Balsall Common and Meriden Group Practice

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected Balsall Common Health Centre, 1 Ashley Drive, Balsall Common, CV7 7RW on 5 November 2014 as part of a comprehensive inspection. The practice is part of a group practice known as Balsall Common and Meriden Group Practice. There is a branch surgery which is Meriden Surgery based at Old School House, 200 Main Road, Meriden, Coventry, West Midlands CV7 7NG. This inspection focused on Balsall Common Health Centre.

We found that the practice was safe, effective, caring, responsive and well-led. We rated the practice as good overall.

Our key findings were as follows:

- There were systems in place to ensure patients received a safe service.
- There was evidence of completed audit cycles undertaken to ensure patients care and treatment was effective and achieved positive outcomes.
- Patients were complimentary about the staff at the practice and said they were caring, listened and gave them sufficient time to discuss their concerns.
- The practice was responsive to the needs of the practice population. There were services aimed at specific patient groups including those with long term conditions.
- There was strong and visible leadership with roles and responsibilities clearly defined. The governance framework ensured clear accountability and was well-led.

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

The provider should:

- Ensure members of staff who undertake a formal chaperone role undergo training so that they develop the competencies required for the role.
- Improve accessibility to appointments for patients through a review of practice opening times and more innovative management of patients who do not attend their appointment.

Summary of findings

- The practice should review the recruitment policy and procedure to ensure that it provides consistent and robust guidance for practice staff when appointing new recruits.

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

There were systems in place to ensure patients received a safe service. There was evidence of regular checks of emergency medicines and equipment. There was information and guidance on local reporting arrangements for safeguarding children and vulnerable adults so that any concerns could be appropriately reported and investigated. Staff understood and fulfilled their responsibilities in reporting incidents, including near misses and significant events. Lessons were learned as they were communicated widely to support improvement.

Are services effective?

Good

There was evidence of completed audit cycles to ensure patients care and treatment was effective and improved the quality of the service. The practice had joint working arrangements with other health care professionals and services. There were effective arrangements to identify, review and monitor patients with long term conditions and those in high risk groups. There was a strong emphasis on evidence based practice which was referenced in patients care and treatment to ensure positive outcomes were achieved. There was a positive learning environment, the practice actively encouraged and supported staff with learning and development opportunities which was used to improve standards of care and treatment.

Are services caring?

Good

Patients said staff were caring and understanding and their privacy and dignity was respected. Patients told us that staff listened and gave them sufficient time to discuss their concerns and they were involved in making decisions about their care and treatment. There were arrangements in place to provide patients with end of life care that was compassionate and respected their needs and wishes. Families were supported to cope with bereavement.

Are services responsive to people's needs?

Good

The practice had arrangements in place to respond to the needs of the practice population. These included services aimed at specific patient groups. The practice was responsive to complaints with evidence demonstrating that the practice acted on issues raised in a proactive manner.

Are services well-led?

Good

The practice had a clear vision and was working towards delivering this. Staff were aware of their responsibilities in delivering a good

Summary of findings

service. There was strong and visible leadership with roles and responsibilities clearly defined. The practice had a number of policies and procedures to govern activity and these were regularly reviewed and updated as necessary. There were robust systems in place for assessing and managing risks and monitoring the quality of the service provision. There was evidence of improvements made as a result of audits and feedback from patients.

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 had an above average older practice population. All patients over 75 years of age had an allocated GP. This is an accountable GP to ensure patients over the age of 75 years received co-ordinated care. Vulnerable older patients with specific urgent care needs had been identified by the practice in order that appropriate care plans could be created and kept under review. There was a dedicated telephone number that could be used in emergencies which would transfer them straight through to the practice.

Patients over the age of 75 years were offered health checks at dedicated clinics that took place. There were arrangements to review patients in their own home if they were unable to attend the practice.

People with long term conditions

Good

Patients with long term conditions were reviewed by the GPs and the nurses to assess and monitor their health condition so that any changes to their treatment could be made. Patients were proactively invited to attend the practice to support the management of their long term condition. Health checks and medication reviews took place and repeat prescriptions were accessible. These arrangements help to minimise unnecessary admissions to hospital.

The practice had specific clinics where dedicated teams of staff reviewed and managed patients with long term conditions such as diabetes, chronic obstructive pulmonary disease (COPD) and asthma. There was evidence of multi-disciplinary working with relevant health care professionals to deliver effective and responsive care.

Families, children and young people

Good

Antenatal care was provided by the midwife who undertook clinics at the practice. Post natal checks were completed by GPs to ensure a holistic assessment of women's physical and mental wellbeing following child birth. This was coordinated with the six week checks for babies. Women were offered cervical screening and there were systems in place to audit results. The practice had achieved excellent results in women's health by appropriate referral to secondary care. This was evidenced by completed audit and peer review.

Summary of findings

Children under the age of 5 years had access to the Healthy Child Programme. The practice had an allocated health visiting team who were based within the health centre. This enabled good working relationship with systems in place for information sharing. Safeguarding procedures were in place for identifying and responding to concerns about children who were at risk of harm.

Working age people (including those recently retired and students)

Good

The practice did not open extended hours however, early morning and late evening appointments were available to accommodate the needs of working age patients. Patients were able to book non urgent appointments and order repeat prescriptions around their working day by telephone or on line. Telephone consultations were available so patients could call and speak with a GP or a nurse where appropriate if they did not wish to or were unable to attend the practice.

NHS checks were available for people aged between 40 years and 74 years. The practice offered a range of health promotion and screening services which reflected the needs for this age group. Opportunistic health checks and advice was offered such as blood pressure checks and advice on stop smoking and weight management.

People whose circumstances may make them vulnerable

Good

The practice had a registration policy in place which enabled people without a permanent address to register at the practice; this could often be people who are living in vulnerable circumstances.

The practice provided an enhanced service to avoid unplanned hospital admissions .This service focused on coordinated care for the most vulnerable patients and included emergency health care plans. The aim was to avoid admission to hospital by managing their health needs at home. An enhanced service is a service that is provided above the standard general medical service contract (GMS). Annual health checks were undertaken for patients with a learning disability.

People experiencing poor mental health (including people with dementia)

Good

Patients with serious mental illnesses were offered an annual review of their physical and mental health needs, including a review of their medicines.

Staff worked closely with local community mental health teams to ensure patients with mental health needs were reviewed, and that appropriate risk assessments and care plans were in place.

Summary of findings

What people who use the service say

We looked at results of the national GP patient survey 2013. Out of the 251surveys sent 135 were completed and returned. Findings of the survey were based in comparison to the regional average for other practices in the local Clinical Commissioning Group (CCG). A CCG is an NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services.

The results of the national GP survey highlighted areas where the practice was above average in comparison to other practices in the local CCG. This included waiting 15 minutes or less after their appointment time to be seen, the last nurse they saw or spoke to was good at listening to them and the last nurse they saw or spoke to was good at giving them enough time. Areas below average were finding the receptionists at the surgery helpful and patient's experience of making an appointment. The practice was worse than average for patients satisfaction with the practice opening hours.

We reviewed comments made on the NHS Choices website to see what feedback patients had given. There were eight comments posted on the website between December 2013 and August 2014. Positive feedback included patients who said they had received the care and treatment that they needed in a timely manner. Areas for improvements included access to appointments and reception staff who were unhelpful. The practice had replied to all of the comments in a constructive manner which showed that practice took the opportunity to engage and listen to patient feedback to improve the quality of the service.

As part of the inspection we sent the practice comment cards so that patients had the opportunity to give us feedback. We received 25 completed cards, the feedback we received was overall positive, patients described the quality of the service as 'Excellent'. On the day of the inspection we spoke with 10 patients including three members of the patient participation group (PPG). PPGs are a way in which patients and GP surgeries can work together to improve the quality of the service. Patients described the staff at the practice as caring and told us that their privacy and dignity was respected. Based on information we reviewed prior to the inspection and feedback from completed cards and discussions with patients on the day. The main issue that patients felt should improve was the appointment system, patients described difficulty accessing appointments in a timely manner.

Areas for improvement

Action the service SHOULD take to improve

- Ensure members of staff who undertake a formal chaperone role undergo training so that they develop the competencies required for the role.
- Improve accessibility to appointments for patients through a review of practice opening times and more innovative management of patients who do not attend their appointment.
- The practice should review the recruitment policy and procedure to ensure that it provides consistent and robust guidance for practice staff when appointing new recruits.

Balsall Common and Meriden Group Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector and included a specialist advisor GP who is currently employed as a GP with experience of primary care services.

Background to Balsall Common and Meriden Group Practice

Balsall Common and Meriden Group Practice is a registered provider of primary medical services with the Care Quality Commission (CQC) and has one registered location (practice).This is Balsall Common Health Centre, 1 Ashley Drive, Balsall Common, CV7 7RW. The practice also has a branch surgery which is Meriden Surgery based at Old School House, 200 Main Road, Meriden, Coventry, West Midlands CV7 7NG. This inspection focused on Balsall Common Health Centre.

The practice is based in a purpose built health centre. The practice is a training practice for GP Registrars (fully qualified doctors who wish to become general practitioners) and a teaching practice for medical students in their final year. The registered patient list size is approximately 12458 patients. The practice is open Mondays, Tuesdays, Wednesdays and Fridays from 08:30am to 6:00pm. However, the practice is closed every Thursdays from 12:00pm until Friday morning 08:30am. The practice manager told us that when the practice is closed on Thursday afternoons general medical service cover was provided by the branch surgery until 6pm after which it was the out of hours provider. The practice has opted out of providing out-of-hours services to their own patients. This service is provided by an external out of hours service contracted by the CCG.

There are seven permanent GPs (four male and three female) which includes five registered partners and two salaried GPs. The practice employs a senior nurse (female) five practice nurses (female) and two health care assistants (female).There are also 16 administrative staff which includes secretaries and reception staff and a practice manager. The registered manager who was also a partner at the practice had left. At the time of our inspection the practice was in the process of submitting relevant applications to the CCQ to ensure a new registered manager was appointed in line with the conditions of their registration.

The practice has a General Medical Service contract (GMS) with NHS England. A GMS contract ensures practices provide essential services for people who are sick as well as for example, chronic disease management and end of life care. The practice also provides some enhanced services such as minor surgery. An enhanced service is a service that is provided above the standard GMS contract.

We reviewed the most recent data available to us which showed that the practice is located in one of the least deprived areas in Solihull. The practice has an above average patient population who are aged 65 years and over and a lower than average patient population aged 0 to 4 years in comparison to the average practice across England. The practice had achieved an above average

practice score across England for the Quality and Outcomes Framework (QOF) for the last financial year 2012-2013. The QOF is the annual reward and incentive programme which awards practices achievement points for managing some of the most common chronic diseases, for example asthma and diabetes.

Why we carried out this inspection

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

How we carried out this inspection

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)

Before visiting, we reviewed a range of information we held about the service. We also asked other organisations and health care professionals to share what they knew about the service. We sent the practice a box with comment cards so that patients had the opportunity to give us feedback. We received 25 completed cards where patients shared their views and experiences of the service. We carried out an announced inspection on 5 November 2014. During our inspection we spoke with a range of staff including the practice manager, clinical and non clinical staff. We spoke with patients who used the service. We observed the way the service was delivered but did not observe any aspects of patient care or treatment.

Good

Are services safe?

Our findings

Safe track record

Patients spoken with did not report any safety concerns to us and we were not aware of any major safety incidents that had occurred at the practice.

The practice manager told us that when they received patient safety alerts they would be actioned where appropriate and shared with the full practice team, and there was evidence to support this. Patient safety alerts are issued when potentially harmful situations are identified and need to be acted on.

There were systems in place to report any incidents that occurred at the practice. When an incident occurred a report was completed and this included any actions required. Discussions with staff demonstrated that they were aware of the process for incident reporting and they told us they received feedback following incidents during meetings.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. This included significant event analysis (SEA). A significant event is any event thought by anyone in the team to be significant in the care of patients or the conduct of the practice. Audits were completed and learning identified. We saw that 18 significant events had been recorded over a period of nine months. There was evidence to demonstrate that significant events were regularly discussed and shared with staff in meetings and they were also available on the practice intranet which made them easily accessible to staff.

Reliable safety systems and processes including safeguarding

There were arrangements in place for ensuring patient safety, this included the contact numbers for local safeguarding teams and clear safeguarding policies and procedures for staff to refer to should they have any concerns. There was a lead GP for children's safeguarding. Staff had received safeguarding vulnerable adults and children's training. Clinical staff had completed level 3 safeguarding children training. This level of training helps develop knowledge, skills and the ability to work collaboratively on the processes for safeguarding and promoting the welfare of children. An alert system was in place to highlight vulnerable adults and children. A recent referral had been completed by a GP at the practice following concerns about a child. This demonstrated concerns were identified and acted on in line with local safeguarding procedures.

Some of the staff acted as chaperones, although had not received formal training in this area and there was no policy in place to guide staff. However, staff who we spoke with were aware of their role and responsibilities when undertaking this duty. The practice should ensure members of staff who undertake a formal chaperone role undergo training so that they develop the competencies required for the role.

Medicines management

The practice had medicines and equipment available to use in the event of a medical emergency. There were systems in place to ensure they were checked regularly so that medicines were not kept beyond there expiry date. Some of the emergency medicines should not be stored above a specified temperature range. However, staff confirmed that there was no system in place to monitor the room temperature so they could be confident that the medicines were stored within the recommended temperature ranges. Emergency medicines also need to be stored in a safe place but should be readily accessible in the event of a medical emergency, we saw that they were stored in an unlocked room that was accessible to patients. We discussed this with the practice manager and a GP partner at the time of the inspection and we were told action would be taken to address the issues raised.

There was a dedicated secure fridge where vaccines were stored. There were systems in place to ensure that regular checks of the fridge temperature was undertaken and recorded. This provided assurance that the vaccines were stored within the recommended temperature ranges and were safe and effective to use.

The practice did not store any controlled drugs, there was a pharmacy based in the health centre which meant that in the event these were required they could be easily accessible.

We found that blank prescriptions were not always stored appropriately to ensure they were only accessible to appropriate staff. We saw that a box containing blank prescriptions were stored in an unlocked area. There was no system in place for recording the serial number of

prescriptions so that all prescriptions could be accounted for and traced in the event this was necessary. We discussed this with the practice manager and a GP partner at the time of the inspection and was told action would be taken to address the issue raised.

A system was in place for repeat and acute prescribing so that patients were reviewed appropriately and any repeat medications were relevant to their health needs. There was an alert system which informed patients and staff that medication reviews were due, if the patient did not attend a medication review a seven day prescription was issued to encourage them to attend the practice. The most recent data available to us showed that the practice prescribing rates for areas for medicines such as hypnotics, antibacterial and Non- Steriodal Anti-Inflammatory were in line with the national average.

Cleanliness and infection control

On the day of our inspection we observed that the practice was visibly clean and tidy. There were systems in place to reduce the risk of cross infection. This included the availability of personal protective equipment (PPE), colour coded cleaning equipment and disposable privacy curtains that were clearly dated. We saw evidence that a number of staff had received training in infection prevention and control. Infection prevention and control policies and procedures were available for staff to refer to enable them to comply with relevant legislation. Staff told us that these policies and procedures were accessible to them.

We found that suitable arrangements were in place for the storage and the disposal of clinical waste and sharps. Sharps boxes were dated and signed to help staff monitor how long they had been in place. A contract was in place to ensure the safe disposable of clinical waste.

The premises was not owned by the practice and the cleaners were employed by the health centre to carry out regular cleaning duties. There were cleaning schedules in place that included daily, weekly and monthly tasks. The cleaning schedules were not signed to demonstrate that the cleaning had taken place consistently. However, there was evidence that the standard of cleaning was monitored by the practice as regular checks were undertaken and meetings took place with the cleaning contractors.

An infection prevention and control audit had been completed by the practice in November 2014. The practice had an overall score of 96%, actions had been identified from the audit and were in progress.

A legionella risk assessment had been completed in June 2014 recently to ensure that any risks to patients from potential contaminated water was identified and acted on. Legionnaires' disease is a form of bacteria which can live in all types of water.

Equipment

Records showed that medical equipment had been calibrated and serviced so that they were safe and effective to use.

Electrical appliances had been tested to ensure they were in good working order and safe to use.

Staffing and recruitment

The registered patient list size was approximately 12458 patients. There were seven permanent GPs which included two salaried GPs. The practice manager confirmed that most of the staff had worked at the practice for a number of years which provided stability within the staff team and ensured patients received continuity in their care. The practiced employed a senior nurse, five practice nurses and two health care assistants .There were also large administrative staffing team which included secretaries and reception staff and a practice manager.

The practice was a training practice for GP Registrars (fully qualified doctors who wish to become general practitioners) and an approved teaching practice for medical students in their final year.

There were systems in place to monitor and review staffing levels to ensure any shortages were addressed and did not impact on the delivery of the service. Staff, including nursing and administrative staff were able cover each other's annual leave and staff from the branch surgery could be deployed when necessary.

The practice manager told us that they rarely used locum GPs however, in the event this was required appropriate documentation was sought prior to them working at the practice.

We looked at three staff files, including the file of the most recent member of staff employed at the practice. There was evidence that most of the appropriate pre-employment checks were completed prior to staff commencing their

post. This included photographic identity, references and a Disclosure and Barring Service (DBS) check at an appropriate level for the role and responsibilities. The DBS check is a criminal records check that helps identify people who are unsuitable to work with children and vulnerable adults. The practice manager told us that new members of staff on commencement of their post received an induction; we saw evidence to support this. However, we saw that there were some gaps in the recruitment procedure, for two administrative staff two references had been requested although only one had been obtained. There was no guidance to the number of references required in the practice recruitment policy There was also no medical health information obtained as part of the recruitment process. Schedule 3 of the Health and Social Care Act 2008 details information required to be available in respect of people employed. This should include for example, satisfactory information about any physical or mental health conditions which are relevant to the person's ability to carry out their role.

Monitoring safety and responding to risk

Risk assessments were in place which included areas of health and safety associated with the general environment. Health and safety meetings took place and provided an opportunity to discuss and address any concerns. There were examples of actions taken to address concerns identified. For example patient information leaflets were displayed reminding patients not to leave unwanted medicines in reception.

The practice had a fire safety policy in place and procedures in place. Fire alarms, equipment and emergency lighting were checked to ensure they were in good working order. Staff had received training in fire safety and fire drills took place to ensure staff were prepared in the event of a fire emergency.

There were arrangements to deal with foreseeable medical emergencies. Staff had received training in responding to a medical emergency. There were emergency medicines and equipment available that were checked regularly so that staff could respond safely in the event of a medical emergency. The practice had an automated external defibrillator (AED). This is a piece of life saving equipment that can be used in the event of a medical emergency. All of the staff asked (including receptionists) knew the location of the emergency medicines and equipment.

Arrangements to deal with emergencies and major incidents

The practice had an up to date disaster recovery plan in place. This covered a range of areas of potential risks relating to foreseeable emergencies that could impact on the delivery of the service. There were contact details of staff and main suppliers that would be needed in the event of an emergency and major incident.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The clinicians who we spoke with were able to describe and demonstrate how they accessed and implemented guidelines based on best practice such as National Institute for Health and Care Excellence (NICE). NICE provides national guidance and advice to improve health and social care. For example, the clinicians utilised 'Map of Medicine' this system allows the practice to locally customise evidence-based care pathways and referral guidance and make them available to clinicians instantly.

Annual reviews were undertaken for patients with specific health needs such as patients with mental health needs, patients over the age of 75 years and patients with a learning disability. For example, we saw that there were 42 patients with a learning disability, a register was in place to ensure patients could be easily identified and their health needs were reviewed. All except seven patients had been reviewed and had care plans in place. Patients with diabetes had annual reviews by the nurses with specialist knowledge in diabetes and there was also a GP lead for diabetes. There were arrangements to review patients in their own home if they were unable to attend the practice.

The practice provided antenatal and post natal care for women, the midwife undertook regular clinics at the practice.

Patients who were receiving end of life care had a named GP and there were arrangements to share information with out of hours services for when the practice was closed. Meetings were held with the palliative care teams to ensure coordinated care that respected patient's needs and wishes and care was based on the national gold standard framework (GSF).

The practice had started a scheme to avoid unplanned hospital admissions by providing an enhanced service. This focused on coordinated care for the most vulnerable patients and included emergency health care plans. The aim was to avoid admission to hospital by managing their health needs at home. At the time of the inspection the practice had had identified the required 2% of high risk patients. An enhanced service is a service that is provided above the standard general medical service contract (GMS). Our discussions with health care professionals indicated that there were good communication systems in place with the GPs and staff at the practice.

The practice referred patients appropriately to secondary and other community care services such as district nurses. The practice used the Choose and Book system for making the majority of patient referrals. The Choose and Book system enables patients to choose which hospital they would prefer to be seen.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included antibiotic prescribing, COPD and reviewing patients on specific medicines. Changes had been made to clinical practice as a result of findings for example, some patients were prescribed an alternative more effective medicine for their health condition based on NICE guidance. The practice referral rates to secondary care for women were found to be better than average in comparison to other practices within the CCG. An audit and peer review was completed to review the referral rates The outcome showed that the referrals made by the practice were of good quality and were appropriate referrals.

The childhood vaccination programme was undertaken by the practice nurse. The most recent data available to us showed immunisation rates were mostly in line with the average for the CCG area.

Some of the GPs in the surgery undertook minor surgical procedures in line with their registration. It should be noted that if a practice is commissioned to undertake enhanced services such as minor surgery their commissioner and their accrediting body will expect an audit of all patients receiving the service. We saw evidence that audits were completed on minor surgery undertaken. Findings were shared with staff in meetings specifically for those staff undertaking minor surgery.

Effective staffing

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We saw training records that showed staff

Good

Are services effective?

(for example, treatment is effective)

were able to maintain their skills and knowledge. Staff had undertaken training in areas such as childhood immunisation, cytology, minor surgery, women's health and updates on various medical conditions.

Staff were also given the opportunity and supported to develop specialist knowledge and expertise. For example, one of the nurses had completed a diploma in diabetes which was funded by the practice and the nurse was also provided study time. Another nurse had completed masters in advance practice and was allowed study time and mentoring by a GP to help achieve the practice element of the course. We identified there were some gaps in formal training such as the Mental Capacity Act (2005) and chaperoning although discussions with staff suggested they understood their roles and responsibilities in these areas. There was a training log to ensure training needs could be easily identified and addressed.

New staff received induction training and regular training sessions were held in house which enabled knowledge and information to be shared.

The practice had systems in place for annual appraisals for all staff including the GPs and this was confirmed by staff.

All of the GPs who worked at the practice had undergone or were due external revalidation of their practice. Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise medicine.

Working with colleagues and other services

Meetings were held with the district nurses and 'Virtual ward' staff. A virtual ward is a method of providing support in the community to people with the most complex medical and social needs. Virtual wards use the systems and staffing of a hospital ward, but without the physical building: they provide preventative care for people in their own homes.

There was a national recall system in place for cytology screening which were carried out by the practice nurse. This ensured women received this important health check including their results in a timely manner and findings were audited to ensure good practice.

The practice provided general medical services to a care home as part of contract with the home. We spoke with the care home manager and discussed the arrangements for reviewing older patients. They were positive about the service received from the practice. They told us that the GPs undertook a visit twice a week to review people living at the home and that GPs were very professional and thorough, undertaking home visits when necessary. The care home manager had a monthly meeting with practice manager and one of the GP partners to discuss any issues. These arrangements helped to minimise unnecessary admissions to hospital.

There were systems in place to ensure that the results of tests and investigations were reviewed and actioned as clinically necessary. This involved review of tests and investigations by the requesting clinician. All of the GPs had a 'Buddy' to ensure tests were reviewed in their absence and any abnormal results were acted on.

Information sharing

The practice was based in a health centre where other health professionals such as health visitors were also located. We found that the practice worked with other service providers sharing information to meet the needs of patients and manage complex cases. Multidisciplinary working was evidenced, for example joint working arrangements were in place with the palliative care team. Our discussions with health care professionals such as health visitors and district nurses suggested that there effective systems in place to share information.

Patients who were receiving end of life care had a named GP and there were systems in place to share information with out-of-hours services for when the practice was closed

Consent to care and treatment

Staff had not received any formal training on the Mental Capacity Act (2005). However, staff who we spoke with demonstrated their understanding of capacity assessments and how the principles would be applied in clinical practice. The Mental Capacity Act (2005) is a law that protects and supports people who do not have the ability to make decisions for themselves. Clinical staff were also able to demonstrate understanding of Gillick competency and Fraser guidelines when assessing children under the age of 16.

The practice had leaflets available for Independent Advocacy service. This service provides support for vulnerable patients including accompanying them to GP appointments to help ensure their views were clearly represented.

Good

Are services effective?

(for example, treatment is effective)

Health promotion and prevention

The practice had a procedure in place for new patients registering with the practice, this included a health check with the nurse. Patients on regular medication were also reviewed by a GP.

Information leaflets and posters were available in the patient waiting area on health promotion and prevention. There was also information that signposted patients to support groups and organisations. The practice's website had a link to patient information leaflets on health conditions and diseases provided by 'Patient.co.uk'. Health information was also included in the practice Newsletter which provided the opportunity to promote health campaigns such as flu vaccinations.

The practice offered advice and support in areas such as stop smoking, weight management and family planning, referring patients to secondary services where necessary. There was also a specialist Ear, Nose and Throat (ENT) clinic held by a consultant two sessions a week where patients could be referred. NHS health checks were available for people aged between 40 years and 74 years. The practice offered a range of health promotion and screening services which reflected the needs for this patient group. Flu vaccinations were offered to high risk groups.

A number of patients including older patients and those with complex needs had a priority marker on their records highlighting they had specific urgent needs in relation to their health. Care plans were in place to monitor and review their health needs. The priority GP was detailed on the patients computer records and patients had been informed.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Our discussions with patients on the day and feedback from comment cards told us patients felt that staff were caring and their privacy and dignity was respected.

The layout of the patient waiting area meant that patient's confidentiality was not always maintained. Patients approaching the reception desk could be overheard when talking to staff. Staff taking incoming calls could also be easily heard. We observed that there were some arrangements in place to maintain confidentiality. There was a sign requesting patients to respect other patients privacy when in the que. However, there was no poster informing patients that they could discuss any issues in private away from the main reception desk. Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room and that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations.

Records showed that some of the staff had received training in equality and diversity. This would help to ensure that staff respected and valued differences and treated patients fairly.

We saw a poster in the patient waiting area which advised patients to book a double appointment if they needed more time during a consultation. This enabled patients to have additional time during a consultation based on their need.

There was a combination of male and female GPs available at the practice which gave patients the option of receiving gender specific care and treatment.

Care planning and involvement in decisions about care and treatment

The results of the national GP survey 2013 showed that the practice was average in the area of 'The number of respondents who stated that the last time they saw or spoke with a GP they was good or very good at involving them in decisions about their care'. This was in comparison to other practices in the local CCG.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

The practice had access to interpreting services if required although the patient demographics meant that most patients could speak English as their first language.

Patient/carer support to cope emotionally with care and treatment

We asked staff about bereavement support for patients. They told us they would signpost patients to bereavement services. Clinical staff also attended regular meetings with relevant professionals and agencies to discuss and review patients who were receiving end of life care based on the national gold standard framework (GSF). As part of the process carers were identified and supported following bereavement.

We saw information leaflets in in the patient waiting area for people who were carers which included contact details of a support group. The practice also had a system for identifying people who were carers to ensure their needs were identified and support could be offered.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the service was responsive to people's needs and had sustainable systems in place to maintain the level of service provided. The practice delivered core services to meet the needs of the main patient population they treated. For example screening services were in place to detect and monitor the symptoms of long term conditions such as asthma and diabetes. There were nurse led services such as the minor illness clinic which aimed to review patients with common illness and aliments. There were vaccination clinics for babies and children and women were offered cervical screening. Patients over the age of 75 years had an accountable GP to ensure their care was co-ordinated.

The practice had implemented the gold standards framework for end of life care. They had a palliative care register and regular multidisciplinary meetings to discuss patients and their family's care and support needs.

We saw that the practice had an active and engaged patient participation group (PPG). PPGs are a way in which patients and GP surgeries can work together to improve the quality of the service There was evidence that the PPG group had acted on feedback from the General Practice Survey. As a result of patient feedback improvements had been made in the telephone system which included more telephone consultations, ensuring appointments were released twice a day and offering appointments and ordering of prescriptions online. The PPG had also identified and responded to the need to recruit new members who were reflective of the practice population. The practice had its own Newsletter which was circulated in the local villages.

Tackling inequity and promoting equality

The practice also had access to an interpreting service for patients whose first language was not English, this included telephone translation service.

There were disabled parking and toilet facilities and a loop induction system for patients with a hearing impairment .The practice had recently completed a Disability Discrimination Act (DDA) audit to show compliance with the Disability Discrimination Act (1995).This act ensures providers of services do not treat disabled people less favourably, and must make reasonable adjustments so that there are no physical barriers to prevent disabled people using their service.

Access to the service

The practice had a registration policy in place which enabled people without a permanent address to register at the practice; this could often be people who are living in vulnerable circumstances.

We looked at the appointment system at the practice. We saw that appointments were available about five weeks in advance. When these appointment were booked appointments were released each day in the morning and the afternoon, these were known as 'same day' appointments and included urgent appointments. Home visits were undertaken for those patients who were unable to attend the practice. Telephone consultations were available so that any patients who had urgent queries could speak to a GP or a Practice Nurse. Patients had the opportunity to book a double appointment if they required additional time.

We reviewed patient feedback from the national GP survey 2013 and comments made about the practice on the NHS choices website. We also looked at completed comments cards and spoke to patients on the day of the inspection. The common theme emerging from these various feedback was the accessibility of appointments, patients described difficulty getting through on the telephone to make a routine 'same day' appointment. Patients said that by the time they got through on the telephone, appointments were often no longer available so had they had to call again.

The practice was open Mondays, Tuesdays, Wednesdays and Fridays from 08:30am to 6:00pm. However, the practice was closed every Thursdays from 12:00pm until Friday morning 08:30am. The practice manager told us that when the practice was closed on Thursday afternoons general medical service cover was provided by the branch surgery until 6pm after which it was the out of hours provider. The practice had opted out of providing out-of-hours services to their own patients. This service was provided by an external out of hours service contracted by the CCG. However, we found that the answer phone message did not make this clear. When patients called on a Thursday

Are services responsive to people's needs?

(for example, to feedback?)

afternoon when the practice was closed during normal working hours, the answer message informed patients to contact the NHS 111 service or the out of hours service provider.

A working age patient who we spoke with on the day of the inspection described difficulty getting face to face appointments that fitted around their working day. The practice manager told us that early and late evening appointments were available which would accommodate working age patients. However, feedback from the national GP survey 2013 showed that the practice was worse than average for patients satisfaction with the practice opening hours. The PPG had looked at the issue of appointments system following feedback from the survey and some improvements had been made to increase accessibility of appointments. However, no recent surveys had been completed to review progress of the appointment system. The practice should improve accessibility to appointments for patients through a review of practice opening times.

We saw that the practice had a number of patients who did not attend their appointments (DNA). Between the months of February 2014 to July 2014 this equated to 18.7 hours of nursing staff time and 13.5 hours of a GPs time. DNA rates were audited and were identified as an issue by the PPG. Action had been taken to raise patients awareness on the importance of cancelling appointments. This included displaying posters in the patient waiting area and information in the practice newsletter highlighting the issue. We were told that no reminders were sent to patients regarding their appointments such as a mobile text message. Feedback from patients suggested that accessing appointments was an issue. The practice should consider more innovative management of patients who do not attend their appointment.

Listening and learning from concerns and complaints

There was an accessible complaints system with evidence demonstrating that the practice recorded and responded to issues raised. The practice had a system in place for handling complaints and concerns. The complaints policy was in line with recognised guidance and contractual obligations for GPs in England. We saw that there had been 37 complaints made in the last 12 months and all had been responded to. There was a complaints register that enabled themes, trends to be identified and acted on. Sharing of lessons learnt and discussions with staff were included in staff meetings.

We saw that there was a poster on display in the patient waiting area informing patients to contact the practice manager should they wish to make a complaint. The practice had a complaints policy which included contact details of organisations that patients could escalate complaints to however, the policy was not on display and the details were not included on the poster. We discussed this with the practice manager who agreed to include this information on the poster to ensure it was accessible to patients.

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 manager and staff who we spoke with demonstrated the values of the practice and a commitment to improving the quality of the service for patients. The GP partners had plans to develop and expand service provision for the future although these plans had not been formally documented.

The GP partners and practice manager wanted to be recognised as an outstanding practice. Our discussion with them demonstrated a commitment to improving the quality of the service for patients through the process of engaging with patients and staff. We identified areas of good practice which supported their vision, aspiration and potential.

Governance arrangements

Records showed that essential risk assessments had been completed, where risks were highlighted measures had been put in place to minimise the risks.

Patients were cared for by staff who were aware of their roles and responsibilities for managing risk and improving quality. There were clear governance structures and processes in place to keep staff informed and engaged in practice matters.

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at some of these policies and procedures and found that they had been reviewed and were up to date.

The GPs at the practice had various lead roles in areas such as diabetes and safeguarding. This provided the opportunity for staff to develop specialist knowledge and expertise. There were also various meetings held in areas such as diabetes and COPD where QOF achievements were discussed to ensure performance was kept under review. Data that we reviewed showed that the practice was on target to achieve its QOF for the current financial year 2014 to 2015.

The GP partners at the practice attended meetings with the local CCG to ensure they were up to date with any changes.

Feedback we received from the CCG and NHS England suggested that the practice engaged well with them and staff members attended forums such as those held for practice managers and practice nurses.

Leadership, openness and transparency

The aims and values of the service were clearly set out, and these were shared with the staff members. Staff were committed to providing a high quality service. They described the culture of the organisation as supportive and open. They also said that they felt that the service was well-led, and that the practice manager and GP partners provided supportive leadership.

The practice had a whistle blowing policy and staff told us that they felt confident to raise any concerns about poor care that could compromise patient safety. Whistleblowing is when staff are able to report suspected wrong doing at work, this is officially referred to as 'making a disclosure in the public interest'.

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

We saw that the practice had acknowledged and responded to feedback from patients which had been left on the NHS choices website and via complaints. These were sometimes detailed responses which showed that the feedback raised had been considered and reflected upon.

The Practice had a PPG and there was evidence that they had had acted on patient feedback which had resulted in some changes to the appointments system. Newsletters provided the opportunity for the practice and PPG to engage with patients. The practice manager and GP partner attended PPG meetings to ensure they remained fully involved and aware of feedback from patients.

The practice gathered feedback from the staff generally through appraisals, meetings and informal discussions. Staff that we spoke with told us that they felt listened to and gave examples such as requests for specific training which had been provided.

Regular meetings were held for different staff groups such as nurses, GPs and administrative staff to ensure important information was disseminated to staff. No overall practice meetings were held however, staff felt meetings for individual staff groups worked well.

Are services well-led?

Good

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

Management lead through learning and improvement

The GPs and practice manager demonstrated throughout the inspection process that they were proactive in their approach to improving the quality of service provided. The practice was able to demonstrate the use of clinical audits and peer review to measure performance and analyse outcomes, for example excellence in women's health.

Learning from complaints, significant events and audits were shared with staff to help learning and improvements.

There was a visible leadership structure and staff members who we spoke with were clear about their roles and responsibilities. They told us that they felt valued, well supported and knew who to go to in the practice with any concerns.

There was a supportive teaching culture with a number of the GP's undertaking teaching roles for trainee GPs and medical students. There was evidence that teaching and training was encouraged and supported for example one of the nurses had been supported to complete a diploma in diabetes.