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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We undertook a planned, comprehensive inspection of Carnewater Practice on 20 January 2015. The practice provides primary medical services to people living in Bodmin and surrounding villages in Cornwall. At the time of our inspection there were approximately 11200 patients. The practice provides services to a diverse population age group and is situated in a town centre location. The practice also has a branch surgery that is open every week day in Lewannick, near Launceston. Appointments are made centrally through Carnewater but patients are able to attend either practice for an appointment.

The practice comprises of a team of six GP partners (four male and two female) and one non GP partner who is the managing partner and holds managerial and financial responsibility for running the business. In addition there are three salaried GPs, five registered nurses, six qualified dispensers and two health care assistants. A full administration team are employed to support the management of the practice.

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

The practice has 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. Carnewater dispensed to patients who did not have a pharmacy within a mile radius of where they lived.

The practice is rated as good. An innovative, caring, effective, responsive and well-led service is

provided that meets the needs of the population it serves.

Our key findings were as follows:

There are systems in place to address incidents, deal with complaints and protect adults, children and other vulnerable people who use the service. Significant events are recorded and shared with multi professional agencies and there is evidence that lessons are learned and systems changed so that patient care is improved.

Summary of findings

Patients reported having good access to appointments at the practice and liked having a named GP which improved their continuity of care. The practice was clean, organised, with facilities and equipment to consult with, examine and treat patients. There were effective infection control procedures in place.

The practice valued feedback from patients and acted upon this. Feedback from patients about their current care and treatment was consistently positive. Staff portrayed a non-discriminatory, person centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. Views of external stakeholders were very positive and aligned with our findings.

The practice are pro-active in obtaining as much information as possible about their patients including carer status, family dynamics, dependency and any other outside influences which do or can affect their health and wellbeing. All the staff know the practice patients very well, are able to identify people in crisis and are professional and respectful when providing care and treatment.

Statistical data analysis demonstrated the practice performed comparatively with all other practices within the clinical commissioning group (CCG) area.

The practice was well-led and had a clear leadership structure in place whilst retaining a sense mutual respect and team work. There were systems in place to monitor and improve quality and identify risk and systems to manage emergencies.

In addition the provider should ensure:

The practice manager has a formal annual appraisal.

Infection control training is updated for all staff. Disposable curtains are replaced appropriately, and in accordance with national guidance.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

Patients we spoke with told us they felt safe, well cared for and confident in the care they received. 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. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

The practice was clean, tidy and hygienic. Systems were in place to maintain the cleanliness of the practice to a high standard. There were systems in place for the retention and disposal of clinical waste.

Are services effective?

Good

The practice is rated as good for providing effective services. Supporting data obtained both prior to and during the inspection showed the practice had systems in place to make sure the practice was effectively run.

The practice had a clinical audit system in place and audits had been completed. Care and treatment was delivered in line with national best practice guidance. The practice worked closely with other services and strived to achieve the best outcome for patients who used the practice.

Supporting data showed staff employed at the practice had received appropriate support, training and appraisal. GP partner appraisals and revalidation of professional qualifications had been completed.

The practice had extensive health promotion material available within the practice and on the practice website.

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.

Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. We found the practice had initiated many positive service improvements for their patient population. The practice had reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and the local clinical commissioning group (CCG) to secure service improvements where these had been identified. Patients reported good access to the practice and appointments were made available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs.

Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. There was evidence of complaints being responded to in a timely way and resolved to the satisfaction of the person who had complained.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. 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 held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. Staff had received inductions, regular performance reviews and attended staff meetings and events.

There was an open and honest culture and staff knew and understood the lines of escalation to report incidents, concerns, or positive discussions. All staff we spoke with felt valued and rewarded for the jobs they undertook and they were encouraged and trained to improve their skill sets. We found there was a high level of constructive staff engagement and a high level of staff satisfaction.

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 was rated as good for the population group of older people.

The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

Care was tailored to individual patient needs and circumstances. Patients were reviewed regularly by the GPs and nurses to promote their health and independence and to help avoid the admission to hospital. There were regular patient care reviews involving patients, and their carers where appropriate.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Patients were pleased with the care they received for their long term conditions and were offered clinics at a time convenient to them for monitoring and treatment of conditions. These included diabetes, heart failure, hypertension, high cholesterol, renal failure, asthma and chronic respiratory conditions. The nurses took a lead role in particular conditions and attended educational updates to make sure their knowledge and skills were up to date.

Specific appointments were made which supported and treated patients with diabetes; they included education for patients to learn how to manage their diabetes through the use of insulin. Health education about healthy diet and life style for patients with diabetes was provided.

The practice used a specific computerised patient record system allowing out of hours service providers to access information about specific patients. This helped promote continuity of care and

Summary of findings

treatment, providing a more seamless service for the patient. The practice's GPs and the out of hours service GPs were then aware of any treatment that had been given to patients with long term conditions, or those at the end of their life.

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.

The practice worked with local health visitors to offer a full health surveillance programme for children under the age of five. Checks were also made to help ensure the maximum uptake of childhood immunisations.

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

The practice is involved in a service called "Tic Tac". This is a shared initiative with other practices in the area. A GP and nurse from the practice hold a lunchtime drop in service at the local high school. The clinic offers advice and treatment to young people.

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 care of patients who were of working age or who had recently retired and students.

Advance appointments, including early morning and evening appointments were available twice a week to assist patients not able to access appointments due to their working hours. Appointments were bookable four weeks in advance and could also be booked online. Saturday morning appointments were also available every two weeks.

The practice operated a triage system whereby if a patient called and wanted to speak to a GP then they were guaranteed a call back within two hours. Patients confirmed this happened and said it worked well.

Suitable travel advice was available from the GPs and nursing staff within the practice and supporting information leaflets were available. Pneumococcal vaccination and shingles vaccinations were provided for patients at risk, either at the practice during routine appointments or at weekends for patients who found it difficult to access the practice during office hours.

Summary of findings

The staff took every opportunity to carry out health checks on patients as they attended the practice. This included offering referrals for smoking cessation, providing health information, routine health checks and reminders to have medication reviews. The practice also offered age appropriate screening tests; examples included testing for prostate cancer and cholesterol testing.

Patients who received repeat medications were able to collect their prescription at a pharmacy of their choice. The practice had an electronic prescribing system in place which sent the approved prescription directly to the chosen pharmacy. This was useful for patients who could not easily access the practice during office hours. The practice had a dispensary attached who served patients who lived in more rural areas.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. There were no barriers to patients accessing services at the practice. Patients were encouraged to participate in health promotion activities, such as breast screening, cancer testing, and smoking cessation.

The practice had a higher than average number of patients with a learning disability. One GP had responsibility for overseeing the care of these patients. Patients with learning disabilities were offered and provided a health check every year during which their long term care plans were discussed with the patient and their carer if appropriate.

Staff were trained in how to help patients who did not have a permanent address in the area, whether as temporary residents, migrant workers or the homeless and traveller populations. They were clear on the processes in place for the patient to register as a temporary patient. Patients whose first language was not English were offered a translation service. The website was also available in different languages.

Practice staff were able to refer patients with alcohol or drug addictions to an alcohol/drug service for support and treatment. Two GPs had particular interests in this field and held clinics at the practice for these patients. The practice also offered a community hospital alcohol detoxification, where patients were assessed then admitted to hospital for detoxification. The practice also held a weekly clinic with a drug and alcohol misuse counsellor.

People experiencing poor mental health (including people with dementia)

Good

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

tailored to patients' individual needs and circumstances, including their physical health needs. Annual health checks were offered to people with serious mental illnesses. GPs had the necessary skills and information to treat or refer patients with poor mental health. The practice had a dedicated GP for patients suffering with dementia living in their own homes and for patients living in residential care. These patients were invited to attend the practice monthly meetings. The practice accessed local memory clinics, and the team for acute complex dementia care. The PPG and lead GP had set up a carer support group to support families and carers.

Summary of findings

What people who use the service say

We spoke with six patients during our inspection. The practice has an active patient participation group (PPG).

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 23 comment cards which contained detailed positive comments.

Comment cards stated that patients were grateful for the caring attitude of the staff and for the staff who took time to listen effectively. Comments also highlighted patients' confidence in the advice and medical knowledge, and praise for the continuity of care and not being rushed. However several comments were made about the dissatisfaction with the ability to book an appointment. Patients said they often had to wait weeks to see the GP of their choice but acknowledged they could see another sooner if they didn't have a preference of who that may be.

These findings were reflected during our conversations with patients. The feedback from patients was overwhelmingly positive about the care they received. Patients said they were happy, very satisfied and they received good treatment. Patients told us that the GPs were excellent.

Patients told us the appointment system was good if they needed a same-day appointment, but that it was more difficult if booking in advance and wanting to see a specific GP. They all told us they could speak to a medical professional on the same day if needed and appointments were made if required. They also told us they could request an appointment with a GP of a specific gender.

Patients told us they had been offered a chaperone during consultations if this was appropriate, and they said there were notices in consultation rooms telling them that chaperones were available.

Areas for improvement

Action the service SHOULD take to improve

The practice manager has a formal annual appraisal.

Infection control training is updated for all staff. Disposable curtains are replaced appropriately, and in accordance with national guidance.

Carnewater 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 pharmacist.

Background to Carnewater Practice

The practice provides primary medical services to people living in the town of Bodmin, Cornwall and the surrounding areas. At the time of our inspection there were approximately 11200 patients. The practice provides services to a diverse population age group and is situated in a town centre location. The practice also has a branch surgery that is open every day in Lewannick, near Launceston. Appointments are made centrally through Carnewater but patients are able to attend either practice for an appointment.

Carnewater Practice is open between Monday and Friday from 8am-6pm with extended opening hours being offered two mornings and two evenings a week and also Saturday mornings every two weeks. Outside of these hours a service is provided by another health care provider, which patients' access by dialling a national service number.

The practice comprises of a team of six GP partners (four male and two female) and one non GP partner who is the managing partner and holds managerial and financial responsibility for running the business. In addition there are three salaried GPs, five registered nurses, six qualified dispensers and two health care assistants. A full administration team are employed to support the management of the practice.

The practice has an established patient representation group (PPG). This is a group that acts as a voice for patients at the practice.

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

The practice has 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. Carnewater dispensed to patients who did not have a pharmacy within a mile radius of where they lived.

Why we carried out this inspection

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

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework (QOF) data, this relates to the most recent information available to the CQC at that time.

Detailed findings

How we carried out this inspection

The inspection team carried out an announced inspection of Carnewater Practice on 20 January 2015. We spoke with six patients and nine members of staff. We spoke with two members of the patient participation group (PPG). The purpose of a PPG is to comment on the overall quality of the service at the practice and to act as an advocate on behalf of patients when they wish to raise issues.

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

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

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

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

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

People experiencing poor mental health (including people with dementia)

Good

Are services safe?

Our findings

Safe track record

We saw evidence that the practice had a good track record for maintaining patient safety. Information from the quality and outcomes framework (QOF), which is a national performance measurement tool, showed that significant events were appropriately identified and reported. GPs told us they completed incident reports and carried out significant event analysis as part of their on-going professional development. For example we saw a report which showed how an urgent referral had been made electronically to the hospital team which got lost because the hospital email address had been changed. The practice had not been notified of this and this resulted in a delay in the referral being actioned. A complaint was made to the hospital and all staff were made aware.

The management team, GPs and practice nurses discussed significant events at their regular monthly meetings. These were also discussed by staff and other external staff that attended the meetings so that the provider as a whole learnt from incidents, shared ideas for improvement and took action to reduce the risk of the event re-occurring. The meeting minutes we reviewed provided evidence of new guidelines, complaints, and incidents being discussed positively and openly. All the staff we spoke with, including reception staff, were aware of the significant event policy and knew how to escalate any incidents. They were aware of the forms they were required to complete and knew who to report any incidents to at the practice.

Learning and improvement from safety incidents

The process following a significant event or complaint was formalised and followed a set procedure. GPs discussed the incidents as they occurred but more formally at monthly clinical meetings where actions and learning outcomes were shared with all staff. We were given two clear examples of where practice and staff action had been prompted to change as a result of incidents. These included changes in protocols and further communication for all staff. There were systems in place to make sure any medicines alerts or recalls were actioned by staff.

Reliable safety systems and processes including safeguarding

The practice had an up to date 'safeguarding children, young people, and vulnerable adults' policy in place. This provided staff with information about safeguarding legislation and how to identify report and deal with suspected abuse. One of the GPs took the lead for safeguarding, and all the staff we spoke with were aware of who the lead was and how they could access the policy on their computers. Staff also had access to the contact details of child protection and adult safeguarding teams in the area.

Staff had received safeguarding training up to appropriate levels; level three for clinical staff and non-clinical staff up to level two. We saw that the training for all staff was up to date. All the staff we spoke with were able to discuss what constituted a child and adult safeguarding concern. They were aware of how to report suspected abuse and who to contact if they needed advice.

Patients said that they felt safe at the practice. The practice offered a chaperone option where a member of staff was available to accompany patients during examinations at their request (or at the instigation of the GP or nurse involved). We saw notices in the waiting area and in consultation rooms informing patients about chaperones.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

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

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Good

Are services safe?

Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. We saw that the practice had in place a policy that all prescriptions were signed before dispensing took place and this was working in practice.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. There were arrangements in place for the destruction of controlled drugs.

The practice had established a service for patients to pick up their dispensed prescriptions at a remote location but did not have a robust system in place to protect the confidentiality of personal information at this location.

Cleanliness and infection control

During our inspection we looked at all areas of the practice, including the GP surgeries, nurses' treatment rooms, and patients' toilets and waiting areas. All appeared visibly clean and were uncluttered. The patients we spoke with commented that the practice was clean and appeared

hygienic. Cleaners were employed by the practice and there was a cleaning schedule in place to make sure each area was thoroughly cleaned on a regular basis. There was also a record that each task had been carried out. The practice was cleaned in line with infection control guidelines, with the cleaners routinely attending every morning and evening.

There was an infection control policy in place .This gave full information about aspects of infection control such as the handling of specimens, hand washing, and the action to be taken following exposure to blood or bodily fluids. The lead nurse was the lead for infection control in the practice. Infection control training was provided for all staff as part of their induction, and we saw evidence that the training had been updated. However, the lead nurse for infection control had not received updated formal training but said they kept up to date by regular discussion with their colleagues. We discussed this with the practice manager who told us updated training for the lead nurse was planned for the near future.

We saw there were hand washing facilities in each surgery and treatment room and instructions about hand hygiene were displayed. Hand wash and paper towels were next to each hand wash basin, and hand gel was available throughout the practice. Protective equipment such as gloves, aprons and masks were readily available. Curtains around examination couches were disposable most had been replaced within the past six months. However one had not been replaced since August 2013. Examination couches were washable and were all in good condition. An infection control audit had been carried out in 2013 whereby some issues were identified as needing improvement. We saw evidence that these had since been undertaken. For example the windowsills were found to be dusty. The cleaning team were notified and improvements made.

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.

Staffing and recruitment

Staff told us there were suitable numbers of staff on duty and that staff rotas were managed well. The practice had a low turnover of staff. The practice said they used locums as staff cover but tried to use the same one for continuity. GPs told us they also covered for each other during shorter staff absences.

The practice used a team approach where the workload for part time staff was shared equally. Staff explained this worked well but there remained a general team work approach where all staff helped one another when one particular member of staff was busy.

Recruitment procedures were in place and staff employed at the practice had undergone the appropriate checks prior to commencing employment. Once in post staff completed an induction which consisted of ensuring staff met competencies and were aware of emergency procedures.

Good

Are services safe?

Criminal records checks were performed for GPs and nursing staff but not all administrative staff.

The practice had clear disciplinary procedures to follow should the need arise.

The registered nurses Nursing and Midwifery Council (NMC) status was completed and checked annually to ensure they were listed on the professional register, to enable them to legally practice as a registered nurse.

Monitoring safety and responding to risk

The practice had a suitable business continuity plan that documented their response to any prolonged period of events that may compromise patient safety. For example, this included computer loss and lists of essential equipment. All staff received any medical alert warnings or notifications about safety by email or verbally from the nominated lead nurse.

There was a system in operation to ensure one of the nominated GPs covered for their colleagues, for example home visits, telephone consultations and checking blood test results.

Regular completed audits were performed of patient outcomes which showed a consistent level of care and effective outcomes for patients. We saw evidence that audit and performance was driving improvement for patient outcomes. For example we saw an audit which related to the use of Diazepam. The practice was able to show that a 14% reduction in prescribing had been reached as a result of better read coding. Read coding records the everyday care of a patient, including family history, relevant tests and investigations, past symptoms and diagnoses. The audit also showed that these patients were being prescribed within national guidelines.

Arrangements to deal with emergencies and major incidents

Appropriate equipment was available to deal with an emergency, for example if a patient should collapse. The staff we spoke with all knew where to easily locate the equipment and emergency medicines. The emergency equipment was well maintained and effective checks were in place to ensure emergency medication and equipment did not expire. All staff, including administration staff had received training in emergency procedures.

Emergency medicines for cardiac arrest, anaphylaxis and hypoglycaemia were available and all staff knew their location.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

All GPs and nurses demonstrated how they accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of clinical and practice meetings where new guidelines were disseminated and the implications for the practice's performance and patients were discussed. The GPs interviewed were aware of their professional responsibilities to maintain their knowledge. We saw that patients were appropriately referred to secondary and community care services. Referrals were discussed during clinical meetings. The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches.

The staff we spoke with and evidence we reviewed confirmed that these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs and these were reviewed when appropriate. Read coding was extensively used for patients. Read coding records the everyday care of a patient, including family history, relevant tests and investigations, past symptoms and diagnoses. They improve patient care by ensuring clinician's base their judgements on the best possible information available at a given time. The GPs and nurses we spoke with were all familiar with read coding and its benefits when assessing patients' conditions.

Practice nurses managed clinical areas such as diabetes or asthma. During regular assessments patients over the age of 55 years were asked if they had any memory problems. Any issues were then monitored and advice given when appropriate.

There was no evidence of discrimination when making care and treatment decisions. Interviews with GPs and nursing staff showed that the culture in the practice was that patients were referred on need and that age, gender, race and disability were not taken into account in this decision-making. The GPs at the practice were male and female.

Management, monitoring and improving outcomes for people

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.

The practice had a system in place for completing clinical audit cycles. These are quality improvement processes that seek to improve patient care and outcomes through the systematic review of patient care and the implementation of change. We saw examples of these at the practice including audits relating to secondary care referrals and medication. We saw that where audits identified actions these were clearly described.

We saw evidence of peer review and support and regular clinical and practice meetings being held to monitor and identify possible issues and improvements in respect of clinical care.

Effective staffing

All of the GPs in the practice participated in the appraisal system leading to revalidation over a five-year cycle. The GPs we spoke with told us these appraisals have been appropriately completed. Nursing and administration staff received an annual formal appraisal and kept up to date with their continuous professional development programme.

There were effective staffing and recruitment policies to ensure staff were recruited and supported appropriately. Paper and computer staff records demonstrated that staff had been recruited and employed in line with the practice policy. Before staff were appointed there was evidence that relevant checks had been made in relation to identity, registration and continuous professional development.

Staff said they all received an annual appraisal and attended regular staff meetings to enable information sharing. Nursing staff received clinical supervision from the GP partners. They also met with the GPs informally to discuss clinical issues and diagnoses. However, the practice manager had not received an appraisal since 2007. Following the inspection we received notification from the practice that this had been arranged for the near future.

All staff told us they had access to training related to their roles. Staff were alerted by the practice nurse to concerns about faulty equipment from MHRA alerts. Patients were treated effectively by informed staff.

Working with colleagues and other services

Good

Are services effective?

(for example, treatment is effective)

We found that the practice worked with other service providers to meet patients' needs and manage complex cases. Blood results, X-ray results, letters from hospital A and E and outpatients and discharge summaries, out of hours providers and the 111 service were received electronically or by post. These are seen and actioned by a GP on the day they are received. Outpatient letters are reviewed in less than five days from receipt. The GP seeing documents and results was responsible for the action required. They either recorded the action or arranged for the patient to be contacted and seen as clinically necessary. We saw that this process worked well.

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

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 data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals. Staff reported that this system was easy to use. Regular meetings were held throughout the practice.

Information about risks and significant events were shared openly at meetings and all staff were able to contribute to discussions about how improvements could be made. The management team attended Clinical Commissioning Group (CCG) meetings and information from these meetings was fed back to staff.

There was a practice website available in several languages with information for patients including signposting, services available and latest news. Patients registered so they could access the full range of information on the website. Information leaflets and posters about local services were available in the waiting area.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 (MCA) and their duties in fulfilling it. We saw that staff had received training in the MCA. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff, for example with making do not attempt resuscitation orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions and were involved in developing their own individual care plans. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision.

All clinical staff demonstrated a clear understanding of Gillick competency when obtaining consent from children and young people. A Gillick competent child is a child under 16 who has the legal capacity to consent to care and treatment. They are capable of understanding implications of the proposed treatment, including the risks and alternative options.

There was a practice policy for documenting consent for specific interventions. An example of this was that for all minor surgical procedures, a patient's written and verbal consent was documented in their electronic notes with a record of the relevant risks, benefits and complications of the procedure.

Health promotion and prevention

Staff were consistent in supporting people to live healthier lives through a targeted and proactive approach to health promotion and prevention of ill-health, and every contact with people was perceived as an opportunity to do so.

Health promotion literature was readily available to patients and was up to date. This included information about services to support them in, for instance, smoking cessation schemes. Patients were encouraged to take an interest in their health and to take action to improve and maintain it.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. There was a clear policy for the practice nurse to follow up patients who did not attend their appointment.

Good

Are services effective?

(for example, treatment is effective)

New patients were invited into the practice when they first registered, so that details of their past medical and family health histories could be recorded. They were also asked about social factors including occupation, lifestyle and medicines. This enabled the GPs and nurses to assess a new patient's risk factors.

GPs and nurses were automatically alerted to patients who were also registered as carers. This helped GPs awareness of the wider context of the patient's health needs. Care checks were undertaken by the nurses who provided additional practical and emotional support.

All patients with a learning disability had been offered a health check in the past twelve months. These were undertaken either at the practice or in the patient's home.

Patients were provided with fitness to work advice to aid their recovery and help them return to work.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey of over 500 patients and a survey undertaken by the practice's Patient Participation Group (PPG) in December 2014. PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care patients receive. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national GP patient survey showed that 81% of respondents said that their overall experience was good or very good or excellent and over 80% of respondents would recommend the practice to another person.

We received 23 completed CQC comment cards, spoke with six patients on the day of inspection and two members of the practice's patient participation group (PPG). We spoke with people from various age groups and with people who had different health care needs.

Patients we spoke with and who completed our comment cards were complimentary about the way they were treated by the doctors and nurses and other members of the practice team. They told us they were treated with respect and their privacy and dignity were maintained. Staff were seen to be respectful, pleasant and helpful with patients and each other during our inspection visit.

Patients informed us that their privacy and dignity was always respected and maintained particularly during physical or intimate examinations. All patient appointments were conducted in the privacy of individual consultation room. Examination couches were provided with privacy curtains for use during physical and intimate examination and a chaperone service was provided when required.

Care planning and involvement in decisions about care and treatment

Patients said they felt involved in planning and making decisions about their care and treatment, they rated the practice well in these areas. 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

There was a person centred culture where the practice team worked in partnership with patients and their families. This included consideration of the emotional and social impact a patients care and treatment may have on them and those close to them. The practice had taken proactive action to identify, involve and support patient's carers. This included providing information at the practice (and on their website) to encourage carers to identify themselves and engage with the practice to access support.

A wide range of information about how to access support groups and self-help organisations was available and accessible to patients from the practice clinicians, in the reception area and on the practice website.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the service was responsive to people's needs and had sustainable systems in place to maintain the level of service provided. The practice held information about the prevalence of specific diseases. This information was reflected in the services provided, for example screening programmes, vaccination programmes and reviews for patients with long term conditions.

The practice was proactive in contacting patients who failed to attend vaccination and screening programmes.

Tackling inequity and promoting equality

Action had been taken to remove barriers to accessing the services of the practice. The practice team had taken into account the differing needs of people by planning and providing care and treatment services that were individualised and responsive to individual needs and circumstances. This included having systems in place to ensure patients with complex needs were enabled to access appropriate care and treatment such as patients with a learning disability or dementia. People in vulnerable circumstances were able to access care and treatment with the practice, including those that were homeless.

The premises and services had been adapted to meet the needs of patients with disabilities. There was disabled parking available and step free access to the entrance doors. A wheelchair was available for patients upon request. The practice was situated on the first floor of the building with easy level access from the front of the building to the reception area. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice. There was also a passenger lift.

Access to the service

The appointments system was easy to use and supported patients to make appointments. Waiting times, delays and cancellations were minimal and managed appropriately. People were kept informed of any disruption to their care or treatment. Patient's comments varied in respect of being able to access the service. We also looked the results of the 2014 GP survey. 60% of the respondents said they were satisfied with their appointment. 50% said they found it difficult to get through by telephone in the morning. 81% of patients who responded said they were satisfied with their overall experience at the practice.

The opening hours and surgery times at the practice were prominently displayed in the reception area, the patient practice information booklet and on the practice website. To improve patient access the practice offered extended opening hours from 7.30am until 7pm twice a week and a Saturday morning surgery every two weeks. These hours of access were particularly helpful to patients who worked. Routine appointments and same day appointments were provided. Routine appointments could be booked up to four weeks ahead. GP consultations were provided in 10 minute appointments. Where patients required longer appointments these could be booked by prior arrangement. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients at the practice and on the practice website.

Listening and learning from concerns and complaints

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

There was a complaints process was publicised in the waiting room. The complaints procedure was on the practice web site and in the practice leaflet. Patients we spoke with had not had any cause to complain but they believed any complaint they made would be taken seriously.

We saw the practice's log and annual review of complaints received. The review recorded the outcome of each complaint and identified where learning from the event had been shared at a practice meeting.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. It actively promoted a learning culture. We saw the business plan that was in place, and saw the practice's vision and values were included in various documents. We spoke with nine members of staff they were all aware of the vision and values of the practice and knew what their responsibilities were in relation to these. We saw that the regular staff meetings helped to ensure the vision and values were being upheld within the practice.

Governance arrangements

All staff understood their role and responsibilities and demonstrated appropriate accountability in the way they supported and treated patients in their care. The practice had a clear governance structure designed to provide assurance to patients and the local clinical commissioning group (CCG) that the service was operating safely and effectively. There were clearly identified lead roles for areas such as medicines management, complaints and incident management, and safeguarding. The responsibilities were shared between the GPs and the practice manager.

Practice nurses told us they were supported through the local practice nurse forum and links with the modern matron and other specialist nurses. Training needs were identified and support given to staff to undertake additional training to increase their skill base.

The practice had a system in place for completing clinical audit cycles. These were improvement processes that sought to improve patient care and outcomes through the review of patient care and the implementation of change. We saw examples of these at the practice including audits relating to secondary care referrals and medication. We saw that where audits identified actions these were clearly described.

Leadership, openness and transparency

Staff communicated a very clear leadership structure which had named members of staff in lead roles. For example there was a lead nurse for infection control and a lead GP for safeguarding. Staff spoke about effective team working, clear roles and responsibilities but within a supportive organisation. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns. Staff described an open culture within the practice and opportunities to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. Staff were aware of where to find these policies if required.

Human resources policies and procedures were in place to support staff. We saw these were available to all staff electronically. Staff told us they were aware of the policies and how to access them. All staff other than the practice manager had an annual review of their performance during an appraisal meeting. This gave staff an opportunity to discuss their objectives, any improvements that could be made and training that they needed or wanted to undertake. Clinicians also received appraisal through the revalidation process. Revalidation is where licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice.

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

Patient feedback was valued by the practice. The practice had a patient participation group (PPG). The PPG representatives who came to the inspection said the practice manager and GP representative were keen to encourage patient feedback and involvement. The PPG said they were regularly consulted about various issues and had been able to influence this decision and suggest additional ideas. This was demonstrated by the instigation of a new text messaging service to remind patients of appointments and keep them updated with important information following feedback from patients who said communication could be improved. The PPG was advertised on the practice website along with information on how patients could offer feedback.

Management lead through learning and improvement

A standardised, formal, systematic process was followed to ensure that learning and improvement took place when events occurred or new information was provided. For example, the practice had a calendar of meeting dates to discuss current issues. There was formal protected time set aside for continuous professional development for staff and access to further education and training as needed.

Are services well-led?

Good

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

The practice had systems in place to identify and manage risks to the patients, staff and visitors that attended the practice. There were environmental 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 had been maintained.