Beeston Village Surgery

Quality Report

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

Ratings

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

Dear Dr. Gurjinder Singh Randhawa

We carried out an announced inspection visit on 6 October 2014. The overall rating for the practice was good.

We found the practice to be good in providing: safe, effective care and for all of the population groups it serves. In addition we rated the practice as outstanding with respect to its responsiveness to patient's needs.

Our key findings were as follows:

- Where incidents had been identified relating to safety, staff had been made aware of the outcome and action taken where appropriate, to keep people safe.
- All areas of the practice were visibly clean and where issues had been identified relating to infection control, action had been taken.
- People received care according to professional best practice clinical guidelines. The practice had regular information updates, which informed staff about new guidance to ensure they were up to date with best practice.
- The service ensured people received accessible, individual care, whilst respecting their needs and wishes.
- We found there were positive working relationships between staff and other healthcare professionals involved in the delivery of service.

We saw areas of outstanding practice including:

- Where an individual patient was anxious about sitting in the waiting room prior to an appointment, the reception staff text them at their appointment time. This allowed the person to go straight into the GP consultation room and was a response to their individual needs.

We also noted that improvements should be made in relation to the following:

Summary of findings

- The practice nurse recorded weekly checks on emergency drugs ('Drug Ledger') and reordered more stock when it fell below a pre-determined account. However, when the nurse was on leave the stock levels were not recorded or monitored.
- The practice had an up to date recruitment policy. However, the recruitment files we inspected did not contain two references as stated in the policy.

Yours sincerely

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

Most aspects of the practice are safe. There were standard operating procedures and local procedures in place to ensure any risk to patient's health and wellbeing was minimised and managed appropriately. Medicines were stored and managed safely. The practice building was clean and well maintained and systems were in place to oversee the safety of the building.

The practice had a recruitment policy however, not all staff had two references prior to employment as stated in their policy.

Weekly checks on emergency drugs were carried out and re-ordered when the levels fell below a pre- determined amount. However, when the person who checked these was on leave, the stock levels were not recorded or monitored.

Are services effective?

Good

The practice is effective. Patients' received care and treatment in line with recognised best practice guidelines. Their needs were consistently met and referrals to secondary care were made in a timely manner. The practice worked collaboratively with other agencies to improve the service for people.

Are services caring?

Good

The practice is caring. The patients who responded to CQC comment cards and those we spoke with during our inspection, gave positive feedback about the practice. Patients described to us how they were included in all care and treatment decisions; they were very complimentary about the care and support they received.

Are services responsive to people's needs?

Outstanding

The practice is responsive. We judged this area to be outstanding in the way they proactively monitored the appointment system in a timely way and responded to patients individual needs. There was a complaints policy available in the practice and staff knew the procedure to follow should someone want to complain. Records showed that staff responded appropriately and learned lessons when things do not go as well as expected or according to plan.

Are services well-led?

Good

The practice is well led. The practice was meeting people's needs in providing a service where the GP partners and nurses had specific

Summary of findings

lead responsibility for areas of care. For example, safeguarding adults and children. Patients and staff felt valued and a proactive approach was taken to involve and seek feedback from patients and staff.	

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 made provision to ensure care for older people was safe, caring, responsive and effective. All patients over 75 years had a named GP. This included those who had good health and those who may have one or more long-term conditions. There were systems in place to ensure that older people had regular health checks and timely referrals were made to secondary care. Good information was available to carers. Older people were represented on the Patient Participation Group (PPG).

People with long term conditions

Good

There were systems in place to ensure patients with multiple conditions received one annual recall appointment wherever possible. This helped to offer the patient a better overall experience in meeting their needs. Healthcare professionals were skilled in specialist areas and their on-going education meant they were able to ensure best practice was being followed. People with long term conditions were represented on the Patient Participation Group (PPG).

Families, children and young people

Good

The practice ensured care for mothers, babies and young people is safe, caring, responsive and effective. The practice provided family planning clinics, childhood immunisations and maternity services. There was health education information relating to these areas in the practice to keep people informed.

Working age people (including those recently retired and students)

Good

The practice ensured care for working age people and those recently retired was safe, caring, responsive and effective. The practice had extended their hours to facilitate attendance for patients who could not attend appointments during normal surgery hours. There was also an online booking system for appointments.

People whose circumstances may make them vulnerable

Good

The practice ensured care for vulnerable people, who may have poor access to primary care was safe, caring, responsive and effective. The practice had arrangements in place for longer appointments to be made available where patients required this

Summary of findings

and access to translation services when needed. There was a hearing loop system for patients who have hearing difficulties and information available in large print for those with a visual impairment.	
People experiencing poor mental health (including people with dementia) The practice ensured care for people experiencing a mental health problem was safe, caring, responsive and effective. The practice has access to professional support such as the local mental health team and psychiatric support as appropriate.	Good 

Summary of findings

What people who use the service say

We received 21 completed patient CQC comment cards and spoke with four patients on the day of our inspection. We spoke with people from different age groups; who had varying levels of contact and varying lengths of time registered with the practice.

The patients we spoke with believed the staff genuinely cared about their wellbeing. Patients felt all staff communicate well with them and that it was a two way process. They said they receive treatment that was effective and explained clearly; so patients knew how they were being treated and why.

Areas for improvement

Action the service SHOULD take to improve

- The practice nurse recorded weekly checks on emergency drugs ('Drug Ledger') and reordered more stock when it fell below a pre-determined amount. However, when the nurse was on leave the stock levels were not recorded or monitored.
- The practice had an up to date recruitment policy. However, the recruitment files we inspected did not contain two references as stated in the policy.

Outstanding practice

- One patient suffering from a long term condition does not like waiting in waiting rooms. The duty Patient Care Advisor (PCA) will call the person at home to let them know the waiting time for their appointment; the person can then plan their arrival to minimise any waiting time in the surgery. (The PCA is a member of the reception team responsible for looking at patients needs and helping them with their enquiry or changing the appointment system to suit their needs.)

Beeston Village Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead inspector. The team included a second CQC inspector, a GP, a practice manager and an expert by experience.

Background to Beeston Village Surgery

The practice is a partnership and there are three general practitioner (GP) partners. Two full time and one part-time, (all male); a practice manager, an advanced nurse practitioner, a practice nurse, a clinical support worker, a patient care advisor and administration/reception staff (all female staff).

The practice is registered with the Care Quality Commission (CQC) to provide the following regulated activities: diagnostic and screening, family planning, maternity and midwifery, surgical procedures and treatment of disease or injury.

The practice has a Primary Medical Services (PMS) contract. PMS is a locally agreed alternative to General Medical Service (GMS) for providers of general practice. Their registered list of patients is 4929.

Surgery times are: Monday 7am – 6.30pm, Wednesday 7am – 6pm, Tuesday, Thursday and Friday 8am – 6.00pm. Advice lines are open between 8am – 10.30am each morning.

When the practice is not open, out of hours cover is provided by Yorkshire Ambulance Service and Local Care Direct.

In addition to the general GP services, the practice offer a range of specialist clinics/services and these include: Antenatal/postnatal – maternity services, child health surveillance check-ups for under 5 years, long term conditions, family planning, contraception implants, immunisations and vaccinations and minor surgery.

Why we carried out this inspection

This inspection was part of comprehensive programme of inspections of general practices. This practice was part of random selection of practices in the Clinical Commissioning Group (CCG) for Leeds South and East.

How we carried out this inspection

Before visiting the practice, we reviewed information we hold about the service and asked other organisations to share what they knew about the service. We asked the surgery to provide a range of policies and procedures and other relevant information before the inspection.

We carried out an announced inspection visit on 6 October 2014. During our inspection we spoke with staff including GPs, practice manager, practice nurses, and administration and reception staff.

We spoke with three patients who used the service and a member of the Patient Participation Group (PPG). A PPG is made up of a group of volunteer patients who meet to discuss the services provided by the practice. We also reviewed CQC comment cards where patients and members of the public shared their views and experiences of the service.

Detailed findings

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

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

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

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problems

Good

Are services safe?

Our findings

Safe Track Record:
The practice had systems in place to monitor all aspects of patient safety. Information from the Clinical Commissioning Group (CCG) and Healthwatch indicated the practice had a good track record for maintaining patient safety. Staff we spoke with were clear and understood their responsibilities to raise significant events. This included the process to report them internally and externally where appropriate.

Information from the Quality and Outcomes Framework, which is a voluntary national performance measurement tool, showed that in 2012-2013 the practice was appropriately identifying and reporting incidents.

There were policies and protocols for safeguarding vulnerable adults and children. Any concerns regarding the safeguarding of patients were passed onto the relevant authority.

Learning and improvement from safety incidents:
We reviewed how the practice managed serious or significant incidents. Records showed the system in place was managed in line with guidance issued by the National Patient Safety Agency. There were up to date policies and protocols in place. Additionally, we saw the practice had risk assessments to try to reduce the risk of incidents occurring. The CCG had also introduced a 'Yellow Card' scheme whereby incidents that had arisen relating to patients when accessing services with other providers, were reported by the staff directly to the CCG as an on line service. For example; a patient had been asked by the hospital to go to the GP surgery to pick up a prescription. The hospital should have provided the prescription and distributed it from the hospital pharmacy.

There had been 14 reported incidents in 2014. Our inspecting GP confirmed none of those incident reports were serious. We saw evidence investigations had taken place in relation to these incidents, the action taken and how learning was implemented. Staff were aware of these and told us how practice had changed as a result. We also saw minutes of staff meetings, these confirmed incidents were discussed and learning was shared with relevant staff.

Safety alerts were reviewed by the practice manager and then emailed to staff and discussed at the clinical/ practice meeting as appropriate. Copies of the alerts were kept on file.

Reliable safety systems and processes including safeguarding:
We saw a proactive approach to safeguarding was followed by the GP safeguarding lead and referrals were made to the appropriate safeguarding agencies. On the day of the inspection we spoke with two GPs who told us they had level two safeguarding training and were in the process of completing level three. They were aware of the national and local guidelines and were able to give examples where they had identified patients at risk and the action they had taken in line with current protocols. Other staff had received safeguarding training relevant to their role and this included processes for safeguarding vulnerable adults and children. We also saw and were told that one of the GPs had written a safeguarding leaflet to remind staff of the safeguarding procedures. They also demonstrated an understanding of safeguarding patients from abuse and the actions to take should they suspect anyone was at risk of harm.

Systems were also in place within the electronic patient records, to alert staff when patients identified as vulnerable adults or children attended for consultation. Any concerns regarding the safeguarding of patients were passed onto the relevant authorities by the lead GP as quickly as possible.

In the practice waiting room we saw posters offering the use of a chaperone during consultations and examinations. Staff told us they asked if patients would like to have a chaperone during an examination. Records showed the staff training had taken place in 2012. Staff also told us when chaperones were needed the role was usually carried out by nursing staff.

We saw the practice had taken into consideration the needs of young children. There was a play area where children could be safely supervised whilst waiting for an appointment.

Medicines Management:
A representative from the Leeds South and East CCG Medicines Optimisation Team visited the practice regularly; this ensured the practice followed good practice

guidance, published by the Royal Pharmaceutical society. The practice also held weekly clinics where medication reviews and queries were answered and discussed with patients.

We saw emergency equipment was available in the surgery and this included emergency medicines. The practice had arrangements for managing medicines to keep patients safe and correct procedures were followed for the prescribing, recording, storage, dispensing and disposal of medicines. We saw the 'Drug ledger' dated 26 September 2014 to 24 October 2014. We noted the week commencing 26 September 2014; the medication check had not been recorded as the practice nurse was on leave. The practice manager was aware the record should be maintained each week. This would ensure there were sufficient stocks of drugs in place should they be needed in an emergency situation.

The practice used a red dot to identify 'dangerous medication' i.e. where medication needs regular monitoring such as Warfarin, Insulin and contraception. We saw records of monitoring that had taken place ensuring patients medication was kept under review and their safety maintained.

There were standard operating procedures (SOP) in place for the use of certain medicines and equipment. The nurses used patient group directives (PGD). PGDs are specific written instructions which allow some registered health professionals to supply and/or administer a specified medicine to a predefined group of patients, without them having to see a doctor for treatment. For example, flu vaccines and holiday immunisations. PGDs ensure all clinical staff follow the same procedures and do so safely.

The data received from NHS England in relation to immunisations of children, in April 2013 showed 100% of the 24 month children age group had received their vaccinations. They also scored better than average for the reduced prescribing of certain antibiotic therapy.

Vaccines were stored in a locked refrigerator. Staff told us the procedure was to check the refrigerator temperature every day and ensure the vaccines were in date and stored at the correct temperature. The practice nurse showed us their daily records of the temperature recordings and the desired refrigerator temperature for storage was maintained.

Cleanliness & Infection Control:

We observed all areas of the practice to be clean, tidy and well maintained. The practice had an infection prevention and control (IPC) policy which identified one of the nurses as the clinical lead for this area and the practice manager as the non-clinical lead.

We saw an infection control audit had taken place in March 2013 and were told by the IPC nurse that a repeat audit would be carried out in November 2014. The previous audit identified one of the clinical areas was carpeted and therefore a potential infection control risk; the carpet was changed to a cleanable floor covering. Additionally the washable curtains in the clinical areas were identified as needing cleaning annually; this now takes place.

The practice had access to spillage kits to enable staff to appropriately and effectively deal with any spillage of body fluids. Sharps bins were appropriately located and labelled. Cleaning schedules were in place.

We saw policies and procedures in place for the two contractors who removed the clinical and non-clinical waste.

The practice complied with relevant guidance relating to Legionella bacteria. An up to date certificate was seen, dated 29 October 2014.

Equipment:

We saw equipment was available to meet the needs of the practice and this included: a defibrillator and oxygen, which were readily available for use in a medical emergency. Routine checks had been carried out to ensure they were in working order.

We saw that equipment had up to date Portable Appliance Tests (PAT) completed and systems were in place for routine servicing and calibration of equipment where required. The sample of portable electrical equipment we inspected had date stickers on them showing the last time they were tested; each one inspected was in date.

Staffing & Recruitment:

The practice had a recruitment policy which had been reviewed on 22 November 2013 and the next review date was 21 November 2014. The policy stated all staff should have a Disclosure and Barring Service (DBS) check and two references from their previous employment. We looked at the staff files for the most recent staff member employed; a nurse and a patient care advisor. The patient care advisor

Good

Are services safe?

was employed in March 2014 and their file contained a DBS check and one reference. The nurse was employed in April 2014 and their file did not have any references or a DBS check. Following the inspection we were provided with evidence of the clinicians up to date DBS and a reference.

All staff had their clinical qualifications checked on an annual basis and we saw evidence of this in the file we inspected.

There were three GPs; two full time and one part time. We were told the practice did not use locum GPs and that annual leave was usually co-ordinated between the three partners. All three GPs had received revalidation and appraisals and the two GPs we spoke with were revalidation assessors.

We discussed with the practice manager how they addressed staffing rotas to provide in-house flexibility and how this was flexible enough to cover unexpected emergencies. The practice review of the rota allowed for sufficient doctors, nursing; healthcare assistants and administration support to be on site at all times. The administration staff said they were flexible and they all helped out when necessary by sharing the workload.

Monitoring Safety & Responding to Risk:

The practice had developed clear lines of accountability for patient care and treatment. Each patient with a long term condition and those over 75 years of age had a named GP. The GP's, nurses and practice manager also had lead roles such as safeguarding lead, medicine management lead and infection control lead. Each lead had systems for keeping staff informed and ensuring they were using the latest guidance. For example, the practice manager received safety alerts, circulated them via email to staff and relevant changes were made to protocols and procedures within the practice. (Hard copies were kept on file.) The practice manager and staff also told us the alerts were discussed at staff meetings where the information was re-enforced.

Areas of individual risk were identified. Posters relating to safeguarding and violence/ aggression were displayed and staff had received Managing Conflict & Aggression in General Practice training in July 2014.

Each morning the staff had a briefing session to discuss the day and any potential or identified issues.

The practice had a mobile number for health care professionals to contact the surgery, rather than them having difficulty getting through at busy practice times. The practice monitored the appointment system daily and as a result of the monitoring had introduced a triage consultation. These systems allowed for a responsive approach to risk management. For example, we were told by staff they had a traffic light system for seeing patients; red – was an emergency and the patient would be seen straight away, amber – the patient would be seen within the hour and green – the patient would be seen the same day. Staff told us this was working well. Additionally two GPs provided the days cover for the emergency and advice service and when the practice was closed, the out of hours 111 service covered.

Arrangements to deal with emergencies and major incidents:

We reviewed the business continuity plan for the practice. The plan identified management plans for dealing with potential foreseeable risks and disruptions to the practice. This ensured systems were in place to monitor the safety and effectiveness of the service in the event of an incident to reduce the risk of patients coming to harm. Staff told us they had access to the information and contact numbers to divert the practice phones to individual staff mobiles where needed.

We found staff received annual cardiopulmonary resuscitation (CPR) training and staff we spoke with told us they had recently had their update training. Emergency medicines and equipment were accessible to staff and systems were in place to alert GP's and nurses in the event of an emergency.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment:

We found care and treatment was delivered in line with local CCG, recognised national guidance, standards and best practice. For example, the clinicians used National Institute for Health and Care Excellence (NICE) quality standards and best practice in the management of conditions such as diabetes. We were told any updates were circulated to staff and where appropriate, discussed at their clinical meeting. We saw The British Thoracic Society (BTS) guidelines were used in the treatment and management of asthma and the NICE guidance was in conjunction with safeguarding children and 'When to suspect child maltreatment.'

The practice also held multiple clinics to meet the needs of the practice population; these included, those patients with long-term conditions such as diabetes clinics, Chronic obstructive pulmonary disease (COPD) clinics. Other clinics included: new patient assessment, medication reviews, childhood immunisation and monitoring, cervical cytology clinics, antenatal and post natal clinics and general health checks.

The practice was actively developing self-management plans with patients. We were shown examples of patient's long-term conditions management plans and these included a COPD and diabetes plan.

The practice had a palliative care register of patients which was monitored and patients care regularly reviewed. Additionally we saw regular palliative care meetings were held at the practice and they included other professionals involved in the individual patients care.

The practice used leaflets in various languages to help patients make informed decisions and we were shown examples of these. We also saw the practice website provided information in different languages.

Management, monitoring and improving outcomes for people:

We found there were mechanisms in place to monitor the performance of the practice and the clinician's adherence with best practice to improve outcomes for people. For example, with support from the Leeds CCG Medicines Optimisation Team, the medicine lead GP monitored prescriptions to ensure the practice were using the most appropriate medication and following good practice guidance, published by the Royal Pharmaceutical society.

We saw the practice had a system in place for monitoring patients with long term conditions and this included learning disabilities; they had 'rolling' monthly audits where performance against indicators were reviewed, i.e. the number of patients reviewed every month with a specific condition.

Additionally the clinicians monitored their performance against the local Quality and Outcomes Framework (QOF) targets. We saw evidence that audits, learning, updates and action taken were monitored and shared at their weekly meetings. Other audits we saw evidence of and which were carried out by the practice included, medication for example, the monitoring of patients on warfarin. We also saw a contraception implant, patient satisfaction audit and this showed patients were satisfied with the service they received.

Effective staffing:

Staff employed to work within the practice were appropriately qualified and competent to carry out their roles safely and effectively. This included the clinical and non-clinical staff.

Records demonstrated that new staff were provided with induction training and were monitored during their first few weeks in post. They also were able to access relevant up to date policy documents, procedures and guidance. We were told by the GPs and practice manager that they did not currently use locum GPs. However, in the event that a locum may be used, there was an up to date 'locum pack' containing local protocols, procedure and guidance for them to follow.

All staff were supervised and received annual appraisals. Clinical staff had clinical supervision and felt that this was a valuable process. We were told and saw from the files we reviewed, that annual appraisals are completed for all staff. They were completed by either the practice manager for non-clinical staff or GP for clinical staff.

Staff had opportunities to receive training in the course of the year and all statutory training had been completed.

Good

Are services effective?

(for example, treatment is effective)

Nurses had support with their on-going professional education and GPs had protected learning time, review of care and treatment/peer review audits and revalidations had been completed.

The practice ensured all staff kept up to date with both mandatory and non-mandatory training and saw evidence of this in the files we inspected. The training staff received included: fire awareness, safeguarding adults and children, Mental Capacity Act, and basic life support. Staff also confirmed they received training specific to their roles and this included, cytology update training, wound management, heart disease, diabetes, COPD.

Working with colleagues and other services:
We saw evidence the practice staff worked with other services and professionals to meet patients' needs and manage complex cases. There were regular monthly meetings with multi-disciplinary teams within the locality. This included district nurses and health visitors. We saw multidisciplinary meetings were held to discuss patients on the palliative care register and support was available irrespective of age. (The practice also scored better than average in meeting this QOF target.) There were also regular informal discussions with these staff. This helped to share important information about patients including those who were most vulnerable and high risk.

The practice had systems in place for recording information from other health care providers. This included out of hours services and secondary care providers, such as hospitals. The Advanced Practitioner told us how they monitored patients who had been in contact with the out of hours service; The practitioner telephoned the patient and then tasked the GP with information they should be made aware of to ensure the patient received appropriate follow up care.

We were informed by the GPs that all clinical correspondence received by the practice was reviewed by the GPs and actioned. The information was then scanned into the patient's electronic notes.

We spoke with practice staff about the formal arrangements for working with other health services, such as consultants and hospitals. They told us how they referred patients for secondary (hospital) care and tried to book an appointment using the choose and book system. Arrangements were carried out wherever possible, before the patient left the surgery.

Information Sharing:
The practice had details on their website informing patients of how their records were held on a computerised, secure, clinical system. The information explained the facility and how, with the patients consent, the practice could share their records with other medical providers of care. The information also stated that it was the patient's choice and they could change their mind whenever they wished; they should let the reception know.

Consent to care and treatment:
We found the healthcare professionals understood the purpose of the Mental Capacity Act (2005) and the Children Act (1989) and (2004). They confirmed their understanding of capacity assessments and how these were an integral part of clinical practice. They also spoke with confidence about Gillick competency assessments of children and young people. This is to check whether these patients have the maturity (at age 16yrs or younger) to make decisions about their treatment. All staff we spoke with understood the principles of gaining consent including issues relating to capacity.

Clinical staff were able to confirm how to make 'best interest' decisions for people who lacked capacity and how to seek appropriate approval for treatments such as vaccinations from children's legal guardians.

The practice had a consent policy available to assist all staff and access to relevant consent form templates.

Health Promotion & Prevention:
All new patients were encouraged to complete a health questionnaire and attend an appointment at the new patient assessment clinic.

The practice nurses were responsible for the recall, monitoring and health education for people with long term conditions (LTC) and these included conditions such as diabetes, hypertension and COPD. They had a clear understanding of the number and prevalence of conditions being managed by the practice. They told us how they recalled patients with these conditions, usually annually or more regularly if required. They ensured no one missed being sent a follow up review. Patients in need of blood tests had these done before attending for appointment, then the outcome of the results could be discussed at their consultation. Patients with more than one LTC were usually offered one recall appointment and the appointment time was longer to improve the patient experience.

Good

Are services effective?

(for example, treatment is effective)

The practice website had a health information section. It included the offer of free advice, structured support and appointments with qualified practitioners regarding alcohol, smoking, weight loss, activity and healthy eating. It directed people to the Healthy Lifestyle Service website for more information.

The practice website also included the bowel cancer screening programme. It stated those aged 60 - 69 and registered with a GP would automatically be sent a free kit to help detect bowel cancer early. Patients who were aged 70 or over were informed of a free telephone number they could call to request your free kit.

All information was available in different languages for example, Polish (due to the large number of Polish patients registered with the practice) and this included on line services; there were translation services available.

Good

Are services caring?

Our findings

We received 21 completed patient CQC comment cards and spoke with four patients on the day of our inspection. We spoke with people from different age groups; who had varying levels of contact and varying lengths of time registered with the practice. Without exception, everyone gave positive feedback about the practice.

Respect, Dignity, Compassion & Empathy:
Staff were familiar with the steps they needed to take to protect people's dignity. The practice had an electronic booking in system for those who did not wish to announce their name to the reception staff. There was a consulting room should patients like to speak in private with a member of staff. All consulting rooms were private and patients who completed the CQC comment cards told us their privacy and dignity was always respected.

The results of the practice survey dated 2013, showed 98% of patients stated they felt listened to and staff made them feel at ease.

The practice waiting room had a hearing loop, and leaflets in large print and different languages to meet the needs of the practice population. There were posters offering the use of a chaperone during consultations and examinations. Staff told us they always asked if patients would like to have a chaperone during an examination. Patients we spoke with also told us they were aware of the chaperone system in use.

Representatives from the Patient Participation Group (PPG) told us they believed the staff at the practice genuinely cared about their well-being. A retired patient told us they liked the efficiency of this practice. They said the practice sent them reminders by text message for appointments and the staff knew their name at the reception desk when they visited.

A patient suffering from a long term condition told us they did not like waiting in waiting rooms. They said the duty Patient Care Advisor would call them at home to let them know the waiting time for their appointment; they then could plan their arrival to minimise any waiting time in the surgery. (The PCA is a member of the reception team responsible for looking at the patients needs and helping them with their enquiry or changing the appointment system to suit their needs.)

We saw there was a children's play area in the waiting room. This assisted people in occupying their children whilst they waited for any appointment.

Care planning and involvement in decisions about care and treatment:
Patients told us they had been involved in decisions about their care and treatment. They told us their treatment was fully explained to them and they understood the information before giving consent.

Patients confirmed their consent was always sought and obtained before any examinations took place and this included consent to share records.

The results of the practice survey dated 2013, showed 94% of patients stated it was very easy or easy to be involved in decisions about their care.

We were told patients always had a chance to ask questions during a consultation; everything was explained, including health benefits and concerns; If they wished to talk about a couple of issues at a consultation they would book a double appointment. The information on the practice website also stated that appointments were 10 minutes long. If a patient would like to speak about multiple problems then the patient care advisors would book a double appointment.

Staff told us how patients were referred for secondary (hospital) care. When a referral was identified, the practice always tried to book an appointment with the involvement of the patient. They respected the patient's wishes wherever possible. They used the choose and book system when choosing where the patient would like to have their care and arrangements were carried out before the patient left the surgery, or a referral letter collected the following day.

Patients from the PPG told us staff at the practice:

- Engaged in clear two way communication.
- Genuinely cared about their well-being.
- Their treatment was effective and explained clearly, so patients knew how they were being treated and why.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment:

We saw information in the practice about advocacy, bereavement support and counselling services. Staff were also aware of contact details for these services when needed.

The GPs told us that patients who were referred on a two week wait for a hospital appointment, i.e. there was suspicion of cancer, the GP would explain their condition to them; they would also be given an information leaflet.

Palliative care meetings with clinical staff and community health professionals were held to discuss patient treatment, care and support. Ensuring they received co-ordinated care and support.

The practice was actively developing self-management plans with patients. We were shown examples of patient's long-tern conditions management plans and these included COPD and diabetes plan.

The practice had on line information leaflets to down load in different languages, and links to other websites for health related information. For example: Common health questions, and self-help guides. Additionally, we saw a number of leaflets were displayed in the waiting room for patients to access. This included information about common conditions and their symptoms, promotion of healthy lifestyles and prevention of ill health.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs:
The practice established a Patient Participation Group (PPG) in 2011/2012. This comprised of registered patients and they endeavoured to ensure the group represented the practice population. They ensured notices were in English and Polish (due to the large number of Polish patients registered with the practice), in areas such as: practice notice boards, the patient information screen, within local pharmacies, information relating to requesting/collecting repeat medication and leaflets passed to patients by staff at the surgeries reception.

The information we inspected stated the PPG was made up of seven patients and represented practice demographics. The PPG clinical representative for the practice was one of the GPs and the non-clinical representative was the practice manager. The information relating to the PPG stated they would meet a minimum of four times a year and their role would be to canvas people's views and agree an action plan.

As a result of the survey 2012/2013, the PPG recorded in the minutes of their meeting, they were pleased to note an increase in the number of patients who were aware that the Clinical Nurse Specialist was qualified to treat minor illness in children and adults. This had formed part of an action plan to make patients who used the service aware.

The results of the survey also showed that people received good outcomes in relation to staff maintaining patient's confidentiality. However, the practice had agreed with the PPG to continue on-going training for staff in confidentiality. This included promoting the use of the interview room for all patients wanting a discussion with the receptionist; on-going training to develop and maintain skills of communication /behaviour within the team when dealing with the public.

The practice was accessible to patients with mobility difficulties. The consulting rooms were large with easy access for patients with mobility difficulties. There were also toilets for disabled patients.

We saw the practice had taken into consideration the needs of young children. There was a play area where the children could be safely supervised whilst waiting for an appointment.

Tackling inequity and promoting equality:
We were told by staff and saw, the appointments system was monitored each day. A Patient Care Advisor team were trained to direct patient calls to the most appropriate member of staff to deal with their request. They also had a system in place to monitor the urgency of a patients need for an appointment and children under five received an appointment the same day. The daily triage was covered by two GPs at the practice to ensure patients received the right advice/ treatment at the right time and place.

As a result of listening to people, the practice had extended their hours to facilitate attendance for patients who could not attend appointments during normal surgery hours. This also allowed for flexible access for vulnerable population groups and working age people, including those in full time education.

In meeting people's needs, the practice advertised that routine appointments were 10 minutes long and if people had multiple problems to discuss, they should arrange to have a double appointment. Patients who needed extra support because of their complex needs were also allocated double appointments.

The results of the practice survey dated 2013, showed 93% of patients stated they had sufficient time during their consultation with the doctor.

The practice reviewed the post hospital discharge list and ensured patients were reviewed to ensure their needs continued to be met. This was either by a telephone call or face to face consultation. We were shown examples of re-admission to hospital audits and evidence showed these had reduced since the implementation of the reviews.

The GPs also held monthly reviews or more frequently as required, for their nursing home patients. Each of these patients had a named GP and this included patients in the practice with long term conditions and those over 75years of age.

Access to the service:
The surgery opening times were detailed in the practice leaflet which was available in the patient waiting room and on their website. The practice has an advice line between, 8am – 10.30am each morning; and their opening times were: Monday 7am – 6.30pm, Wednesday 7am – 6pm,

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Tuesday, Thursday and Friday 8am – 6pm. The practice 'Patient Care Advisor Team' answers all calls to the practice and use a traffic light system to triage and make appointments.

Additionally a range of appointments were available which patients could access by booking on line – up to six months in advance, attending in person or asking for a telephone consultation. The GPs and staff told us emergency, same day appointments were always available with a GP and home visits were also available where appropriate. We were told one of the GP's monitored the appointment system and patient access.

Repeat prescriptions were available to re-order either in person, on-line, posted, faxed or emailed. Information relating to this was available in the practice leaflet and on their website.

Listening and learning from concerns & complaints:

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

The patient survey completed in 2013 showed 87% of patients felt they had enough opportunity to give feedback, raise concerns and complaints, or make suggestions. 3% of people said they did not have the opportunity and 10% were not sure. As a result the PPG action plan showed they had recommended the practice should incorporate details of the complaints procedure into the practice website. We saw the practice website had been updated to include the recommendations of the PPG and an online copy of the procedure was available.

We were also informed by the practice manager and staff, that all complaints or information of concern were discussed at the weekly GP/clinical meeting and shared at their practice meetings. This included the action taken and learning for the practice.

We saw a summary of the complaints received this year (three in total). We also saw that the review of complaints took place in January and October each year. A meeting to discuss these was planned for the beginning of the month.

Patients told us on the day of inspection that the practice staff communicated with them well and said it was a two way conversation; they felt valued, listened to and staff genuinely cared about their well-being.

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:

There was an established management structure within the practice. The practice manager, GPs and staff were clear about their roles and responsibilities and the vision of the practice. They worked closely with the local CCG and were committed to the delivery of a high standard of service and patient care. Their vision was:

- To deliver a safe, effective, high quality service at all times.
- To ensure all patients and Carers have a positive experience through decision making and communication.

Patients were encouraged to be involved in decision making. The Practice engaged with patients in various ways, including Patient Participation Group (PPG). We saw from the PPG and staff meetings, including the practice TARGET training days that patients and staff were involved in developing and achieving the vision of the practice.

Monitoring took place, and this included audits to ensure the practice were achieving targets and delivering safe, effective, caring, responsive and well led care of a high quality at all times.

An example of how the practice proactively monitored the service, to ensure it continued to meet people's needs and their vision included, the patient survey carried out 2013. One of the questions asked of patients was, 'Extended Hours. The surgery is now open from 7am on a Monday and Thursday. Had this benefited you?' Another question was, 'Is there a treatment/service currently unavailable that you would like the practice to provide?'

Governance Arrangements:

The practice had effective management systems in place. The practice had policies and procedures to govern activity and which were accessible to staff. We saw the policies incorporated national guidance and legislation, were in date; reviewed and updated. We found clinical staff had defined lead roles within the practice. For example, the management of long term conditions, safeguarding children and adults, medication prescribing and one of the GPs had a specialist interest in minor surgery. Records showed and staff confirmed that they had up to date training in their defined lead role.

The practice held a meeting prior to opening each morning to discuss any updates for staff and this was repeated with the GPs at the end of their surgeries each day. The practice also held regular meetings where governance, quality and risk were discussed and monitored. We saw the most recent notes of these meetings and evidence that the monitoring was taking place.

One of the lead GPs regularly met and worked with the local CCG, and the practice used the Quality and Outcomes Framework (QOF) to measure their performance. We saw that the clinical team regularly discussed QOF data at their clinical meetings and where appropriate action plans were agreed, monitored and reviewed. The QOF indicators discussed included, new indicators - the percentage of patients aged 18 or over presenting on their first appointment with depression. The information discussed how the practice would monitor the person to ensure they were followed up in an agreed time frame. Another indicator was people at risk of dementia. At this meeting the clinicians agreed that an alert would be added to the practices on-line, 'home page' of eligible patients. The screening would then be done opportunistically by the GPs when patients meeting the criteria, visited the practice.

Leadership, openness and transparency:

The practice was committed to on-going education, learning and individual and team development of staff. The performance of staff was the subject of monitoring and appraisal at all levels; which reflected the organisational objectives. There were leading roles within the team for different aspects of the service. For example, a nurse led on infection control and vaccinations/ immunisation programmes.

We saw the practice's training matrix for staff. The practice was able to identify what training each person had received, the dates they attended, when it was due to expire and when any refresher training was due.

There was good communication between clinical and non-clinical staff. The practice held a short team meeting each morning before surgery started to discuss and plan their day. Where staff were not available for this i.e. they worked part time, they told us they would be brought up to date when they arrived at work.

The clinical staff met weekly to discuss any changes and any incidents that had occurred. The practice had a proactive approach to incident reporting. They discussed if

Are services well-led?

Good

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

anything however minor could have been done differently at the practice. All were encouraged to comment on the incidents, and staff told us this was done in a very positive manner.

Staff we spoke with told us that all members of the management team were approachable, supportive and appreciative of their work. They were encouraged to share new ideas about how to improve the services they provide. Staff also spoke positively about the practice and how they worked collaboratively with colleagues and health care professionals.

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

The practice had gathered feedback from patients through the patient participation group and patient surveys. We reviewed the most recent data available for the practice on patient satisfaction which was from their survey in 2013. The evidence from this demonstrated that patients were satisfied with the care and treatment provided by the practice and how they were treated.

Staff told us they attended staff meetings and practice staff briefing sessions each day. They said these provided them with the opportunity to discuss the service being delivered, feedback from patients and to raise any concerns they had. They also told us how they felt valued and supported in their work and the culture was one of openness and transparency.

We saw an independent survey had taken place, where staff were asked to give feedback on one of the partner GPs. The outcome was very good and showed the GP to have a management style that was open, transparent and supportive.

The PPG member we spoke with felt the GP partners listened to their views and welcomed feedback to inform how the practice could best meet the needs of their patient groups.

The results of the patient 2013 survey showed that people received good outcomes in relation to staff maintaining patient's confidentiality. However, the practice had agreed with the PPG to continue on-going training for staff in confidentiality. This included promoting the use of the interview room for all patients wanting a discussion with the receptionist. From speaking with staff and observing practice during our inspection we saw these measures were taking place.

Management lead through learning & improvement:

We found that GPs were committed to continuous learning, improvement and innovation. Clinical meetings took place each week and improvements through learning were discussed and shared where appropriate with the practice team.

Staff we spoke with discussed how action and learning were shared with all relevant staff and meeting minutes we reviewed confirmed that this occurred. Staff we spoke with could describe how they had improved the service following learning from incidents and reflecting on their practice.

A GP from the practice also attended the Clinical Commissioning Group (CCG) protected time education initiative. This provided GP practice staff with protected time for learning and development.

We were told that the practice staff learnt together on TARGET (Time for Audit, Research, Governance, Education and Training) days and also when mandatory training was undertaken, such as basic life support. Additionally staff attended individual training to ensure they had the skills and competencies to do their job.