Alrewas Surgery

Quality Report

The Surgery
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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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected this service on 29 October 2014 as part of our new comprehensive inspection programme.

The overall rating for this service is good. We found the practice to be good in the safe, effective, caring, responsive and well-led domains. We found the practice provided good care to older people, people with long term conditions, families, children and young people, the working age population and those recently retired, people in vulnerable circumstances and people experiencing poor mental health.

Our key findings were as follows:

- Patients were kept safe because there were arrangements in place for staff to report and learn from key safety risks. The practice had a system in place for reporting, recording and monitoring significant events over time.
- The practice had recognised that access to appointments had been highlighted in the patient survey and was working with the Patient Participation Group (PPG) to address this. The appointment system had been amended to provide more on the day appointments.
- There were systems in place to keep patients safe from the risk and spread of infection.
- Evidence we reviewed demonstrated that patients were satisfied with how they were treated and that this was with compassion, dignity and respect. It also demonstrated that the GPs were good at listening to patients and gave them enough time.
- Staff were all clear about their own roles and responsibilities, and felt valued, well supported and knew who to go to in the practice with any concerns.

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

The provider should:

- Ensure that all equipment at the practice is serviced and calibrated.
- Review the risks associated with disruption to the cold chain and consider the need for a validated cool box for transporting vaccines.

Summary of findings

- Review the emergency equipment / medication available in the practice to ensure that it is required.
- Review the referral process to secondary care services to ensure consistency and timeliness across the GPs.

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 safe. There were effective systems in place to ensure patients were protected from the risk of abuse or avoidable harm. The practice had a system in place for reporting, recording and monitoring significant events. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons learnt were shared with all staff. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for effective. National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely. Patients' care and treatment was planned and delivered in line with current guidance and best practice. This included assessment of capacity and the promotion of good health. Staff received training appropriate to their roles and further training needs had been identified and planned. The practice could identify all appraisals and development plans for staff. There was evidence of multidisciplinary working.

Are services caring?

Good

The practice is rated a good for caring. Data showed patients rated the practice higher than others in the locality for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to patients to help them understand their care. We saw that patients were treated with kindness and respect ensuring confidentiality was maintained. Emotional support was provided for those patients who had suffered bereavement.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. Patients reported good access to the practice, with urgent appointments available the same day. The practice offered extended hours one day a week. The practice had good facilities and was well equipped to treat people and meet their needs. The practice provided co-ordinated and integrated care for the patients registered with them. There were a range of clinics to provide help and support for patients with long-term conditions and the practice also appointments run by the physiotherapy department and podiatry.

Summary of findings

There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff.

Are services well-led?

Good

The practice was rated as good for well-led. The practice had a strong and visible leadership which was well supported by the staff team. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt well supported by management. The practice had a number of policies and procedures to govern activity and regular management meetings took place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active Patient Participation Group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older people. Every patient over the age of 75 years had been notified of their named GP. This ensured continuity of care for patients over 75 years of age. The practice had identified vulnerable older patients and had developed individual care plans to support patients to ensure their care needs were made and avoid unnecessary hospital admissions. These care plans are in the process of being shared with the out of hour's provider. Patient notes identified when patients were also carers. The practice worked in partnership with the community nursing team, including the community matron to support older patients receiving a service. Influenza and shingles vaccinations were offered to older patients according to national guidance for older people. Patients were made aware of these campaigns through the practice newsletter, the website and the parish magazine.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. We found that the staff had the knowledge, skills and competencies to respond to the needs of patients with a long term condition such as diabetes and asthma. The practice maintained registers of patients with long term conditions. We found robust systems in place to ensure that all patients with a long term condition received regular reviews and health checks at a time suitable to them. Patients were invited for a review of all of their long term conditions in the month of their birth. Staff were proactive in following up patients who did not make appointments for their reviews.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. We saw that the practice provided services to meet the needs of this population group. Urgent appointments were available for children who were unwell. Staff were knowledgeable about how to safeguard children from the risk of abuse. Systems were in place identifying children who were at risk, and there was a good working relationship with the health visitor attached to the practice. The health visitor also attended the clinical meetings at the practice. There were effective screening and vaccination programmes in place to support patients and health promotion advice was provided. Information was available to young people regarding sexual health and family planning advice was

Summary of findings

provided by staff at the practice. New mothers and babies were offered an integrated eight week check, where they saw the GP, practice nurse and health visitor. Antenatal clinics were also held at the practice.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age people (including those who have recently retired and students). The practice offered a range of appointments which included pre-bookable appointments, on the day, urgent appointments, as well as telephone consultations. The practice offered extended hours one evening a week. The practice was pro-active in offering on line services as well as offering a full range of health promotion and screening services with reflected the needs of this age group. The practice offered all patients aged 40 to 75 years old a health check with the practice nurse. Family planning services were provided by the practice for women of working age. Diagnostic tests, such as electrocardiograms (ECG) and routine blood tests were carried out at the practice. Flu clinics were held on Saturdays.

People whose circumstances may make them vulnerable

Good

This practice is rated as good for the population group of people who circumstances make them vulnerable. We found that the practice enabled all patients to access their GP services. Staff told us that they supported those who were in temporary residence or lived on narrow boats nearby to register with the practice. For example, the hospital appointments for one patient of no fixed abode were delivered to the practice, and staff sent a text message to inform the patient. The practice held a register of patients with a learning disability. The practice carried out annual health checks for people with learning disabilities.

The practice was able to sign post vulnerable patients to various support groups and third sector organisations. Staff knew how to recognise signs of abuse in vulnerable adults. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group experiencing poor mental health (including people with dementia). The practice held registers of patients with mental health needs, including depression and dementia. Patients experiencing poor mental health received an annual health review to ensure appropriate

Summary of findings

treatment and support was in place. Patients were referred to the Primary Care Mental Health (PCMH) Team and patients were seen at the practice if appropriate. The PCMH worker visited the practice weekly, offering on to one sessions. This enabled patients to receive counselling and treatment in surroundings that were familiar to them.

Summary of findings

What people who use the service say

We spoke with five patients on the day of the inspection. Patients were very satisfied with the service they received at the practice. They told us they could get an appointment at a time that suited them, including same day appointments. They told us they had confidence in the staff and they were always treated with dignity and respect.

We reviewed the 61 patient comments cards from our Care Quality Commission (CQC) comments box that we had asked to be placed in the practice prior to our inspection. We saw that almost all comments were extremely positive. Patients said they felt the practice offered an excellent service and staff were supportive, helpful and professional. They said staff treated them with dignity and respect, and were friendly and helpful.

Five patient comment cards contained comments that were less positive, and of these, three comments were about the appointment system. However all of the comment cards indicated that patients were satisfied with the care provided by the practice, and they said their dignity and privacy was respected.

We looked at the national GP Patient Survey published in December 2013. The survey found that 84% of patients rated Alrewas Surgery as good or very good, which was within the middle range. The results showed that 84% of patients said that their overall experience of the practice was good and that 85% of patients would recommend the practice to someone new to the area, which was also within the middle range.

Areas for improvement

Action the service SHOULD take to improve

The practice should ensure that all equipment at the practice is serviced and calibrated.

The practice should review the risks associated with disruption to the cold chain and consider the need for a validated cool box for transporting vaccines.

The practice should review the emergency equipment / medication available in the practice to ensure that it is required.

The practice should review the referral process to secondary care services to ensure consistency and timeliness across the GPs.

Alrewas Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The lead inspector was accompanied by a GP specialist advisor and an expert by experience who had personal experience of using primary medical services.

Background to Alrewas Surgery

Alrewas Surgery is located in the village of Alrewas and provides primary medical services to patients who live in the following areas: Alrewas, Fradley, Bromley Hayes, Kings Bromley, Orgreave, Croxall, Wychnor, Catton, Edingale, Harlaston, Lullington and Elford.

The practice has three permanent GPs (one male and two female), two GP registrars, a practice manager, two nurse practitioners and one practice nurse, two healthcare assistants, and reception and administrative staff. There are 5658 patients registered with the practice. The practice is open from 8.15am to 5.45pm Monday to Friday, although the practice is closed from 12.30pm to 2.30pm on a Monday. The practice offers extended hours on Monday evenings from 6.30pm to 8pm. Patients can access the service for routine appointments from 8.30am. The practice treats patients of all ages and provides a range of medical services. Alrewas Surgery has a higher percentage of its practice population in the 65 and over age group than the England average.

The practice provides a number of clinics for example long term condition management including asthma, diabetes and high blood pressure. It offers child immunisations, minor surgery and travel health. The practice also provides a minor injury and phlebotomy service.

Alrewas Surgery has a General Medical Services contract.

Alrewas Surgery is a training practice for GP Registrars. GP registrars are doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine.

Alrewas Surgery does not provide an out-of-hours service to its own patients but has alternative arrangements for patients to be seen when the practice is closed.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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.

This provider had not been inspected before and that was why we included them.

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

Detailed findings

How we carried out this inspection

Before the inspection we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We received information from the Clinical Commissioning Group (CCG) and the NHS England Local Area Team.

We carried out an announced visit on 29 October 2014. During our inspection we spoke with two GPs, one registrar, one nurse practitioner, the practice manager, the data quality and IT administrator and one member of reception staff. We spoke with five patients who used the service about their experiences of the care they received. We reviewed 61 patient comment cards sharing their views and experiences of the practice. We also spoke with a representative from the Patient Participation Group.

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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and to improve quality in relation to patient safety.

We saw records which showed that multiple sources of information were used by the practice to check the safety of the service and action was taken to address any areas in need of improvement. These included significant events and complaints. We found clear procedures were in place for reporting safety incidents, complaints or safeguarding concerns. Staff we spoke with knew it was important to report incidents and significant events to keep patients safe from harm. Staff told us they were actively encouraged and supported to raise any concerns that they may have and were able to explain and demonstrate the process in place.

We saw that a log of incidents, complaints and significant events had been kept at the practice. We saw they had all been appropriately investigated. We saw that reviews of incidents and significant events over time had been completed to identify if there were any reoccurring concerns across the service.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. The practice kept records of significant events that had occurred between September 2013 and October 2014 and these were made available to us. We saw that staff were responsible for completing significant event forms, and significant event audits or analysis were carried out each time there was a patient safety incident. All incidents were recorded on a well maintained register, which recorded details of the incident, action taken and lessons learnt. For example, we saw the telephone system had not been transferred to the out-of-hours service over a holiday period. When patients telephoned the practice during this period they were given the incorrect message. To prevent this occurring the instructions were added to the 'what to do at night' checklist and staff were instructed to double check to telephone system before locking up. The practice manager and GPs told us incidents were discussed at the management meetings and shared with all staff at the relevant meetings. We looked at minutes of these meetings which described the learning from incidents and any actions that staff needed to take.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review the risks to vulnerable children, young people and adults. All staff had received training in safeguarding vulnerable adults and children. The training records demonstrated all staff had received training to a level appropriate to their role and responsibilities. Staff we spoke with also confirmed they had completed safeguarding training. Staff confirmed they were able to access policies and procedures through the practice's intranet site. Staff explained to us the processes they would follow in the event they became concerned that a patient may be at risk of harm. Contact details for external agencies and the flow chart to follow for making referrals was easily accessible and on display around the practice. Staff spoken with demonstrated they were aware of the safeguarding lead for the practice with whom they would share their concerns.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments; for example children subject to child protection plans, and patients who were also carers.

A chaperone policy was in place and visible around the practice, and included on the practice's website. Staff who acted as chaperones confirmed they had received chaperone training. A list of trained chaperones was on display around the building, and included all nursing staff and five members of reception staff. A member of staff spoken with who had received chaperone training understood their responsibilities when acting as a chaperone including where to stand to observe the examination.

Patient records were written and managed in a way to help ensure safety. Records were kept on an electronic system, EMIS Web, which collated all communications about a patient including electronic and scanned copies of communications from hospitals.

The practice worked with other services to prevent abuse and to implement plans of care. Staff told us they had a very good working relationship with the health visitor attached to the practice. We saw from the minutes of clinical staff meetings that the health visitor attended these meetings whenever possible. Staff told us the health visitor kept them fully updated about children under five years

old, but there was a gap when children started school. The practice was looking to develop closer links with the school nursing team, once the team leader vacancy had been filled.

Medicines Management

We checked medicines stored in the treatment rooms and the medicine refrigerators and found they were stored securely and were only accessible to authorised staff. We saw that there was an efficient system for stock rotation. A monthly stock check was completed to ensure all medicines remained in date and were safe to use. Batch numbers and expiry dates of medicines were recorded electronically, and all medicines were in date and accounted for.

Medicines that required refrigeration were stored in two refrigerators. We saw evidence that the temperature of the refrigerators used for storing these were checked daily ensuring they were stored within the manufacturer's guidelines. Staff accurately described the temperature range that medicines and vaccines should be stored at and the actions they would take if the refrigerator temperature had not been maintained. Guidance was available for staff on how to maintain the supply and storage of vaccines at the required temperatures. The practice had an arrangement with two local pharmacies to store vaccines if the electricity supply was interrupted. However, the practice did not have validated cool boxes for transporting the vaccines.

We saw there were signed Patient Group Directives (PGD) in place to support the nursing staff in the administration of vaccines. A PGD is a written instruction from a qualified and registered prescriber, such as a doctor, enabling a nurse to administer a medicine to groups of patients without individual prescriptions.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. This covered how changes to patients' repeat medicines were managed and authorisation of repeat prescriptions. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary.

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.

The practice had established a service for patients to pick up their dispensed prescriptions at two locations and had systems in place to monitor how these medicines were collected.

Cleanliness & Infection

All of the patients we spoke with during the inspection told us that the practice was always clean and tidy. Comments made in the patient survey also supported this. We saw that the practice was clean and orderly. We saw there were cleaning schedules in place and cleaning records were kept.

Clinical staff had undertaken infection control training. The nurse practitioners shared the infection control lead role with administration support. An infection control audit had been carried out in October 2013 and action had been taken to address the issues identified. For example, new examination couches and chairs with wipe-able coverings had been purchased. The 2014 infection control audit was in the process of being completed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement infection control measures. For example, personal disposable equipment including disposable gloves, aprons and coverings were available for staff to use. Staff confirmed they used single use equipment for most procedures, such as tourniquets used when taking blood from patients. Blood pressure cuffs were however not single use and clinical staff confirmed these were cleaned after each use.

The practice had taken reasonable steps to protect staff and patients from the risks of health care associated infections. We saw that relevant staff had received the relevant immunisations and support to manage the risks of health care associated infections. There was a policy for needle stick injuries. We saw that this policy had been adhered to following two needle stick injuries that had occurred in recent months.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). A legionella assessment had been completed in January 2013 and was due to be repeated in January 2015. We saw records that confirmed the practice was carrying out regular checks in line with this policy in order to reduce the risk of infection to staff and patients.

Good

Are services safe?

Equipment

Staff told us there were systems in place to ensure that all equipment was tested and maintained regularly and we saw records that supported this. However, we found that equipment kept in one GP's bag had not been tested recently as it had not been presented for testing in 2013. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. We saw evidence of calibration of relevant equipment, for example weighing scales.

Staffing & Recruitment

Effective recruitment and selection processes were in place to ensure staff were suitable to work at the practice. We saw an up to date recruitment policy outlining the recruitment process to be followed for the recruitment of all staff. The policy detailed all the pre-employment checks to be undertaken before a person could start to work at the practice. Most staff had worked at the practice for many years. We looked in the file of three members of staff who had recently been recruited. We saw that almost all of the appropriate checks had been carried out. However, we noted that employment histories did not include months and years, making it difficult to identify any gaps, and a health check was not always completed. The practice manager assured us that these shortfalls would be addressed and the application form amended accordingly.

Checks through the Disclosure and Barring Service (DBS) had been completed for all clinical staff who worked at the practice, and staff who had been employed recently. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable adults and children. However, not all staff who acted as chaperones had DBS checks completed and risk assessments were not in place for staff without DBS checks. The practice manager assured us that risk assessments had been completed following our inspection, and DBS checks requested for staff who acted as chaperones. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable adults and children.

Patients were cared for by suitably qualified and trained staff. We saw evidence that health professionals, such as doctors and nurses, were registered with their appropriate professional body and so fit to practice. There was a system in place that ensured health professionals' registrations were in date.

The practice manager told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure there were enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave.

The practice manager told us they employed locum GPs when required. We saw that the required recruitment checks were in place for the locum GP currently working at the practice. The registered manager told us the locums completed the same work as the partner GPs, which included home visits, emergency appointments and checking results.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor the risk to patients, staff and visitors to the practice. Health and safety policies and procedures were available for staff to refer to. We saw that there had been a fire risk assessment carried out in October 2012 and an action plan put in place following this. We saw that the majority of actions had been completed. The practice employed a caretaker who was responsible for carrying out routine maintenance. Health and safety information was displayed for staff to see and there was an identified health and safety representative. We saw that health and safety issues were discussed at staff meetings and separate health and safety meetings were held every three months.

We saw that the practice had worked with the local Clinical Commissioning Group to identify high risk patients. Individual care plans had been developed for each patient, and would be shared with the out of hour's provider using special notes. The aim of this was to reduce the amount of unplanned admissions to hospital.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). We saw that the trolley contained some equipment that was rarely or never used, and the amount of oxygen in the cylinder could only be checked by switching on the oxygen cylinder.

Good

Are services safe?

Staff confirmed they knew how to respond to medical emergencies and told us where the emergency equipment was stored. They told us they had been trained in basic life skills and that this training was done annually / every three years (depending on role and responsibilities) to ensure they were up to date with their knowledge and skills. All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly to make sure they were fully functional.

There were systems in place to respond to emergencies and major incidents within the practice. There was a business continuity plan available which identified potential safety risks including changes in service demand, the disruption to staffing levels and loss of domestic services. The business continuity plan provided action plans and important contact numbers for staff to refer to which ensured the service would be maintained during any emergency or major incident.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients' needs were assessed and care and treatment was delivered in line with current legislation and recognised best practice. The GPs told us they used the National Institute for Health and Care Excellence (NICE) guidelines and locally developed guidelines when planning care. They told us that any new information or clinical guidelines were discussed at clinical meetings. This was supported by the minutes of the clinical meetings we reviewed.

GPs demonstrated adherence to local guidelines and protocols regarding clinical decisions such as changes in care pathways. The GPs attended educational meetings facilitated by the Clinical Commissioning Group (CCG), and engaged in annual appraisal and other educational support. The annual appraisal process requires GPs to demonstrate that they have kept up to date with current practice, evaluated the quality of their work and gained feedback from their peers.

We saw that each GP led in specialist clinical areas, such as diabetes, heart disease and asthma, and the practice nurses supported this which allowed the practice to focus on specific conditions. Clinical staff spoken with were very open about asking for and providing colleagues with advice and support. For example the GP trainee told us the GPs were approachable even when the workload was busy and they always felt comfortable asking for help.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race were not taken into account in this decision making.

Management, monitoring and improving outcomes for people

The practice routinely collected information about patients care and outcomes. It used the Quality and Outcomes Framework (QOF) to assess its performance and undertaken regular clinical audit. The QOF rewards practices for providing quality care and helps to fund further improvements. We saw there was a robust system in place to frequently review QOF data and recall patients when needed.

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included: cervical screening, minor surgery and referral times. As a result of the referral time audit, referral forms had been added to the computer, and template letters introduced to make it easier and quicker to prepare a draft letter. As these changes had only recently been introduced, the practice planned to carry out a further audit to assess the effectiveness of the changes. Doctors in the surgery carried out minor surgical procedures in line with their registration and NICE guidance. We saw that the staff were appropriately trained and carried out regular clinical audits on their results which were used in their learning.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with the practice's required training such as safeguarding training and basic life support. All GPs were up to date with their yearly continuing professional development requirements and all have been revalidated. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council.)

The practice was a training practice for GP registrars. GP registrars are qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine. There was a comprehensive induction programme in place to support new doctors into the practice. A GP registrar we spoke with told us they felt very well supported at the practice. They told us they valued the GP buddying system which provided them with a daily named GP they could go to for advice and support.

All staff undertook annual appraisals which identified training needs from which action plans were documented. Staff interviews confirmed the practice was proactive in providing training and funding for relevant courses, for example NVQ in customer service / administration, prescribing course for the nurse practitioners and phlebotomy course.

The nurse practitioners, practice nurse and health care assistants had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, on administration of

Good

Are services effective?

(for example, treatment is effective)

vaccines and cervical cytology. Those with extended roles, for example seeing patients with long term condition such as asthma and diabetes, were also able to demonstrate they had appropriate training to fulfil these roles.

Working with colleagues and other services

We found that the practice worked with other service providers to meet patients' needs and manage complex cases. A number of clinics run by professionals employed by other NHS organisations such as the local acute trust, community trust and the mental health team were held at the practice. These provided people with access to physiotherapy, counselling services and podiatry services.

Blood results, X-ray results, letters from the local hospital including discharge summaries, out-of-hours providers and the 111 service were received either electronically or as a paper copy. Each GP reviewed information from other services about their patients on the day it was received. Each GP was responsible for the action required and would either record the action or arrange for the patient to be contacted and seen as clinically necessary. Systems were in place to ensure that patient information was reviewed when GPs were on leave. One GP acted as a duty doctor each day, and dealt with any correspondence or results received. Within the last month, the practice had started to use an electronic system for document management (Docman). This system enabled documents to be scanned onto the electronic system and then allocated to the named clinician or trainee. Required actions were recorded on the electronic system and passed on to the relevant person to action.

The practice offered a Choose and Book option for patient referrals to specialists, although the use of this system between clinicians varied. The Choose and Book appointments service aims to offer patients a choice of appointment at a time and place to suit them. There was also variation between how the referrals were completed, from handwritten, typed or dictated notes for the secretary to action. The time taken for the referrals to be completed also varied depending on when the GP passed the information to the secretaries.

The practice held meetings at least every three months with the multidisciplinary team to discuss patients on the palliative care register. External health care staff were also invited to attend the clinical staff meetings. A number of other services were also located in the same building as the practice, for example, the district nurses.

The practice staff told us this improved communication as community based staff were able to discuss any concerns about patients with the GPs as required as they were located in the building.

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 hours provider to enable patient data to be shared in a secure and timely manner.

All members of staff had done training about information governance to help ensure that information at the practice was dealt with safely with regard to patients' rights as to how their information was gather, used and shared.

Consent to care and treatment

We saw that the practice had policies on consent, the Mental Capacity Act 2005, and assessment of Gillick competency of children and young adults, and information around the Frasier guidelines. 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. Clinical staff told us that patients had a choice about whether they wish to have a procedure carried out or not. They told us they took the time to fully explain procedures and checked the patient understood before proceeding.

The GPs spoken with told us they had received training on the Mental Capacity Act and assessing patients' mental capacity. Mental capacity is the ability to make an informed decision based on understanding a given situation, the options available and the consequences of the decision. People may lose the capacity to make some decisions through illness or disability. Nursing staff told us if they had any concerns about a person's capacity to make decisions, they would ask a GP to carry out an assessment. Although nursing staff had not received separate training on the Mental Capacity Act, they told us it was incorporated into other training, for example, safeguarding training and as part of the prescribing course.

Staff told us they could sign post patients to advocacy services to support them, and information about services was available in the waiting room. Staff also had access to the Independent Mental Capacity Advocacy (IMCA) Service, to support patients who lacked capacity.

Good

Are services effective?

(for example, treatment is effective)

There was a policy in place for documenting consent for specific interventions. For example, for minor surgical procedures, a patient's expressed consent was documented either in the electronic notes or a consent form was completed. We were shown an audit that confirmed the consent process for minor surgery had been followed in 100% of cases.

Health Promotion & Prevention

New patients were required to complete a questionnaire providing details of their medical history. New patients were offered a health check with a suitable clinician if required. The practice offered the NHS health checks to all patients aged 40 to 75 and this was confirmed by patients spoken with.

The practice provided a range of support to enable patients to live healthier lives. Examples of this included, well men group for men aged 65 years and over, travel advice and vaccinations, weight management and smoking cessation. We were also told that the practice carried out child immunisations and offered family planning advice and support. A range of leaflets were available in the waiting room.

The practice offered a full range of immunisations for children. The percentage of children receiving the vaccines was generally in line with or above the average for the local clinical commissioning group.

Flu vaccination was offered to all over the age of 65, those in at risk groups and pregnant women. The percentage of eligible patients receiving the flu vaccination was slightly below the national average. The shingles vaccine was offered according to the national guidance for older people.

Information supporting national screening programmes such as Chlamydia screening was available as were the testing kits.

The nurse practitioner we spoke with told us that health promotion information was available for all patients. They told us that they discussed promoting a healthy lifestyle with patients when they carried out reviews for patients with long term conditions.

The practice had numerous ways of identifying patients who needed additional support, and were proactive in providing additional help. For example, the practice kept a register of all patients with learning disabilities and each patient was offered an annual physical health check.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey published in December 2013and a survey of 381 patients undertaken by the practice's Patient Participation Group (PPG). 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 the care. The evidence from these sources showed patients were generally satisfied with how they were treated and that this was with compassion, dignity and respect. Staff gave an example of how they supported a mother and baby whilst waiting for an ambulance, by providing a private room and a member of staff staying with them at all times. Data from the national patient survey showed that the practice was rated in the middle range for patients rating the practice as good or very good. The survey showed that 93% patients felt that the doctor was good at listening to them, which is above the Clinical Commissioning Group (CCG) area average. 95% of the patients who responded said that they had confidence and trust in the doctor they had seen last at the practice, which is above the Clinical Commissioning Group (CCG) area average.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 61 completed comment cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were supportive, helpful and professional. They said staff treated them with dignity and respect, and were friendly and helpful. Five patient comment cards contained comments that were less positive, and of these, three comments were about the appointment system: having to ring at 8.15am for the same day appointment and not enough pre bookable appointments. However all of the comment cards indicated that patients were satisfied with the care provided by the practice, and they said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in the consulting and treatment rooms so that patients' privacy and dignity was maintained during examinations. We noted that consulting / treatment room doors were closed during consultations and that conversations taking place could not be overhead. We observed staff knocked on closed doors and waited to be invited in before entering.

Throughout the inspection we saw and heard staff speaking with patients in a helpful and respectful manner. We asked patients about confidentiality and no one expressed any concerns. One completed comment card made reference to appointment letters containing confidential information being sent to the wrong address. We saw that this had been reported as a significant event and had been investigated. The reception area and waiting room had been refurbished and redesigned. This had improved privacy at the reception desk, as patients waited at the end of the carpeted area when the reception desk was already occupied. A free standing welcome notice board also provided a division between the waiting area and the reception desk. The seated waiting area was away from the reception desk, preventing conversations from being overheard. The practice switch board was located away from the reception desk and was shielded by a glass partition, which helped to keep patient information private, although a small number of calls were answered at the reception desk.

Staff told us that the practice cared for patients whose circumstances may make them vulnerable. This included looked after children (in the care of the local authority), people who lived on nearby narrow boats and a Buddhist Monastery. Staff told us that these patients were supported to register as either permanent or temporary patients, as the practice had a policy to accept any patient who lived within their practice boundary irrespective of race, culture, religion or sexual preference. They told us all patients received the same quality of service from all staff to ensure their needs were met.

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection told us that they felt fully informed and involved in the decisions about their care. They told us they felt listened to and supported by staff and were given sufficient time during consultations to discuss any concerns. One patient told us the clinician had just explained during their consultation what the next course of action would be. Another patient told us that the clinician talked through all the steps with them and asked for the patient's opinion. This enabled the

Good

Are services caring?

patient to make an informed decision about the choice of treatment they wished to receive. Patient comments on the comment cards we received were also positive and supported these views.

The patient survey information we reviewed showed patients generally responded positively to questions about their involvement in planning and making decisions. The data from the national patient survey showed that the practice was above the CCG area average with 81% of respondents saying they felt the GP was good at involving them in decisions about their care and 71% said the same for the nurse. However, the number who said the GP (83%) and the nurse (78%) were good at explaining treatment and results was below the CCG area average.

Staff told us that the population of the patients at the practice were mainly white, British people, with a very small number of ethnic minority patients registered with the practice. Staff told us that support for people whose first language was not English tended to come from their own supporters, although an interpreter service was available.

The practice had taken on the enhanced service for the avoidance of unplanned hospital admissions. Enhanced services are additional services provided by GPs to meet the needs of their patients. To meet this objective they have recently completed 92 care plans for vulnerable patients. Every patient over 75 years of age had a named GP. The practice had 10 patients on their palliative care register. We saw that multi-disciplinary meetings between GPs, palliative care nurses and district nurses were held every three months to review care plans for patients near the end of their life. The practice used special notes to ensure that the out of hours service were also aware of the needs of these patients when the practice was closed.

There were 16 patients on the practice's learning difficulties register. Staff told us that annual health reviews were carried out for patients with learning difficulties and care plans developed following the review. There were 18 patients on the practices' register for patients with mental health difficulties. There was a system in place to ensure that patients with mental health difficulties received an annual health review. Staff told us that patients with long term conditions, such as diabetes or high blood pressure were called for a review of their care and treatment in the month of their birthday and were provided with an extended appointment at a time convenient for them.

Patient/carer support to cope emotionally with care and treatment

The GP patient survey information we reviewed showed patients were positive about the emotional support provided by the practice. For example, 89% of patients surveyed said the last GP they saw or spoke to was good at treating them with care and concern with a score of 81% for nurses. These results for the GPs were above the CCG area average, although for the nurses it was below. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, patients described the care they received as excellent.

Notices and leaflets in the waiting room and on the patient website signposted people to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. Staff were aware that patients may become socially isolated and told us they signposted people to the local walking group or ukulele group.

Staff told us that patient deaths were dealt with care. They told us families were invited to collect the death certificate in person, so that the GP could discuss the certificate with them. All staff were notified of patient deaths, and cards sent to the next of kin. Staff were aware that families could be signposted to other services for support, for example CRUSE or the counselling service at the local hospice. One patient wrote on the comment card that the recent death of their spouse was very sympathetically handled by the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood the different needs of the population it served and acted on these to design services. A phlebotomy (taking blood) service had been established at the practice so that patients did not have to travel to the local hospital. Clinical staff told us that patients who were prescribed warfarin (anti blood clotting medicine) were encouraged to attend for regular blood checks and monitoring of their condition. The blood results were available at the time of the test, and the dosage of warfarin could be amended and recorded at the same time.

The needs of the practice population were understood and systems were in place to address identified needs. This included accident and emergency referrals and the introduction of an urgent care dashboard. The dashboard provided practices with the facility to identify frequent attenders to accident and emergency. The practice told us that from November 2014 they would be reviewing unplanned admissions on a weekly basis and following up the most vulnerable patients and those who could have used their services instead of accident and emergency.as part of the Choose Well campaign. The Choose Well campaign was supported by the local Clinical Commissioning Group to assist patients who felt unwell and were unsure about where to go in selecting the right place for treatment:

The practice had an active Patient Participation Group (PPG) to help it to engage with a cross- section of the practice population and obtain patient views. 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 the care. We spoke with a representative of the PPG who explained their role and how they worked with the practice. They told us that the group recognised there wasn't a good distribution of patients from different age groups. They were trying to address this through information in the practice booklet and on the practice website. There was evidence of meetings with the PPG every two months throughout the year. The representative told us the PPG had a good working relationship with the practice, and the patients were taking a greater role in setting the agenda and driving through any changes. For example, they told us they were involved in fund raising for community defibrillators and improving communication in the practice by using an electronic notice board.

Tackling inequity and promoting

The practice proactively removed any barriers that some people faced in accessing or using the service. Staff told us that the practice cared for looked after children with emotional and behaviour difficulties, people who lived on nearby narrow boats and a Buddhist Monastery. Staff told us that these patients were supported to register as either permanent or temporary patients, as the practice had a policy to accept any patient who lived within their practice boundary irrespective of race, culture, religion or sexual preference. They told us all patients received the same quality of service from all staff to ensure their needs were met.

Staff we spoke with told us there was a small minority of patients who accessed the service where English was their second language. They told us the patient was usually accompanied by a family member or friend who would translate for them. Staff told us they could arrange for an interpreter if required. We did not see any leaflets in different languages for patients, although information could be translated via the website. There were two female GPs at the practice, who were able to support patients who preferred to have a female doctor. This also reduced any barriers to care and supported the equality and diversity needs of the patients.

There were arrangements to ensure that care and treatment was provided to patients with regard to their disability. There was a hearing loop system available for patients with a hearing impairment. There was a disabled toilet and wheelchair access to the practice for patients with mobility difficulties.

Access to the service

The practice opened from 8.15am to 5.45pm Monday to Friday, although closed for lunch from 12.30pm to 2.30pm every Monday. GP appointments were available from 8.30am to 12.30pm and 3pm to 6pm every weekday. Extended hours were available on a Monday evening from 6:30pm to 8pm. These appointments could be pre booked with a GP or practice nurse and were particularly useful to patients with work commitments.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice website and the practice booklet outlined how patients could book appointments and organise repeat prescriptions. This included how to arrange urgent appointments and home visits and how to book appointments and or prescriptions through the website. Patients could also make appointments by telephone or in person to ensure they were able to access the practice at times and in ways that were convenient to them. The appointment system offered half on the day appointments and half pre-bookable appointments (up to three weeks in advance). Text message reminders were sent to patients who had registered for this service. Although patients were generally satisfied with the appointment system, comments were made regarding the difficulties around getting through on the telephone at 8.15am to book an on the day appointment.

Staff told us that patients who required urgent appointments could access services the same day, at the end of the booked appointments. The GPs told us that any urgent appointments and home visits were shared between the GPs on duty at the time. Telephone consultations were also provided if required. One patient we spoke with told us they would always been seen the same day if they needed an emergency appointment.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. This was provided by an out-of-hours service. If patients called the practice when it was closed, their call was diverted to the out-of-hours service.

Following the recent refurbishment of the surgery, access to the building had been improved by installing doors that opened automatically. The waiting room at the practice was adequate. Leaflets for health promotion were available for patients to take away with them should they wish to do so.

The practice was accessible to patients. The practice was located in a single storey building. The waiting room and corridors provided space for patients who used a wheelchair or walking aid to access the practice easily. There were accessible toilet facilities, automatic entrance doors and parking spaces for people with disabilities were available.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy is in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. Patients were made aware of how to complain through the complaints leaflet, the practice booklet and information on the website. None of the patients we spoke with had any concerns about the practice or had needed to use the complaints procedure.

We found that there was an open and transparent approach towards complaints. We saw that the practice recorded all complaints and actions were taken to resolve the complaint as far as possible. The practice had received five complaints during 2013 / 2014 and three complaints so far during 2014 / 2015. We saw that these had been handled satisfactorily and discussed at the management meeting and practice meeting (if appropriate).

The practice reviewed complaints on an annual basis to detect themes or trends. We looked at the report of the last review (September 13 to October 14) and the main theme (four out of seven) related to appointments.

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, safe and effective medical care and promote good outcomes for people. The practice vision and values included commitment to patient needs, to provide healthcare which was available to the population, to be courteous, approachable, friendly and accommodating, and always act with integrity and complete confidentiality. The registered manager and practice manager told us the values and ethos of the practice was based around individual and team objectives. They told us they were looking to further develop these in the near future. They told us that in light of the unexpected staff changes during the previous 12 months, they were looking to strengthen the contingency plans relating to the replacement of key members of staff. This involved considering increasing the number of GP partners at the practice, and developing staff to build resilience within the teams and remove the reliance on individuals.

The practice was proactive in its approach to develop the services they provided. We were told by the practice manager and registered manager that the practice was looking to improve patient access by further developing the nurse practitioner role and targeting those patients whose needs could be met by the nurse practitioner rather than the GP.

Governance Arrangements

All staff had access to policies, procedures and clinical guidelines either through paper copies which were stored in files or through information available on the practice's intranet. Staff were aware of the access arrangements on the computer system. All documentation on the intranet was kept up to date with dates of reviews recorded. Staff told us they were able to access policies when they needed information or were guided to read the latest information. We saw from staff meeting minutes that changes and updates were discussed and staff confirmed these discussions took place.

The practice held a range of meetings, which included management and business meetings, clinical staff meetings and Quality and Outcomes Framework (QOF) meetings. All practice staff meetings and administration staff meetings were also held. The dates of the meetings had been planned for 2014 and these were clearly on display around the practice. We looked at minutes from a number of the different types of meetings and saw that performance, quality and risks had been discussed.

The practice held a General Medical Services (GMS) contract with NHS England for delivering primary care services to their local community. As part of this contract, quality and performance was monitored using the Quality and Outcomes Framework (QOF). The QOF rewards practices for the provision of 'quality care' and helps to fund further improvements in the delivery of clinical care. We looked at the QOF data for this practice which showed it was performing in line with national standards scoring 99.4 out of a possible 100 points.

The practice also regularly carried out clinical audits internally, for example inadequate rates for cervical smears, time taken for referrals to be sent, and delivery of minor surgery. Findings were shared with staff and actions and recommendations were recorded.

We saw that the practice worked to the identification of risks and risk management. The practice manager showed us their risk log which addressed a wide range of potential issues, such as Control of Substances Hazardous to Health (COSHH), fire safety, buildings and prevention of the legionella virus. Risk assessments were in place and updated as required. Health and safety meetings were held every three months, although health and safety issues were also discussed at all of the other meetings.

Leadership, openness and transparency

There was a clear leadership structure which had named members of staff in lead roles. For example one of the GP partners was the lead for safeguarding, and another had the role of Caldicott guardian. A Caldicott Guardian is a senior person responsible for protecting the confidentiality of a patient and service-user information and enabling appropriate information-sharing. The nurse practitioners shared the infection control lead role with administration support. We spoke with staff from different teams and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

We saw from minutes that team meetings were held regularly. The practice manager told us they were looking to increase the frequency of the administration team meetings as these were less frequent than others. Staff told

Are services well-led?

Good

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

us there was an open culture within the practice and they had the opportunity and were happy to raise issues at the meetings. Staff training events were held most months at the practice.

The practice manager was responsible for human resources policies and procedures. A staff handbook was available to all staff, and this included sections on bullying and harassment and whistleblowing. The handbook directed staff to the relevant policies and procedures held electronically.

Staff told us that they felt the practice was well led. We saw that there was strong leadership within the practice and the senior management team were visible and accessible. There was evidence of strong team working, both individually within teams and across teams. Records showed that regular meetings took place for all staff groups. Staff told us that the GPs and practice manager were very supportive. Staff spoken with told us that management were open to ideas and listened to suggestions made by staff regarding improvements. One example of this was the implementation of the practice newsletter.

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

The practice had gathered feedback from patients through patient surveys, comment cards and complaints. The focus of the 20013 / 2014 patient survey was the appointment system, including booking and cancelling appointments. The practice was working with the Patient Participation Group (PPG) to address the issues highlighted in the survey. 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 the care. An action plan had been developed and implemented. Actions included better communication with patients about booking appointments on line, extended opening and nurse practitioner appointments.

The practice had an active Patient Participation Group (PPG) as well as a virtual PPG group. The minutes of the meetings, survey results and action plan were available on the website and on the notice board in the waiting room.

The practice recognised the importance of the views of patients and had systems in place to do this. This included the use of patients' comments, analysis of complaints, patient surveys and working in partnership with the Patient Participation Group (PPG). The PPG recognised that it did not contain representatives from various population groups, in-particular mothers with babies, children and young people and working age people. The PPG met bi-monthly, alternatively on Monday at 12.45pm or Thursday at 5.30pm to accommodate members' commitments and availability. A selection of staff, including a GP Partner, practice manager and practice nurse attended the meetings. Results of patients' surveys and PPG comments were shared with patients through the practice website. We saw that the PPG had developed an action plan and the practice had worked with the PPG to carry out the issues within the action plan. The chair person for the PPG confirmed that they had a very good working relationship with the practice and that the partners were open and honest and listened to what they said.

The practice gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us that they received an annual appraisal and there was a policy in place to support this. Staff told us that the practice was very supportive of training and that they had monthly practice based learning sessions. The meeting schedule for the whole of the year was on display around the practice.

The practice was able to evidence through discussion with the GPs and practice manager and via documentation that there was a clear understanding among staff of safety and of learning from incidents. Concerns, near misses, Significant Events (SE's) and complaints were appropriately logged, investigated and actioned. For example, we saw that the outcome of complaints received and resolved had been discussed at the management meeting held on 13 October 2014. We saw the practice significant events log for 2013 / 2014 which gave details of the incident, who was involved, action taken and lessons learned.

The practice had been a GP training practice for qualified doctors to become general practitioners for over 20 years. The ethos of learning and improvement in terms of knowledge and skills was evident throughout the inspection.

Are services well-led?

Good

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

Two of the GP partners were responsible for the induction and overseeing of the GP registrar's training and supporting medical students. GP registrars are doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine. We spoke with a GP registrar who told us there was strong leadership within the practice. There was a buddying system in place to support GP registrars that provided them with a named GP on a daily basis who they had direct access to for advice and support.

We were shown evidence that staff in all roles were provided with a thorough induction process. The practice manager told us they were planning to develop their induction processes along the same line as the induction used for the GP registrars. We saw that staff had access to a range of training opportunities. We looked at records which showed that all staff training was up to date.