, caring, effective, responsive and well-led service was provided that met the needs of the population it served.

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Our key findings were as follows:

- Patients reported having good access to appointments at the practice. The practice was clean, well-organised, had good facilities and was well equipped to treat patients.
- The practice valued feedback from patients and acted upon this. Feedback from patients about their care and treatment was consistently positive. The culture of the practice was patient centred. Staff were motivated

Summary of findings

and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. Views of external stakeholders were very positive and were aligned with our findings.

- The practice was well-led and had a clear leadership structure in place. There were systems in place to monitor and improve quality and identify risk and systems to manage emergencies.
- There were arrangements for the efficient management, storage and administration of medicines within the practice and within the dispensary.
- Patients told us they felt safe, that staff were professional and they felt confident in clinical decisions made. There were effective safeguarding procedures in place.
- Significant events, complaints and incidents were investigated and discussed. Staff learned from these events and shared their learning within the team.

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

Importantly, the provider must:

Ensure that each patient who requires it has a care plan which shows their needs have been assessed and shows what care is planned and how it will be delivered in line with current legislation.

Recruitment processes must be improved to include proof of identity, including a recent photograph, references, a full employment history, and a risk assessment to determine the decision regarding carrying out a criminal record check, using the Disclosure and Barring Service (DBS).

In addition the provider should:

Staff training records should be improved so that staff that need training updates are easily identifiable.

Treatment rooms should be kept locked when not in use in order to ensure the security of blank prescription forms and other sensitive material.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. There were enough staff to keep people safe. However, recruitment processes were incomplete and could compromise patient safety.

Are services effective?

Good

The practice is rated as good for effective. However some improvements were needed. Care and treatment was not consistently being delivered in line with current published best practice. Care was not always planned to meet identified needs nor was it always reviewed. Care plans were not in place for people with complex health needs.

Referrals to other services were made in a timely manner. The practice regularly undertook clinical audit, reviewing their processes and monitoring the performance of staff. Staff had received training appropriate to their roles and arrangements had been made to support clinicians with their continuing professional development. The practice worked with other healthcare professionals to share information.

Are services caring?

Good

The practice is rated as good for providing caring services. All the patients we spoke with during our inspection were very complimentary about the service. All the patients who completed a comment card in the weeks before our inspection were entirely positive about the care they received. We saw staff interacting with patients in a caring and respectful way.

Staff were motivated and inspired to offer kind and compassionate care and put significant effort in to providing care that took account of each patient's physical support needs and individual preferences. Patients were involved in making decisions about their treatment and were given sufficient time to speak with the GP or nurse. Patients were referred appropriately to other support and treatment services.

Are services responsive to people's needs?

Good

The practice was rated as good for providing responsive services.

Summary of findings

The practice is rated as good for providing responsive services. The practice reviewed the needs of their local population and engaged with the NHS England Area Team and local Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

Patients reported good access to appointments. Urgent appointments were available the same day. There was a clear complaints policy and procedure demonstrating that the practice responded quickly to issues raised and brought them to resolution. There was evidence of shared learning from complaints with staff and other stakeholders.

Are services well-led?

Good

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

The practice had a clear vision and strategy to deliver this. Staff were clear about the vision and their responsibilities in relation to it. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and regular governance meetings had taken place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had a virtual patient participation group (PPG) which was called upon when needed.

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

Requires improvement

The practice is rated as requires improvement for the care of older patients. The practice provided personalised care to meet the needs of the older patients in its population but did not always consider proactive assessment and review, for example in end of life care and reducing admissions to hospital.

The practice was responsive to the needs of older patients, including offering home visits and rapid access appointments for those with enhanced needs and home visits.

People with long term conditions

Good

The practice is rated as good for the population group of patients with long term conditions. Emergency processes were in place and referrals made for patients in this group who had a sudden deterioration in health. When needed, longer appointments and home visits were available together with structured annual reviews to check their health and medicines needs were being met. For those patients with the most complex needs the GPs worked with relevant health and social care professionals to deliver a multidisciplinary package of care. The practice had in place personalised care plans to support patients with long term conditions to improve the quality and coordination of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Parents we spoke with were very happy with the care their families received.

There were well organised baby and child immunisation programmes available to help ensure babies and children could access a full range of vaccinations and health screening.

The practice had effective relationships with health visitors and the school nursing team, and was able to access support from children's workers and parenting support groups. Systems were in place to alert health visitors when children had not attended routine appointments and screening. Health visitors and midwives ran weekly clinics from the practice. The practice referred patients and worked closely with a local family and child service to discuss any vulnerable babies, children or families.

Men, women and young people had access to a full range of contraception services and sexual health screening including chlamydia testing and cervical screening.

Summary of findings

The practice was working towards being EEFO approved. (The term EEFO does not stand for anything. EEFO is a word that has been designed by young people, to be owned by young people.) EEFO works with services in the community to make sure they are young people friendly. Once a service has been EEFO Approved it means that service has met the quality standards. For example, confidentiality and consent, easy to access services, welcoming environment and staff trained on issues young people face. Part of this scheme is the C-Card scheme. The C card is given so that a younger person can get free condoms at different places across Cornwall & the Isles of Scilly.

Appropriate systems were in place to help safeguard children or young people who may be vulnerable or at risk of abuse.

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 offered online services as well as a full range of health promotion and screening which reflected the needs for this age group.

The practice offered early evening appointments to accommodate the needs of working patients however patients had access to telephone consultations. However, this was a very loose arrangement which was advertised on the practice website but was not promoted in the practice itself. Appointments were offered only if the patient could not attend at any other time.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of patients whose circumstances may make them vulnerable. The practice held a register of patients with learning disabilities. The practice had carried out annual health checks for patients with learning disabilities. The practice offered longer appointments for patients requiring more time with their GP.

Staff knew how to recognise signs of abuse in vulnerable adults and children. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and who to contact within the practice.

People experiencing poor mental health (including people with dementia)

Good

The practice had carried out annual health checks for people experiencing poor mental health. The practice regularly worked with multi-disciplinary teams in the case management of people

Summary of findings

experiencing poor mental health including those with dementia. The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations such as MIND.	

Summary of findings

What people who use the service say

The practice had provided patients with information about the Care Quality Commission prior to the inspection. Our comment box was displayed and comment cards had been made available for patients to share their experience with us. We collected six comment cards, all of which contained positive comments.

Comment cards were detailed and stated that patients appreciated the service provided, the caring attitude of the staff and the staff who took time to listen effectively. There were comments praising GPs, nurses and the reception team. Comments also highlighted a confidence in the advice and medical knowledge and a feeling of not being rushed.

These findings were reflected during our conversations with the nine patients we spoke with and from looking at the survey from 2014. The feedback from patients was overwhelmingly positive. Patients told us about their experiences of care and praised the level of care and support they consistently received at the practice. Patients said they were happy, very satisfied and said they had no complaints and received good treatment. Patients told us that the GPs and nursing staff were excellent.

Patients were happy with the appointment system although said they sometimes had to wait for their appointment or it took longer to see the GP of their choice. We were told patients could either book routine appointments four weeks in advance or make an appointment on the day. We saw receptionists helped patients choose an appointment to suit the patient.

Patients knew how to contact services out of hours and said information at the practice was good. Patients knew how to make a complaint. None of the patients we spoke with had done so but all agreed that they felt any problems would be managed well. Other patients told us they had no concerns or complaints and could not imagine needing to complain.

Patients were satisfied with the facilities at the practice and commented on the building always being clean and tidy. Patients told us staff respected their privacy, dignity and used gloves and aprons where needed and washed their hands before treatment was provided.

Patients found it easy to get repeat prescriptions and appreciated having the dispensary on site.

Areas for improvement

Action the service MUST take to improve

Ensure that each patient who requires it has a care plan which shows their needs have been assessed and shows what care is planned and how it will be delivered in line with current legislation.

Recruitment processes must be improved to include proof of identity, including a recent photograph, references, a full employment history, and a risk assessment to determine the decision regarding carrying out a criminal record check, using the Disclosure and Barring Service (DBS).

Action the service SHOULD take to improve

Staff training records should be improved so that staff that need training updates are easily identifiable.

Treatment rooms should be kept locked when not in use in order to ensure the security of blank prescription forms and other sensitive material.

Extended hours offered by the practice should be more widely publicised so that patients are aware of this service.

The Clays Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team also included a GP specialist advisor, a practice manager specialist advisor and a nurse specialist advisor.

Background to The Clays Practice

The Clays Practice cares for approximately 11,000 patients providing primary medical services to people living in the village of Roche and the surrounding areas. The practice also has two branch surgeries in the villages of Bugle and St Dennis.

The practice comprises of a team of five GP partners (four male and one female). GP partners hold managerial and financial responsibility for running the business. In addition there were one and a half additional salaried GPs, four registered nurses, three health care assistants, a practice manager, and additional administrative and reception staff.

Patients using the practice also have access to community staff including district nurses, community psychiatric nurses, health visitors, physiotherapists, speech therapists, counsellors and midwives.

Prior to this inspection, the CQC intelligent monitoring placed the practice in band 2. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

The Clays practice is open between Monday and Friday 8.30am – 6pm. Additional appointments are offered for half an hour every day at the end of normal surgery hours. These appointments are designed for patients who are unable to access appointments during normal office hours. Outside of these hours a service is provided by another health care provider.

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. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

The inspection team carried out an inspection of The Clays practice . This was an announced inspection on 11th February 2015. We spoke with nine patients and 15 members of staff.

We observed how administrative staff dealt with patients in person and over the telephone. We discussed anonymised patient care plans. We spoke with and interviewed a range

Detailed findings

of staff including GPs, the practice manager, the practice nurses, reception and administrative staff. We also reviewed comment cards where patients shared their views and experiences of the service. These had been provided by the Care Quality Commission (CQC) before our inspection took place. In advance of our inspection we talked to the local clinical commissioning group (CCG) and the NHS England local area team about the practice

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

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

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

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety, for example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses.

.Learning and improvement from safety incidents

The practice was open and transparent when there were near misses or when things went wrong. There was a system in place for reporting, recording and monitoring significant events, incidents and accidents. We asked for and saw records were kept of significant events that had occurred during the past year, and these were made available to us. We found details of the event, steps taken, specific action required and learning outcomes and action points were noted.

Significant events were discussed at the practice's monthly team meetings. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

We saw there had been a significant event in relation to a patient's transfer to hospital. This had identified some key learning points, which had been shared with the relevant staff.

We discussed the process for dealing with safety alerts with the practice manager. Safety alerts inform the practice of problems with equipment or medicines or give guidance on clinical practice. They told us alerts came into the practice from a number of sources. They were reviewed by one of the GP partners and the practice manager, information was then disseminated to relevant members of staff.

Reliable safety systems and processes including safeguarding

Patients told us they felt safe at the practice and staff knew how to raise any concerns. A named GP had a lead role for safeguarding. They had been trained to the appropriate advanced level. There were policies in place to direct staff on when and how to make a safeguarding referral. This

included flow charts displayed for staff reference. The policies and flow charts included information on external agency contacts, for example the local authority safeguarding team.

Practice staff said communication between health visitors and the practice was good and any concerns were followed up. For example, if a child failed to attend routine appointments.

A chaperone policy was in place and was visible in the waiting room. Chaperone training had been undertaken by all nursing and healthcare staff. Staff were able to describe what their duties were should they need to chaperone a patient.

There were environmental risk assessments for the building. For example annual fire assessments, electrical equipment checks, control of substances hazardous to health (COSHH) assessments and visual checks of the building.

Medicines management

The practice had a dispensary attached, which provided dispensing for people who live further than a mile from a pharmacy. We looked at all the areas in the practice where medicines were stored. We also spent time in the dispensary talking to staff, looking at records and observing patients collecting their medicines. The dispensary was well ordered and working calmly, with sufficient staff available.

Refrigerators were available in the dispensary for storing medicines. The temperature of these refrigerators was checked and recorded daily. Records showed these were within the safe range for storing medicines.

Nursing staff were responsible for the ordering of vaccines for the practice. Vaccines were stored in dedicated refrigerators in the main part of the practice. Records of the daily temperature for the refrigerators showed they were kept at a safe temperature for storing vaccines.

The dispensary held stocks of controlled drugs. These are medicines that require extra checks and special storage

arrangements because of their potential for misuse. Standard procedures were in place that set out how they were managed. These were followed by the practice staff. For example controlled drugs were kept in a controlled drugs cupboard. Access to them was restricted and the keys held securely.

Systems were in place for patients to order repeat prescriptions. Dispensary staff generated the prescriptions which were checked and signed by the doctor before patients were given their medicines.

Dispensed prescriptions waiting collection were stored neatly so patient's names were not visible to people in the waiting area. We heard staff checking with patients to make sure they were given the correct medicines. Patients who were not using the practice dispensary could collect their medicines directly from their choice of pharmacy.

Stocks of blank prescriptions were stored securely in the dispensary. A range of standard operating procedures were in place for dispensary staff to follow. These were regularly reviewed.

Dispensing staff working at the practice had received training to undertake dispensing tasks. Staff had an annual appraisal.

Cleanliness and infection control

We looked around the practice and saw it was clean, tidy and well maintained. Patients we spoke with told us they were happy with the cleanliness of the facilities. Comments from patients who completed CQC comment cards reflected this.

One of the practice nurses was the nominated infection control lead. We saw there was an up to date infection control policy and detailed guidance for staff about specific issues. For example, action to take in the event of a spillage. All of the staff we spoke with about infection control said they knew how to access the practice's infection control policies. Infection control training was provided for all staff annually, although not all staff had attended a training course during the current year.

The risk of the spread of infection was reduced as all instruments used to examine or treat patients were single use, and personal protective equipment (PPE) such as aprons and gloves were available for staff to use. The treatment room had flooring that was impermeable, and easy to clean. Hand washing instructions were also displayed by hand basins and there was a supply of liquid soap and paper hand towels..

We looked at records and saw the domestic staff completed cleaning schedules, on a daily, weekly, monthly and annual basis. One of the practice nurses carried out regular infection control audits. We saw records confirming recent checks had been carried out on the sharps bins and the patient toilet areas.

We saw there were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We looked at some of the practice's clinical waste and sharps bins located in the consultation rooms. All of the clinical waste bins we saw had the appropriately coloured bin liners in place and all of the sharps bins we saw had been signed and dated as required.

Staff were protected against the risk of health related infections during their work. We asked the reception staff about the procedures for accepting specimens of urine from patients. They showed us there was a box for patients to put their own specimens in. The nursing staff then wore PPE when emptying the box and transferring the specimens. We confirmed with the nurse practitioner that all clinical staff had up to date hepatitis B vaccinations. We saw there were spillage kits (these are specialist kits to clear any spillages of blood or other bodily fluid) located throughout the building.

We saw that regular checks of the water system for legionella (a type of bacteria found in the environment which can contaminate water systems in buildings) were carried out, the most recent being in November 2014.

Equipment

Emergency equipment available to the practice was within the expiry dates. The practice had a system using checklists to monitor the dates of emergency medicines and equipment which helped to ensure they were discarded and replaced as required. Equipment such as the weighing scales, blood pressure monitors and other medical equipment were serviced and calibrated where required.

Portable appliance testing (PAT), where electrical appliances were routinely checked for safety annually, was last carried in 2014. Staff told us they had sufficient equipment at the practice.

Requires improvement

Are services safe?

Staffing and recruitment

We looked at the recruitment records of two staff employed within the past year. Both did not contain evidence that appropriate recruitment checks had been undertaken prior to employment. For example, there was no proof of identification, no written references, no risk assessments to determine the decisions re carrying out criminal records checks via the Disclosure and Barring Service (DBS). We also asked to see the recruitment files for the nursing staff. These were unavailable for us to see on the day as we were told the cupboard they were kept in was locked and the person with the key was on annual leave.

There was an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe.

Staff spoke positively about communication, team work and their employment at the practice. They told us they were actively supported in their employment and described the practice as having an open, supportive culture and being a good place to work.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

We saw treatment rooms had locks on the doors. However, we saw that these rooms were left unlocked when not being used. Some of these rooms contained emergency drugs and could have posed a risk if used inappropriately.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, there were emergency processes in place for identifying acutely ill children.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen and a defibrillator (used to attempt to restart a patient's heart in an emergency). All staff asked knew the location of this equipment.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. A resuscitation trolley was located in the main treatment room. The defibrillator and oxygen were accessible and records of weekly checks of the defibrillator were up to date.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure and access to the building.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They worked to guidelines from local commissioners and discussed best practice at GP meetings. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with current guidelines and these were reviewed when appropriate.

GPs and nurses remained up-to-date by attending courses in subjects relevant to their practice. We were able to see the records kept by the practice manager of all training courses and educational meetings they had attended. All the GPs and nurses interviewed were aware of their professional responsibilities to maintain their professional knowledge and skills.

GPs had areas of personal interest in which they specialised within the practice, for example in contraception and child health. Their expertise they shared amongst their peers to support their continual development. GPs and nurses were very open about asking for and providing colleagues with advice and support.

The practice referred patients appropriately to secondary and other community care services. National data showed the practice was in line with national standards on referral rates for all conditions.

All new patients to the practice were offered a health assessment carried out by the practice nurse to ensure the practice was aware of their health needs. Patients who relied on long term medication were regularly assessed and their medication needs reviewed. There were systems in place to ensure that the GPs reviewed the diagnostic and blood test results of their patients. If a GP requested a diagnostic test such as a blood test the results would be returned to them electronically.

The practice provided specialised appointments to meet the needs of patients. These included diabetes, asthma, and chronic obstructive pulmonary disease (COPD), a disease which results in breathing difficulties.

We spoke with the practice manager about the top 2% of their patients at most risk of frequent hospital admission. They were aware of this requirement and how it needed to be managed. However, the GPs we spoke with were not aware of this. Care and treatment was not consistently being delivered in line with current published best practice. Care was not always planned to meet identified needs nor was it always reviewed. Care plans were not in place for those 2% of people with complex health needs.

Interviews with GPs and staff showed that the culture in the practice was that patients were referred on need and decisions were not adversely influenced by patient age, gender or race.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles, which led to improvements in clinical care. We saw a number of clinical audits had recently been carried out. The results and any necessary actions were discussed at the primary healthcare team meetings.

Examples of clinical audits included an audit on the use of antibiotics in October 2014. The audit had identified some actions which could lead to improvements in patient care. We found the practice had responded to the issues identified and had updated the protocol for treating patients with antibiotics. A second audit cycle was to be carried out again within 12 months.

The practice were keen to ensure that staff had the skills to meet patient's needs. For example, nurses had received extensive training including immunisation, diabetes care, cervical screening and travel vaccinations.

GPs at the practice undertook minor surgical procedures and joint injections in line with their registration and NICE guidance. The staff were appropriately trained and kept up to date. There was evidence of regular clinical audit cycles in this area which was used by GPs for improving patient care as well as revalidation of their professional qualifications and personal learning purposes.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as basic life support. However, the system in place made it difficult to easily identify when staff needed updated training.

Good

Are services effective?

(for example, treatment is effective)

Role specific training was also provided. The practice nurses had been trained to administer vaccines and had attended updates on cervical screening. One of the GPs planned to attend a training course on contraceptive implant fitting to increase their skills and knowledge in that area.

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

All clinical staff had received an annual appraisal. However administrative staff had not. This had been noted and was planned for the coming month. Nursing staff told us they felt supported by each other but said there had been no formal professional nurse team meetings held and did not have the opportunity to discuss any issues of concern or learning points together.

The patients we spoke with were complimentary about the staff. Staff we spoke with and observed were knowledgeable about the role they undertook. Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. These duties included immunisation of babies and children, cervical screening and blood taking.

Working with colleagues and other services

The practice worked effectively with other services. Examples given were mental health services, health visitors, specialist nurses, hospital consultants and community nursing.

Once a month there was a multidisciplinary team meeting to discuss vulnerable patients, high risk patients and patients receiving end of life care. This included the multidisciplinary team such as physiotherapists, occupational therapists, health visitors, district nurses, community matrons and the mental health team.

The practice worked with other service providers to meet patients' needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hour's provider to enable patient information to be shared in a secure and timely manner. The practice had a list of patients who were vulnerable, at risk due to long term conditions and those receiving palliative care. A patient with a long term condition explained that the out of hour's service had been made aware of their needs because the practice had shared important information when they were unwell. Electronic systems were also in place for making referrals to secondary care services.

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

Consent to care and treatment

Staff were aware of the Mental Capacity Act (2005). For example they described how they recorded requests around resuscitation.

When patients did not have the capacity to make decisions, the nurses we spoke with described the process by which best interest decisions were made. The nurses also described and gave a clear understanding of the Gillick competencies which set out principles to follow regarding consent from patients under 16 years of age.

We saw how consent to treatment was recorded (both on the computer and written consent was obtained) when a minor operation was being undertaken.

Health promotion and prevention

New patients were offered a 'new patient check', with either a GP or one of the nurses, to ascertain details of their past

Good

Are services effective?

(for example, treatment is effective)

medical histories, social factors including occupation and lifestyle, medications and measurements of risk factors (e.g. smoking, alcohol intake, blood pressure, height and weight).

Information on a range of topics and health promotion literature was available to patients in the waiting area of the practice. This included information about screening services, smoking cessation and child health. Patients were encouraged to take an interest in their health and to take action to improve and maintain it. Staff told us about some of the services offered to patients. These included 'exercise on prescription' and access to a local health and wellbeing service. The practice's website also provided some further information and links for patients on health promotion and prevention.

The practice offered a full range of immunisations for children, as well as travel and flu vaccinations, in line with current national guidance.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with nine patients during our inspection. They were all happy with the care they received. People told us they were treated with respect and were positive about the staff. Comments left by patients on the six CQC comment cards we received also reflected this. Words used to describe the approach of staff included friendly and helpful.

We looked at data from the National GP Patient Survey, published in spring 2014. This demonstrated that patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example we saw that 80% of patients said they felt listened to and had confidence in their GP.

We observed staff who worked in the reception area as they interacted with patients. Their approach was considerate, understanding and caring, while remaining respectful and professional.

People's privacy, dignity and right to confidentiality were maintained. For example, the practice offered a chaperone service for patients who wanted to be accompanied during their consultation or examination. A private room or area was also made available when people wanted to talk in confidence with the reception staff. This reduced the risk of personal conversations being overheard.

Staff were familiar with the steps they needed to take to protect people's dignity. Consultations took place in purposely designed consultation rooms with an appropriate couch for examinations and curtains to maintain privacy and dignity. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in those rooms could not be overheard.

The practice had policies in place to ensure patients and other people were protected from disrespectful, discriminatory or abusive behaviour. The staff we spoke with were able to describe how they put this into practice.

Care planning and involvement in decisions about care and treatment

The patient survey information showed patients responded positively to questions about

their involvement in planning and making decisions about their care and treatment, they rated the practice well in these areas. Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in their care decisions. They told us they felt listened to and supported by staff and had sufficient time during consultations to make informed decisions about the choice of treatment they wished to receive.

Patient/carer support to cope emotionally with care and treatment

We looked at six CQC comments cards that had been completed and spoke to nine patients. All comments were positive. Comments stated that they were pleased with the service, were treated with respect and said that the GPs went above and beyond what was required to make sure the care offered was appropriate. Patients said they always had enough time to discuss their problems and could make longer appointments if they needed them.

There was information on what to do in times of bereavement and patients we spoke with told us they were supported through all emotional circumstances. 88% of patients who responded to the most recent GP survey said that the GPs treated them with care and concern.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Patients told us that the practice responded to their individual health needs well. They said that preferences, such as to see a doctor of the same sex, were responded to where possible. Nine patients we spoke with confirmed that their GP had an in-depth knowledge about their needs and the needs of their family. Some said that several generations of their family were registered with the practice out of choice because of the friendly and caring approach they experienced. Patients told us that the practice was reliable, particularly at times of crisis or when in urgent need.

Patients said the prescription system was good. Some patients used the on line request service, whilst others called in to collect theirs from the dispensary.

Secondary care referral to hospitals or other health care providers were made promptly. Patients were able to pick their own routine appointment time through a choose and book system.

The practice was pro-active in contacting patients who failed to attend vaccination and screening programmes and worked to support patients who were unable to attend the practice. For example, patients with learning disabilities were visited in their homes if necessary to give their influenza vaccinations.

Tackling inequity and promoting equality

The partner GPs were knowledgeable about changes in the local population in terms of ethnicity and diversity of patients registering with the practice. For example, we were told that some patients were of Eastern European and Polish backgrounds. The practice had access to online and telephone translation services. However, GPs told us that in most instances patients tended to bring a friend or family member with them to help translate.

The practice had level access from the car park to the front door. Inside the GP consultation rooms and the treatment rooms were on the ground floor, providing level access for patients with limited mobility or using a wheelchair.

The premises were modern and purpose built. The practice premises was managed by a management company and they were responsible for variations to the building. A hearing induction audio loop was available for patients who were hard of hearing and staff were knowledgeable about the different needs of the patients who attended. There was disabled toilet access and baby changing facilities were available.

Access to the service

Patients told us if they needed to see a GP there were urgent and emergency appointments available on the same day. Patients were able to book appointments by telephone or the practice online appointment service. The practice opening hours were clearly displayed in the practice and on their website and patient information leaflet. If patients required GP assistance out of practice hours then details of who to contact were clearly displayed in the practice, on their website and in the practice information leaflet. We were told that extended hours were offered to patients wo could not attend an appointment within the normal opening hours. This was usually managed by offering an appointment at the end of normal surgery time. However, this was not promoted or displayed in the practice waiting room or in the practice literature so patients were not always aware of this service.

Most patients, especially younger people, were not worried which GP or nurse they saw, but those with complicated and/or long-term conditions usually tried to see their preferred GP. These patients were appreciative of the reception staff and told us they really helped patients who were regular and known to them.

Patients told us they were happy with the appointment system. They made and contacted the practice easily for an appointment, were given an appointment when needed and often saw their GP of choice. Patients said they sometimes there appointments were late but were informed if there was a delay by reception staff.

Listening and learning from concerns and complaints

We saw clear evidence that this was a practice with a leadership and learning culture. There was a clear understanding which included learning from significant events and partnerships with other agencies. There was 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 the

Good

Are services responsive to people's needs?

(for example, to feedback?)

designated person responsible for handling complaints in the practice was the practice manager. If a complaint was about this person then it was dealt with by the lead GP and we saw evidence of this.

We reviewed some complaints that the practice had received which had been dealt with in line with the practice policy and had been brought to a conclusion which was satisfactory to the patient. We saw that the practice had received 12 complaints from April 2013 to March 2014.

We saw minutes from staff meetings which showed that all complaints were discussed and reflected upon. It was evident that if changes could be made to improve outcomes for the patients then this was done. We saw that compliments were also received regularly. We looked at thank you cards and letters of appreciation praising the staff for the care and treatment received.

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 management team had a clear vision and purpose. The GPs we spoke with demonstrated an understanding of their area of responsibility and they took an active role in ensuring that patients received a good service.

The practice leaflet and website stated that the practice were interested in the views of their patients and carers and these views were fed into the practice so that they could consider how the service could be improved. GPs and the practice manager attended neighbourhood and Clinical Commissioning Group (CCG) meetings to identify needs within the community and tailored their

services accordingly. They worked with local safeguarding, domestic violence and young people's organisations to make sure they were aware of the requirements within their patient population.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity. We looked at five of these policies and procedures. All five policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse responsible for infection control and a GP lead for safeguarding. We spoke with 15 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

Leadership, openness and transparency

We spoke with staff and they were clear about their own roles and responsibilities. They all told us they thought the practice was well led and felt well supported and knew who to go to in the practice with any concerns.

Staff said there was an open culture within the practice and they had the opportunity and were happy to raise issues at any time. They said that even though the practice was large, communication was still effective through day to day events, email and more formally though meetings and formal staff appraisal.

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

The practice had a virtual patient participation group in place which they called upon as and when needed. A patient participation group is one of the ways GP practices can demonstrate they are fulfilling their responsibility to consult with patients to help inform and improve the services they offer.

In Spring 2014 the practice used an independent company to carry out an annual survey of its patients. These included all aspects of the practice, from staffing to the environment and care given. For example 88% of patients of 34surveyed said they were satisfied with the care and treatment they received. 77% of patients asked said they were very happy with their treatment by the receptionists.

Patients who used the practice, those close to them and their representatives told us the GPs and nurses actively engaged and involved them in decision-making. This engagement focused on their individual health needs, the choices of treatment available to them and the impact on their wellbeing rather than practice improvements.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and training records and saw that regular appraisals took place which included a personal development plan.

The practice had completed reviews of significant events and other incidents and formally shared action and learning from these events with the staff group to ensure the practice improved outcomes for patients.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **The registered person must operate effective recruitment procedures. They must ensure that the information specified in schedule 3 is available in respect of a person employed for the person of carrying out a regulated activity, and such other information as appropriate.** Regulation 21 (b) **Recruitment processes must be improved to include proof of identity, including a recent photograph, two references, a full employment history and a risk assessment to determine the decision re carrying out criminal records checks, using the Disclosure and Barring Service (DBS).**