Cranleigh Medical Practice

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Outstanding
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We undertook a comprehensive inspection of Cranleigh Medical Practice on 7 October 2014.

Overall we have rated the practice as good. We found that the practice provided safe, effective, caring and well led services to all patients and outstanding care to the frail elderly population. The practice was also rated as outstanding for being responsive and ensuring services were organised to meet people's needs. The practice had a strong ethos of providing the highest quality care possible to patients. The staff we spoke with were motivated and committed and felt well supported in their roles. Patients described the practice as caring, professional and efficient.

Our key findings were as follows:

- Systems were in place to ensure that information about safety was recorded and monitored and learning from incidents was used to support improvement.
- Staff received appropriate professional development and felt well supported in their roles.
- Feedback from patients showed that they felt that staff were caring, helpful and professional.
- Systems were in place to ensure high standards of cleanliness and infection control.
- Some patients were concerned about the length of time they had to wait to get an appointment with a GP of their choice.

We saw a number of areas of outstanding practice. These were:

- Work undertaken to improve the quality of care for the frail elderly which included inviting patients identified as at risk of admission to hospital for a comprehensive geriatric assessment and involving them in the development of their own care plan. There was evidence that hospital admissions had been avoided as a result of the care plans.
- All staff had attended a dementia training day provided on-site by the council and the practice had been identified by them as a 'dementia friendly' organisation.
- The practice had identified mental health as a significant issue amongst its population and had a designated lead GP for mental health. The consultant

Summary of findings

psychiatrist attached to the community mental health team met monthly with the GPs in the practice to discuss specific cases and to provide guidance and advice about referrals.

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. 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 was enough staff to provide a safe level of service at all times.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above the average for the locality. The National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of mental capacity and the promotion of good health. Staff had received training appropriate to their roles and further training needs had been identified and planned. The practice could identify all appraisals and the personal development plans for all staff. Multidisciplinary working was evidenced.

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice highly for several aspects of care. The patient feedback we saw showed patients felt they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for responsive. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice. All patients had a named GP for continuity of care. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence that showed the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff.

Summary of findings

Are services well-led?

Good

The practice is rated as good for well-led. The practice had developed a clear vision. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity. 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 and events.

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

Outstanding ☆

The practice is rated as outstanding for the population group of older people.

An example of outstanding practice was how the practice had proactively identified frail elderly patients 'at risk' of admission to hospital. Once identified these patients were invited with their relatives for a comprehensive geriatric assessment with their own GP where they were involved in developing their own care plan which they kept at home. With patient consent the care plan was shared with the ambulance service and out of hour doctors. The practice had been able to demonstrate improved outcomes for elderly patients as a result. There was evidence that the introduction of care plans had avoided hospital admission for a number of patients. The practice had also made links with local organisations. For example, the practice visited an older person's day centre in Cranleigh to promote the concept of care plans for the frail elderly. The practice had shared it work across the clinical commissioning group (CCG) area through the Frail Elderly Forum and other practices were being encouraged to adopt the same care plan template.

The practice had a retirement village and four nursing/care homes in its catchment area. Each of these had designated GPs from the practice who undertook weekly visits in addition to requested visits when necessary. The homes and the retirement village had been provided with details of out of hours arrangements and had been given a direct dial telephone number so they could bypass the practice public telephone system and gain quick access to their named GP for advice.

People with long term conditions

Good ●

The practice is rated as good for the population group of people with long term conditions. For each long term condition there was a GP, nurse lead and administrator who ensured patients had structured and co-ordinated annual reviews to check their health and medication needs were being met. Where possible the practice ensured that appointments for patients with more than one long term condition were minimised in order to reduce the number of visits to the surgery for patients. When required longer appointments and home visits were available. For those people with the most complex needs the named GP worked with relevant health and care professionals such as dieticians to deliver a multidisciplinary package of care.

Summary of findings

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. The practice provided an urgent access system from 8am to 6.30pm every day. This allowed children with common minor illnesses to be seen quickly. All children aged under one year were seen by the GP. The practice had developed links with young people in the community. For example, a practice nurse had visited the local secondary school to increase pupil awareness of services available and to provide reassurance to young people about confidentiality. One of the GPs had also given a talk to members of a local youth group. There was a privately run youth counselling service based in the practice premises. The practice facilities were suitable for children and babies. There was a designated room for baby changing and breast feeding.

The practice shared a building with health visitors and school nurses. This helped promote joint working. There was a designated GP lead for child protection who met monthly with the health visitors to identify and discuss children and families at risk. All staff had received training on child protection and were aware of their roles and responsibilities in relation to this. The practice worked with the local carers support agency to identify and support young carers.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of working-age people (including those recently retired and students). The needs of the working age population had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. Patients could make appointments in a variety of ways including in person, by telephone or on line via the practice's website. The practice also offered patients same day telephone consultations with a GP. Patients needing emergency same day appointments were accommodated in the daily urgent access clinic at a time convenient to them. Repeat prescriptions could also be ordered on-line. The practice offered extended opening hours every Tuesday until 8pm and on Saturday mornings from 8.30 am to 11.00 am to meet the needs of its 'commuter' population. Appointments for NHS health checks and reviews of patients with long term conditions were also available during extended access times.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice provided a service to a large travelling community who lived on two

permanent sites in the local area. There was a lead GP for people with learning disabilities. The GP acted as a designated link to a local school for children with learning disabilities and ran a weekly clinic there. The lead GP also saw every patient with a learning disability for an annual medical review. The practice supported homeless people by acting as a point of contact to coordinate their care with different agencies, for example the community mental health team.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). The practice had identified mental health as a significant issue amongst its population particularly in relation to alcohol dependence and drug misuse. The practice had a designated lead GP for mental health. The consultant psychiatrist attached to the community mental health team met monthly with the GPs in the practice to discuss specific cases and to provide guidance and advice about referrals. The practice made referrals to the local alcohol and drug counselling services and psychological therapy services for working age adults which were based on the practice premises. The practice had played an active part in Surrey County Council's 'dementia friendly' initiative which aimed to build enabling and supportive communities where people with dementia and their carers were understood, valued and could enjoy life. All staff had attended a dementia training day provided on-site by the council and the practice had been identified by them as a 'dementia friendly' organisation.

Summary of findings

What people who use the service say

We reviewed 79 comment cards where patients and members of the public shared their views and experiences of the service. The majority of comments were positive about the service they experienced. Patients said they felt the practice offered an excellent service and staff were friendly, caring, helpful and professional. They said staff treated them with dignity and respect. Less positive comments related to the fact that patients could not always get to see their named GP on the day they wanted.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a survey of 181 patients undertaken by the practice's patient participation (PPG). 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 PPG survey showed that the majority of patients rated the clinical staff at the practice as excellent in terms of listening to them and treating them with care and concern. Data from the national patient survey showed that 83 per cent of respondents rated the practice as good or very good.

Outstanding practice

The practice used additional investment from the clinical commissioning group (CCG) to help avoid unplanned hospital admissions for older people. The practice had a nominated GP and a dedicated administrator for care of the frail elderly, who worked closely with the community matron to identify elderly patients at risk of admission to hospital. Patients identified at risk were invited with their relatives for a comprehensive geriatric assessment with their named GP and were involved in the development of their own care plan, a copy of which they kept in their own home. Patients kept their care plan at home and with their consent the details were shared electronically with the out of hour's doctors and the ambulance service. The care plan template used by the practice had been developed by one of the GPs and was based on the key elements required for a comprehensive generic assessment.

The practice had undertaken an audit of the impact of care plans for the frail elderly and had identified improved outcomes as a result. For example, as a result of three patient's care plans being looked at in their homes, hospital admission for each of them had been avoided.

Links had been made with local organisations. For example, the practice visited an older person's day centre in Cranleigh to promote the concept of care plans for the frail elderly and to initiate joint working.

As a result of its work the practice had been nominated to develop a primary care based model of pro-active care for the frail elderly that was to be rolled out across all practices in the CCG area in 2015.

The practice had identified mental health as a significant issue amongst its population particularly in relation to alcohol dependence and drug misuse. The practice had a designated lead GP for mental health. The consultant psychiatrist attached to the community mental health team met monthly with the GPs in the practice to discuss specific cases and to provide guidance and advice about referrals. The practice made referrals to the local alcohol and drug counselling services and psychological therapy services for working age adults which were based on the practice premises. There was also a privately run youth counselling service based in the practice premises to which the GPs could make referrals. The practice had played an active part in Surrey County Council's 'dementia friendly' initiative which aimed to build enabling and supportive communities where people with dementia and their carer's were understood, valued and could enjoy life. All staff had attended a dementia training day provided on-site by the council and the practice had been identified by them as a 'dementia friendly' organisation.

Cranleigh Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector a GP Specialist Advisor and a Practice Manager Specialist advisor.

Background to Cranleigh Medical Practice

The practice is situated in the centre of Cranleigh and provides a range of primary care services to approximately 15,100 patients. The practice has ten GPs made up of five GP partners and six salaried GPs. There are five female GPs and five male. The practice is a training practice and has one GP registrar and three trainee GPs attached to it. The practice also employs six practice nurses and two healthcare assistants. The practice is open from 8am until 6.30pm Monday to Friday. It does not close for lunch. There are extended opening hours on Tuesday evenings until 8pm and on Saturday mornings 8.30am to 11am for pre-booked nurse and doctor appointments.

The practice provides a large number of clinics for particular patient groups. These include asthma and chronic obstructive pulmonary disease (COPD), antenatal care, cervical screening, bowel cancer screening, chlamydia screening, family planning, diabetes, hypertension, minor surgery, leg ulcers and wounds, vascular, warfarin, childhood immunisations and smoking cessation clinics. The community nursing team, community matron, health visitors and school nurses are based in the same building as the practice. Midwifery, dermatology, physiotherapy, psychogeriatric and vascular surgery clinics are also run from the same premises.

The practice has a higher than average number of registered patients over 65 years of age for England. This is partly due to the proximity of a retirement village on the outskirts of Cranleigh. There are four nursing/care homes in the locality. The percentage of registered patients suffering deprivation (affecting both adults and children) is lower than the average for England.

The practice had opted out of providing Out of Hours services to their own patients. Patients were able to access Out of Hours services through NHS 111.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations including the Guildford and Waverley clinical commissioning group (CCG), NHS England and Healthwatch to share what they knew. We carried out an announced visit on 7 October 2014.

During our visit we spoke with a range of staff including, the GPs, the practice manager, the assistant practice manager, practice nurses, administrative staff and receptionists. We

Detailed findings

also spoke with a representative from the practice's patient participation group (PPG). We reviewed care records of patients and examined practice management policies and procedures.

We observed how staff talked to people on the telephone and in the reception and waiting area. We also reviewed 79 comment cards where patients and members of the public shared their views and experiences of the service.

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

The practice had robust systems in place to ensure that safety incidents, concerns, complaints and near misses were reported, recorded and acted on. All the staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses.

We reviewed significant event and complaints records for the last year and the notes of meetings where they were discussed. We saw that the practice consistently reviewed and acted on safety issues raised as a result.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We looked at significant events records for the last year. Records identified the date, the details of the event and the action required as a result. The practice held regular meetings with those involved to discuss significant events that had occurred. The notes of the meetings showed that learning had taken place and actions had been taken as a result. The findings were shared with all relevant staff including doctors, nurses administrative and reception staff.

The practice had a system for ensuring all external safety alerts were responded to appropriately. All incoming alerts were reviewed by the practice manager who ensured that information was disseminated to relevant staff and that appropriate action was taken. We saw evidence that action had been taken as a result.

Reliable safety systems and processes including safeguarding

The practice had policies and procedures in place in relation to safeguarding children and vulnerable adults. The practice had designated GP leads for both child and adult safeguarding. Training records showed that all staff had received training on safeguarding children and vulnerable adults which was appropriate to their role. When we spoke with staff they were able to show that they understood the relevance of safeguarding in general practice and they knew who to contact if they had concerns. They were able to provide examples of concerns they had raised about patients as a result. Details of who to contact if staff had concerns about children or adults at risk were clearly displayed around the practice.

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children registered with the practice and had a monthly meeting with the health visitor to discuss children and families identified at risk.

The practice had a chaperone policy in place and the details of how to access this service were posted on the walls in the consulting rooms and the screens in the waiting areas. This ensured that patients could have someone else present for any consultation, examination or procedure if they wished. This could be a family member or friend or a formal chaperone from the practice's clinical team.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found that medicines were stored securely and were only accessible to authorised staff. There were clear arrangements for ensuring medicines were kept at the required temperatures to ensure the cold chain was maintained.

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.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. Staff we spoke with were able to demonstrate a good understanding of how they applied the protocol in practice. All prescriptions were reviewed and signed by a GP before they were given to the patient.

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. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs.

Cleanliness and infection control

We observed that the practice provided a clean and hygienic environment for patients. The practice had a

contract with an external cleaning company. The practice specified the cleaning requirements and frequencies of cleaning in line with infection control guidance, and checked regularly that the cleaning company was meeting these requirements The cleaning staff signed a log book to record the work that had been done in each individual room on a daily basis.

The practice had a lead nurse for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. Training records showed that most staff had up to date training on infection control relevant to their role. This included on line training and in-house sessions run by the lead nurse on infection control and hand hygiene.

There was evidence that the lead nurse had undertaken the Infection Prevention Society audit of infection control this year. The results of the audit had been presented to practice staff and key areas for improvement and the actions required had been discussed. The practice told us that these issues would be revisited at the next routine infection control audit.

The practice had and an up to date infection control policy with supporting procedures which were available for staff to refer to for example in relation to using personal protective equipment and the disposal of waste. This enabled them to plan and implement control of infection measures and to comply with relevant legislation.

Hand hygiene techniques signage was displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

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). We saw records that confirmed the practice carried out regular checks in line with this policy in order to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us and we observed that the practice had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw records to show that equipment was tested and maintained regularly. We saw evidence of calibration of relevant equipment, for example weighing scales.

Staffing and recruitment

We looked at staff records which showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service. There was evidence that the practice had undertaken a robust risk assessment around its decision not to undertake criminal records checks for administrative staff.

The practice manager told us that medical staffing levels for the practice had been determined using a national formula for the number of GPs required for the number of registered patients. The practice regularly analysed its list size and the number of appointments required to ensure staffing levels were sufficient. The practice also utilised and enhanced the skills of practice nurses and health care assistants to ensure that efficient and effective use was made of the staff available. For example, the practice had trained three practice nurses to be minor illness nurse specialists. They provided a daily urgent access minor illness clinic to improve access for patients who needed to be seen on the same day. This enabled GPs to spend more time with complex cases and chronic conditions which relieved demand for GP appointments.

For sickness and annual leave the practice had sufficient staff to cover posts internally. The practice used several regular, long term locum GPs to provide additional medical cover when required. We saw evidence that appropriate checks had been undertaken for locum staff

Staff told us there were usually enough staff to maintain the smooth running of the practice. They told us they tried to ensure that there were always enough staff on duty to keep patients as safe as possible.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. We saw that a range of up to date risk assessments had been undertaken. These included the risk assessments of work environment and the premises, equipment and the risks that would result from of a flu pandemic.

Good

Are services safe?

Arrangements to deal with emergencies and major incidents

There were arrangements in place to deal with on-site medical emergencies. We saw evidence that all staff had received up-to-date training in basic life support appropriate to their role. We saw that emergency medicines and equipment, which included oxygen cylinders and a defibrillator, were kept in the practice and that these were checked monthly by one of the practice nurses.

The practice had arrangements in place to deal with foreseeable emergencies. We saw that there was a comprehensive and up-to-date business continuity plan in place. The plan outlined the arrangements to deal with foreseeable events such as loss of energy supplies, severe weather, loss of the computer system and essential data and fire.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice ensured they kept up to date with new guidance, legislation and regulations which were cascaded via email. The GPs we spoke with were familiar with current best practice guidance accessing guidelines from the National Institute of Clinical Excellence (NICE) and from local commissioners. All staff had electronic access to referral guidelines, practice protocols, patient pathways and links to educational resources.

The GPs told us that they each took the lead for specific clinical areas such diabetes, heart disease and asthma. There was also a designated practice nurse to support each of these. The clinical staff we spoke with all said they operated in an open way and always felt able to ask and provide support for each other in relation to managing patients. Each GP and practice nurse had a GP or nurse mentor within the practice who they met with informally to share and discuss clinical issues and practice. They told us that all of the GPs and practice nurses met every morning for coffee to help facilitate knowledge sharing and discuss new best practice guidelines. Health professionals from other organisations also attended the coffee morning on a regular basis, for example the consultant psychiatrist attended monthly to discuss specific patients and provide advice on referrals.

Management, monitoring and improving outcomes for people

The practice provided us with evidence of clinical audits undertaken during the last two years. Examples of clinical audits included the prescription of omega-3 fatty acids for post-myocardial infarction patients and whether the development of care plans for frail elderly made a difference to outcomes for patients. The practice was able to demonstrate changes as a result of the audits. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). For example, in response to a safety alert from the Medicines and Healthcare Products Regulatory Agency (MHRA) the practice undertook an audit of the prescribing of an anti-sickness medicine. As a result the practice stopped prescribing the medicine to patients identified at risk of ill effect.

The practice used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. For each of the long term conditions the practice had allocated a lead GP, lead nurse and administrative assistant who were responsible for managing the patient pathway and ensuring QOF targets were achieved. We saw that in 2012/13 the practice had consistently high scores across all of clinical domains. For example, the practice achieved 100% of the QOF points for asthma.

We saw evidence that the practice also participated in local benchmarking run by the clinical commissioning group (CCG). This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area.

Effective staffing

We looked at training records and found that staff were up date with the practice's extensive mandatory training programme which included basic life support, fire safety, health safety and welfare, moving and handling, safeguarding and information governance. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by General Medical Council can the GP continue to practice and remain on the performers list with NHS England).

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Each clinical staff member had a mentor GP or nurse who they met with informally on a weekly basis for guidance and support on clinical issues. All staff undertook annual appraisals which identified key achievements, areas for improvement, performance objectives and learning and development needs. Feedback from other staff members was sought and fed in to the appraisal process. All the staff we spoke with felt well supported in their roles. They told us they had sufficient access to training opportunities. The practice held monthly in house training sessions where time was protected to ensure that all staff could attend. Recent sessions included dementia awareness and infection control.

The practice was a training practice and we noted a strong ethos of supporting development and learning within the

Good

Are services effective?

(for example, treatment is effective)

practice. This was demonstrated by strong arrangements for mentoring and supervision and ensuring staff were trained to meet patient needs. For example the practice had trained three of its practice nurses to become minor illness nurse specialists.

The practice made effective use of the skills and knowledge staff had in order to provide more efficient and effective services for patients. For, example by training three practice nurses to become minor illness nurse specialists the practice had been able to provide a daily urgent access clinic. This improved accessibility for patients who needed to be seen the same day and enabled GPs to spend more time with patients with complex health needs and chronic conditions.

Working with colleagues and other services

There was evidence that the practice worked closely with other organisations and health care professionals. For example, we saw that the GPs had weekly meetings with the community matron to discuss frail elderly patients who may be at risk of admission to hospital and to ensure support was provided to patients who had recently been discharged home. The GP lead for child protection met with the health visitors every month to discuss children and families that might be at risk. There were monthly meetings with community staff, palliative care nurses and the palliative care consultant where the needs of patients on the "palliative care" register were discussed as part of the Gold Standards Framework. This aimed to ensure that people at the end of their life had a high standard of care.

The consultant psychiatrist attached to the community mental health team met monthly with the GPs in the practice to discuss specific cases and to provide guidance and advice about referrals.

The practice had a designated GP for patient's resident at each of the four nursing/care homes it looked after. The GPs visited the homes weekly and more frequently if required. There were also two GPs designated to the local retirement village, each of them visiting once a week and more frequently if patients needed to be seen. Staff had direct access to the GPs for telephone advice.

Information sharing

The practice used electronic systems to communicate with other providers. Examples of this included electronic access hospital blood test and imaging results. For emergency patients, the practice had systems in place to ensure care plans were shared with Accident & Emergency departments, the same applied for patients who attended out of hours services.

The practice had set up a specific email channel with the discharge co-ordinators at the local acute hospital to facilitate better information sharing about patients.

Consent to care and treatment

The practice had a consent policy in place. All of the GPs we spoke with were aware of their responsibilities in relation to obtaining consent to care and treatment. We saw that consent was clearly recorded in the patient records that we looked at. Written consent for minor operations was scanned in to patient records.

We saw that frail elderly patients were supported to make decisions through the use of care plans which they and their relatives were involved in agreeing. The care plan had a section stating the patient's preferences for treatment and decisions relating to end of life care where appropriate. Care plans for patients with dementia or having end of life care included capacity assessments and documentation for power of attorney for health and finances where appropriate.

Health promotion and prevention

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant. The practice also offered NHS Health Checks to all its patients' aged 40-75.The practice had a strong culture of promoting healthy lifestyles and encouraging patients to take responsibility for their own wellbeing. In conjunction with the patient participation group (PPG) the practice held a two day health event in the village centre to help raise awareness and promote a range of health issues including alcohol awareness, mental health issues and healthy lifestyles. The event involved other organisations such as the local leisure centre, local ambulance services and a local mental health provider. The practice also linked with the local leisure centre to refer patients for exercise on prescription.

The practice had links with local schools and had provided several presentations to pupils about health issues.

The practice offered a full range of immunisations for children, travel vaccines and flu and shingles vaccinations in line with current national guidance. Seasonal flu vaccinations were available to at risk patients such as

Good

Are services effective?

(for example, treatment is effective)

patients aged 65 or over. The practice provided a smoking cessation clinic and offered a full range of screening services including chlamydia testing, cervical screening and bowel cancer screening. The practice provided ambulatory blood pressure monitors to patients to screen for hypertension. There was a range of patient literature on health promotion and prevention available for patients in the waiting area. The practice website also signposted patients to further information about living well. The PPG had organised regular health information evenings for patients. The last two focussed on prostate cancer and another on dementia.

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, a survey of 181 patients undertaken by the practice's patient participation group (PPG). 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 PPG survey showed that the majority of patients rated the clinical staff at the practice as excellent in terms of listening to them and treating them with care and concern. Data from the national patient survey showed that 83 per cent of respondents rated the practice as good or very good.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 79 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were friendly, caring, helpful and professional. They said staff treated them with dignity and respect. Less positive comments related to the fact that patients could not always get to see their named GP on the day they wanted.

Staff told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. Reception staff told us they offered patients a separate room if they wished to discuss anything in private away from the front desk. We saw that there was a system in place which allowed only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. Background music was also played in the waiting areas to help obscure private conversations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, results from the PPG survey showed that 87 per cent of respondents rated the clinical staff as excellent in terms of involving them in making decisions about their care.

Staff told us that translation services were available for patients who did not have English as a first language.

We saw evidence that the practice ensured that all frail elderly patients identified as at risk of admission to hospital were involved in developing their own care plan. This included involving them in decisions about end of life care and resuscitation.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example the PPG survey showed that the majority of respondents rated the clinicians as excellent in terms of treating them with care and concern. The comment cards we received were also consistent with this survey information. They highlighted the fact that staff treated with people with compassion and that they were always caring and supportive.

Patient information provided in the patient waiting room, on the TV screen and patient website also signposted people to a number of support groups and organisations. This included information about bereavement counselling services. Links had also been made with carers support organisations who visited the practice and worked with the practice's lead carers support administrator to increase the number of carers registered at the practice, and to share information on the support available for carers through displays in the waiting areas.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was able to demonstrate that it understood the needs of its population and that it addressed the needs identified. For example, the practice had identified a higher than average patient population over the age of 85. As a result the practice had appointed a frail elderly coordinator who used practice data to identify those elderly patients at risk of admission. Patients identified and their relatives were invited for a comprehensive geriatric assessment and were involved in developing their own care plan.

The practice had an active patient participation group (PPG) which met every month, with two of the GP partners and the practice manager. Each year the group ran a survey to look at the areas that patients had said were important to them. The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the PPG and from its surveys. For example, the 2013 PPG survey identified that patients found it difficult to get an appointment with a clinician of their choice at a time that suited them. As a result the practice developed and implemented a new duty doctor system which increased the availability of GP appointments. The practice also increased patient access to its on line appointment booking to help facilitate access to appointments with specific GPs.

The practice asked members of the PPG to participate in interviews for a new GP when the senior partner retired. Their input resulted in two GPs being recruited to the team.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning and delivery of its services. The practice was situated on the ground and first floors of the building with the majority of services for patients on the ground floor. We observed that there were two lifts in the main waiting area for access to the upstairs rooms. There were designated disabled parking bays in the public car park for patient use, with easy access to the practice entrance which had wide automatic doors. There was an electronic check-in which was accessible to wheelchair users. 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. All the corridors and doorways in the building complied with disability regulations and there were disabled access toilets on both the ground and the first floors. There was a baby changing / feeding room in the main reception area.

The practice provided a telephone translation service for people whose first language was not English. There was an induction loop for people who were hard of hearing. Patient information leaflets were also provided in large print and easy read format. The practice provided equality and diversity training via e-learning and the training records we looked at showed that most staff had up to date training in this area.

Access to the service

Appointments were available from 8am to 6.30pm on weekdays. There were extended opening hours on Saturday mornings 8.30am to 11.00am and Tuesday evenings until 8pm. These surgeries were for pre-booked appointments only and aimed to meet the needs of the practice's 'commuter' population. The practice also ran special extended seasonal flu clinics on Saturdays and Tuesday evenings for patients who were unable to attend clinics during the week.

Information about appointments was available to patients on the practice website and in the practice leaflet. This included how to arrange routine and urgent appointments, home visits and how to book appointments through the website. There were arrangements in place to ensure patients could access 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.

The patient feedback we received showed that patients were mostly happy with the appointment system. However some patients were unhappy that they could not always see the GP of their choice at a time that suited them and often had to wait weeks to do so. The practice had already identified this as an issue and had put a number of measures in place to increase GP availability, including the introduction of nurse led minor illness clinics and employing additional GP sessions.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its 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.

We saw that information was available to help patients understand the complaints system on the practice website, the practice leaflet and on display in waiting and reception areas.

We looked at the complaints record and responses to patients for the year 2013 to 2014. The practice had received 33 complaints during this period. There was evidence that complaints were responded to in a timely way and that action points and learning were recorded and shared with relevant staff. The practice held regular meetings to discuss complaints and there was an annual review meeting to discuss all the complaints received. There was evidence that the practice analysed the type of complaints it received so that trends could be identified. The practice also met regularly with its PPG to share and discuss the qualitative nature of anonymised complaints received and the practice's response to them.

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 developed a clear vision statement which set out its aim to be a forward thinking and innovative practice delivering high quality primary care services care to its patients. This had been developed by the partners and the practice manager at the away day they held annually to review how they worked together.

The staff we spoke with could articulate their understanding of the practice ethos to deliver high quality care but they were not familiar with the vision statement that had been developed by the partners.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity which were available to staff through the practice's intranet. We looked at four policies and saw that the practice had a version control system in place to ensure that each policy was reviewed annually, updated and current. We saw evidence that most staff had signed to confirm that they had read and understood the policies.

The practice had a clear and comprehensive structure and schedule of meetings to govern its business. This included bi-monthly business meetings for the partners, weekly meetings to discuss significant events, complaints, and the quality and outcomes framework (QOF). We looked at the notes for these meetings which showed that the practice regularly reviewed performance, quality and risks. There were weekly nursing team meetings and weekly heads of department team meetings which included information technology (IT), management and administration. There were also regular multidisciplinary meetings to discuss patients on the palliative care register and the frail elderly at risk of admission to hospital.

The practice used the QOF to measure their performance. The QOF data for this practice showed that it achieved high scores in all of the clinical domains. There was evidence of regular meetings to discuss QOF and the actions required to maintain or improve performance.

The practice had completed a number of clinical audits, for example a review of patients in the practice being prescribed an anti-sickness drug following a safety alert and a review of the effectiveness of care plans for the frail elderly.

The practice had arrangements for identifying, recording and managing risks to patients, staff and visitors. We saw that a range of up to date risk assessments had been undertaken which included the work environment and the premises, equipment and flu pandemic.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example, the IT lead and the lead nurse. There was a lead staff list made available to all staff which identified lead roles in a number of areas including safeguarding, information and governance, clinical governance, commissioning and prescribing. The staff we spoke with were all clear about their own roles and responsibilities. They all told us that they felt valued, well supported and knew who to go to in the practice with any concerns.

There were monthly meetings for all practice staff. Staff told us that there was an open culture within the practice. They felt confident about raising concerns and that they would be listened to.

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

The practice had gathered feedback from patients through the patient participation group (PPG), annual surveys and complaints. The practice had an active PPG which met every month, with two of the GP partners and the practice manager. Each year the group ran a survey to look at the areas that patients had said were important to them. We looked at the PPG's report on the last patient survey which provided an analysis of the results and identified areas for action. There was evidence that the practice had implemented an action plan as a result.

Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. The practice had a whistle blowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Each clinical staff member had a mentor GP or nurse who they met with informally on a weekly basis for guidance and support on clinical issues. We looked at four staff files and saw that regular appraisals had taken

Are services well-led?

Good

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

place which included a personal development plan. Staff told us that the practice was very supportive of training and they had the skills and knowledge they needed to fulfil their roles. The practice held monthly training sessions for all practice staff where time was protected to ensure they could all attend. Recent sessions included dementia awareness and infection control. We noted a strong ethos of supporting development and learning within the practice. This was demonstrated by strong arrangements for mentoring and supervision and ensuring staff were trained to meet patient needs. For example the practice had trained three of its practice nurses to be minor illness nurse specialists.

There was evidence that the practice had completed reviews of significant events and other incidents and shared with staff via meetings to ensure the practice improved outcomes for patients.