

Charnwood Surgery

Quality Report

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Date of inspection visit: 26 April 2017

Date of publication: 30/06/2017

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

Ratings

Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Charnwood Surgery on 26 April 2017. Overall the practice is rated as good.

Our key findings across all the areas we inspected were as follows:

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events.
- The practice had clearly defined and embedded systems to minimise risks to patient safety.
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- Results from the national GP patient survey were much higher than local and national averages and showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.

- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients who commented on their care said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

The areas where the provider should make improvement are:

- Improve the system for the identification of carers.
- Ensure secondary thermometers are being used in vaccine refrigerators.
- Ensure fire drills are carried out at appropriate intervals.

Summary of findings

- Include clinical input for nurse appraisals.
- Ensure cleaning carried out by practice staff is recorded.

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?

The practice is rated as good for providing safe services.

Good



- From the sample of documented examples we reviewed, we found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the practice. When things went wrong patients were informed as soon as practicable, received support and truthful information.
- The practice had clearly defined and embedded systems, processes and practices to minimise risks to patient safety. However we found that fire drills had not been carried out.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- The practice had adequate arrangements to respond to emergencies and major incidents.

Are services effective?

The practice is rated as good for providing effective services.

Good



- Data from the Quality and Outcomes Framework showed patient outcomes were at or above average compared to the national average.
- Staff were aware of and acted on current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills and knowledge to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff. However we noted that there had been no clinical input in to the nurse appraisals.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- End of life care was coordinated with other services involved and regularly discussed.

Are services caring?

The practice is rated as good for providing caring services.

Good



- Data from the national GP patient survey showed patients rated the practice much higher than others for several aspects of care.

Summary of findings

- Survey information we reviewed showed that patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- The practice used a number of strategies to identify carers and offered them support, however the number of carers identified was lower than average.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population.
- The majority of patients who made comment said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day as well as the majority of routine appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Information about how to complain was available and evidence from three examples reviewed showed the practice responded quickly to issues raised. Learning from complaints was shared in order to encourage improvement.

Good



Are services well-led?

The practice is rated as good for being well-led.

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had policies and procedures to govern activity and held regular meetings.
- An overarching governance framework supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- Staff had received inductions, annual appraisals and attended staff meetings and training opportunities.
- The provider was aware of the requirements of the duty of candour. In examples we reviewed we saw evidence the practice complied with these requirements.

Good



Summary of findings

- The partners encouraged a culture of openness and honesty. The practice had systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken.
- The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. The practice engaged well with the patient participation group.
- There was a focus on continuous learning and improvement at all levels.
- GPs who were skilled in specialist areas used their expertise to offer additional services to 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

The practice is rated as good for the care of older people.

Good



- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. They offered a number of services which we were not commissioned but useful to older people such as ear syringing and simple dressings.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible.
- All staff were involved in identifying patients who may have benefitted from other support such as those who were experiencing loneliness and were able to refer to a local group who could offer advice and further signpost.
- There was a named accountable GP for all patients which maintained a high level of continuity of care.
- Consideration was given to carer's needs, for example by securing a patient and their carer in the same care home.

People with long term conditions

The practice is rated as good for the care of people with long-term conditions.

Good



- Specialist nurses were used to manage long-term conditions.
- Patients at risk of hospital admission were identified as a priority.
- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.

Summary of findings

- All these patients had a named GP and there was a system to recall patients for a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- Referrals to specialists were made in an appropriate and timely way with referrals done on the spot to avoid any delays in referral and patients given a choice of provider at the same time.
- Patients were able to attend health education events relating to long term conditions through the local federation.

Families, children and young people

The practice is rated as good for the care of families, children and young people.

- There were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children of substance abusing parents and young carers.
- Children and young people were treated in an age appropriate way and recognised as individuals, with their preferences considered.
- Immunisation rates were high for all standard childhood immunisations and non-responders were followed up.
- Appointments were available on the day for children.
- The practice worked with midwives, health visitors and school nurses to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics.
- Clinicians kept their knowledge, skills and competences up to date in order to recognise and respond to an acutely ill child.
- Post-partum contraception was provided for mothers at their post-natal check.

Good



Working age people (including those recently retired and students)

The practice is rated as good for the care of working age people (including those recently retired and students).

- The needs of these populations had been identified and the practice had adjusted the services it offered to ensure these

Good



Summary of findings

were accessible, flexible and offered continuity of care, for example; they had trialled extended opening hours and found there was a very low take up. Telephone consultations were always available at a time to suit the patient.

- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- Extended services were provided in house reducing the need to travel to hospital.

People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

Good



- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice offered longer appointments for patients with a learning disability or any vulnerability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- Staff knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- Information on how to access GP services and support groups was made available through a number of avenues including the practice leaflet, website and social media. The practice aimed for patients to feel able to access their services without fear of stigma and prejudice.
- Longer appointments were offered where required.
- The practice made exceptions to accommodate vulnerable patients; for example by registering a vulnerable care home patient despite their care home quota being at capacity.
- All staff were aware of and used the first contact referral service for vulnerable patients which put them in touch with numerous avenues of support.
- If patients are vulnerable, this is identified in their patient record so all staff are aware.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good



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

- The practice carried out advance care planning for patients living with dementia.
- 100% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which is much better than the national average.
- Patients at risk of dementia were identified and offered an assessment.
- The practice were members of the national Dementia Action Alliance and had recently completed 'dementia friends' training to enable all staff to be able to have a greater understanding of and therefore more able to support patients living with dementia appropriately.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- Care was tailored to patient's individual needs and circumstances, including their physical health needs. This included annual health checks for people with serious mental illnesses.
- Access to a variety of treatments was facilitated such as listening and advice, cognitive behavioural therapy and counselling.
- The practice utilised a mental health facilitator who was also invited to all multi-disciplinary team meetings
- We saw an example whereby the practice had not felt appropriate secondary care had been given to a patient suffering poor mental health and they had raised this with stakeholders and with the services concerned in order to avoid the same problem reoccurring and try and improve services for patients.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was performing above local and national averages. 259 survey forms were distributed and 105 were returned. This represented 7.7% of the practice's patient list.

- 95% of patients described the overall experience of this GP practice as good compared with the CCG average of 85% and the national average of 85%.
- 96% of patients described their experience of making an appointment as good compared with the CCG average of 72% and the national average of 73%.
- 86% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 80%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received ten comment cards, nine of which were positive about the standard of care received. All but one of the patients who commented said they were very satisfied with the care they received and thought staff were friendly, helpful and supportive. Many patients commented on the ease with which they could get a timely appointment. The practice displayed the results of the NHS Friends and Family Test in the waiting room and we saw that in February 2017 100% of patients who responded were extremely likely to recommend the practice to friends or family and in March 2017 there were no responses completed.

Areas for improvement

Action the service **SHOULD** take to improve

- Improve the system for the identification of carers.
- Ensure secondary thermometers are being used in vaccine refrigerators.
- Ensure fire drills are carried out at appropriate intervals.
- Include clinical input for nurse appraisals.
- Ensure cleaning carried out by practice staff is recorded.

Charnwood Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist adviser and a practice manager specialist adviser.

Background to Charnwood Surgery

Charnwood Surgery is a GP practice providing primary medical services under a General Medical Services (GMS) contract to around 1370 patients within a residential area. The practice's services are commissioned by West Leicestershire Clinical Commissioning Group (WLCCG).

Charnwood Surgery is located on Linkfield Road in Mountsorrel which is situated between Rothley and Quorn and approximately five miles from Loughborough and seven miles from Leicester. It is on a main bus route between Leicester and Loughborough and the route serves the local villages.

The practice is situated in a wheelchair accessible single storey building and has a small parking area for cars which includes disabled parking. Street parking is also available nearby.

The service is provided by two part time male GP partners who between them provide nine sessions per week. There is also a part time nurse practitioner, a part time practice nurse and a part time phlebotomist. They are supported by a part time practice manager and a team of reception/administration staff. The practice is also a training practice for GP trainees although there were no trainees at the time of our inspection.

The practice is open from 9.00am to 1.00pm and 3.00pm to 6.00pm Monday to Friday with the exception of Thursday when they are open from 9.00am to 12.00pm and closed for the remainder of the day. Appointments are available from 09.00am to 11.30am and from 3.30pm to 6.00pm on Mondays, from 09.00am to 11.30am and from 3.30pm to 5.30pm on Tuesday, Wednesday and Friday and from 09.00am to 11.30am on Thursdays.

When the practice is closed during the day patients are able to contact one of the GPs via mobile telephone. After 6.30pm patients are able to contact the Out of hours services which are provided by Derbyshire Health United (DHU) via the NHS 111 service. Patients are directed to the correct numbers if they phone the surgery when it is closed.

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. The 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.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations; Healthwatch, NHS England and West Leicestershire Clinical Commissioning Group to share what they knew. We carried out an announced visit on 26 April 2017. During our visit we:

Detailed findings

- Spoke with a range of staff including both GP partners, the practice manager, the practice nurse and reception staff.
- Observed how patients were being cared for in the reception area and talked with family members.
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

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 were provided for specific groups of people and what good care looked 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 living with dementia).

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.

Are services safe?

Our findings

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and recording forms were available in the reception area. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- From the sample of three documented examples we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed on a monthly basis. The practice carried out an analysis of the significant events.
- We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, one significant event related to a pregnant patient being given an incorrect vaccine, we saw that a full apology had immediately been given to the patient. The practice contacted the consultant to ensure there were no contraindications and following discussion the learning was that only one vaccine at a time would be prepared.
- The practice also monitored trends in significant events and evaluated any action taken. There were no themes in the incidents which had been reported.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were

accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. One of the GP partners was the lead member of staff for safeguarding.

- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place. We found that the schedules indicated that the practice was cleaned by an external cleaner twice a week. This was not in line with national guidance as some areas required daily cleaning. We were told that other staff carried out cleaning if required but this was not recorded. We were told that this would be rectified. Additionally there was no protocol for cleaning relating to minor surgery. Following our inspection a cleaning schedule relating to minor surgery was implemented.
- At the time of our inspection, one of the GP partners was the infection prevention and control (IPC) clinical lead. This role had been held until recently by one of the practice nurses until they left employment at the practice. A nurse prescriber had been recruited and they were going to take up the IPC lead role which would include liaison with the local infection prevention teams to keep up to date with best practice. There was an IPC protocol and staff had received up to date training. Annual IPC audits had been undertaken. We looked at the most recent audit and found that it was not comprehensive. Following our inspection the practice completed a full infection control audit with an associated action plan.

Are services safe?

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred. The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. The practice were the lowest antibiotic prescriber in the locality.
- We found that the refrigerator used to store vaccines did not have a secondary thermometer in place in order to cross-check the accuracy of the temperature. We were told that this had already been purchased but not yet used. Following our inspection the practice manager assured us that the secondary thermometer was in use and the data downloaded on a weekly basis.
- Blank prescription forms and pads were securely stored and there were systems to monitor their use.
- Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.

We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available.
- The practice had an up to date fire risk assessment and evacuation processes were discussed annually at a practice meeting. However the practice had not carried

out regular fire drills. The practice manager was the designated fire warden and staff had received fire safety training. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.

- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements to respond to emergencies and major incidents.

- The practice was small enough and the layout such that in the case of an emergency staff would be able to summons help by alerting other staff verbally to any emergency.
- All staff received annual basic life support training and there were emergency medicines available.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan for major incidents such as telephone failure or loss of utilities. The plan included emergency contact numbers for staff and had been distributed to all staff.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians were aware of and able to identify relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and discussion at clinical meetings.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 92.9% of the total number of points available compared with the clinical commissioning group (CCG) average of 96.9% and national average of 95.3%.

The practice had an overall exception reporting rate of 5.8% which was comparable to the CCG and national average. Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects.

The data we held indicated that the practice had higher than average exception reporting in some clinical domains. For example in the areas of cancer, stroke, dementia and depression. However, a sample of patient records showed exception reporting to have been made appropriately and data provided by the practice indicated that the high exception reporting related to system generated exceptions rather than exceptions made by the practice.

Data from 2015-2016 showed:

- Performance for diabetes related indicators was lower to the CCG and national averages. For example the percentage of patients with diabetes, on the register, in

whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less was 57% compared to the CCG average of 77.08% and the national average of 77.58%.

- Performance for mental health related indicators was higher than the CCG and national averages. For example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months was 100% compared to the CCG average of 95% and the national average of 89%. The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months was also 100%, compared with the CCG average of 87% and the national average of 84%.

There was evidence of quality improvement including clinical audit:

- We looked at five clinical audits which had been commenced in the last two years; two of these were completed audits where the improvements made were implemented and monitored.

Findings were used by the practice to improve services. For example, the practice had carried out a subdermal implants audit to ensure procedures were in line with the Diploma of the Faculty of Sexual and Reproductive Health standards. The results of the audit identified areas for improvement which were implemented and included recording in patient notes that patient information leaflets had been given and that the implant was palpable after insertion.

Another audit was carried out as a result of an error in the practice computer system which had affected GP practices. QRISK2 is a clinical tool used to help identify patients that would benefit from a statin. The error meant that the results produced by the clinical tool could not be relied upon. As a result the practice reviewed patients who may have been affected and carried out consultations with those that could be contacted and statin commenced if appropriate and appropriately followed up.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

Are services effective?

(for example, treatment is effective)

- The practice had an induction programme for all newly appointed staff. This covered such topics as infection prevention and control, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions such as diabetes and chronic obstructive pulmonary disease.
- Nursing staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Practice nurses had attended update training where relevant. The GPs also administered vaccines and they told us they stayed up to date with any changes by means of discussion and online resources.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, informal discussions, and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months. However we found that the nurse appraisals were carried out by the practice manager and therefore did not have clinical input.
- Staff received training that included: safeguarding, fire safety awareness, basic life support, equality and diversity and information governance. Staff had access to and made use of e-learning training modules, external and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- From the sample of documented examples we reviewed we found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services. There was also a system to monitor referrals.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Information was shared between services, with patients' consent, using a shared care record. We saw evidence that meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs or safeguarding concerns.

The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances. A unified end of life pathway was used with anticipatory medicines put in place and close working with the local hospice.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff we spoke with understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, GPs carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP assessed the patient's capacity and, recorded the outcome of the assessment.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation and counselling.
- Patients were signposted to local smoking cessation clinics and life style changes were promoted by clinical staff. GPs were able to offer support to patients relating to weight management.

Are services effective?

(for example, treatment is effective)

- There was a self-care noticeboard in the waiting room which held a wealth of information to support patients to help themselves to live healthy lives.

The practice's uptake for the cervical screening programme was 90%, which was better than the CCG average of 83% and the national average of 81%. There was higher than average exception reporting for cervical screening with the practice exception reporting 13% of eligible patients compared to the CCG average of 3.5% and the national average of 6.5%.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were better than the CCG and national averages. For example, rates for the vaccines given to five year olds were 100% in the year 2015-16. There was no comparable data available for under two year olds. However the practice provided us with data for April 2016 to January 2017 which showed that rates for the vaccines given to under two year olds ranged from 89% to 100%.

There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme. Appointments for cervical screening were available with a female sample taker and non-attenders were flagged on their clinical record for discussion. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer and the uptake rate was in line with local and national averages. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.

- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All but one of the ten patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them as individuals and with dignity and respect.

We spoke with two members of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Patient comments reflected that staff were compassionate and supportive.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was well above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 93% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 89% and the national average of 89%.
- 92% of patients said the GP gave them enough time compared to the CCG average of 86% and the national average of 87%.
- 95% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 92% and the national average of 92%.
- 89% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.

- 99% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 92% and the national average of 91%.
- 99% of patients said the nurse gave them enough time compared with the CCG average of 93% and the national average of 92%.
- 100% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 97% and the national average of 97%.
- 99% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 97% of patients said they found the receptionists at the practice helpful compared with the CCG average of 86% and the national average of 87%.

The views of external stakeholders were positive and in line with our findings. We spoke with the manager of a local care home where some of the practice's patients lived and they spoke very positively about the responsiveness and personalised level of care provided by the practice.

Care planning and involvement in decisions about care and treatment

Patient feedback from the comment cards we received indicated that patients 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 available to them. We also saw that care plans were personalised.

Results from the national GP patient survey showed patients responded very positively to questions about their involvement in planning and making decisions about their care and treatment. Results were well above local and national averages. For example:

- 93% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 86% and the national average of 86%.
- 90% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 99% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 91% and the national average of 90%.

Are services caring?

- 96% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that interpretation services were available for patients who did not have English as a first language. Patients were also told about multi-lingual staff who might be able to support them.
- Information leaflets were given to patients about different options regarding their care in order for them to make an informed decision. For example in respect of family planning whether to use an implant or a coil and the pros and cons of different options were discussed.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. Support for isolated or house-bound patients included signposting to relevant support and volunteer services.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified eight patients as carers (0.6% of the practice list). Written information was available to direct carers to the various avenues of support available to them.

A member of staff acted as a carers' lead to help ensure that the various services supporting carers were coordinated and effective. Once carers were identified the lead was responsible for sending them a carers pack which also signposted them to different avenues of support. Information was also available in the waiting room about support for young carers. Until March 2017 the practice had held a monthly carers clinic which carers could attend for an appointment with a Carers Health and Wellbeing Advisor in order to gain advice on resources, help and support available.

Receptionists held conversations with patients whilst in the waiting room and routinely made them aware of the First Contact referral service to access support services, if for example they identified they were experiencing loneliness. If patient consent was given the receptionist made a referral for them.

Staff told us that if families had experienced bereavement, one of the GP partners contacted them and when necessary this was followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- Through its membership of the local GP federation, the need had been identified for patient information and health education events around long term conditions. The practice's patients had been invited to attend these events which were intended to provide them with a greater understanding of their conditions and the support available to them.
- The practice had trialled offering extended hours to accommodate working patients who could not attend during normal opening hours but had found there was a very low uptake and had therefore discontinued it. However telephone consultations were available at times which were convenient to patients.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for patients who had clinical needs which resulted in difficulty attending the practice.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- The practice sent text message reminders of appointments. Additionally if a patient had memory problems which reception were aware of they called the patient on the day of the appointment to remind them.
- When specialist clinic appointments were booked four weeks in advance patients received a telephone reminder two days before the appointment.
- The GP partners contacted patients outside of practice opening hours when they felt it necessary and patients had direct access to one of the GP's mobile phone numbers.

- The practice received and made inter practice referrals with other practices in their federation in order to increase the facilities available locally for patients. For example the practice accepted referrals from other practices for the fitting of an intrauterine device (coil).
- Patients were able to receive travel vaccines available on the NHS as well as some only available privately.
- The practice was situated in a wheelchair accessible single storey building and had a parking area for cars which included disabled parking. There was a hearing induction loop installed for people with impaired hearing and those who used a hearing aid. Interpretation services were also available as well as a number of different languages being spoken by some of the staff.
- The practice were members of the national Dementia Action Alliance and had recently completed 'dementia friends' training to enable all staff to be able to have a greater understanding of and therefore more able to support patients living with dementia appropriately.
- The practice had carried out a Disability Discrimination Act audit to assess accessibility and as a result had identified the need for a door bell outside the practice in order for patients who may be having difficulty accessing the building being able to summon assistance from a staff member. The bell was fitted following our inspection.

Access to the service

The practice was open from 9.00am to 1.00pm and 3.00pm to 6.00pm Monday to Friday with the exception of Thursday when they were open from 9.00am to 12.00pm and closed for the remainder of the day. Appointments were available from 09.00am to 11.30am and from 3.30pm to 6.00pm on Mondays, from 09.00am to 11.30am and from 3.30pm to 5.30pm on Tuesday, Wednesday and Friday and from 09.00am to 11.30am on Thursdays.

In addition to pre-bookable appointments that could be booked in advance, urgent appointments and telephone appointments were also available for patients that needed them. We looked at appointment availability and found that the next available appointments for either an urgent, routine or telephone appointment were that day. Additionally one of the GP partners was always available when the practice was closed and the relevant mobile phone number was available on the practice answer phone message.

Are services responsive to people's needs?

(for example, to feedback?)

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was much higher than local and national averages.

- 89% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 74% and the national average of 76%.
- 100% of patients said they could get through easily to the practice by phone compared to the national average of 73%.
- 98% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 77% and the national average of 76%.
- 100% of patients said their last appointment was convenient compared with the CCG average of 92% and the national average of 92%.
- 96% of patients described their experience of making an appointment as good compared with the CCG average of 72% and the national average of 73%.
- 90% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 60% and the national average of 58%.

With the exception of one, the patient comments we received commented that they were able to get appointments when they needed them.

The practice had a system to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

This was done by gathering information to allow for an informed decision to be made on prioritisation according to clinical need. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait

for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- The practice manager was the designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. There was a complaints poster displayed in the waiting room and leaflets explaining the complaints procedure were available to take away. This included information about advocacy support services. This information was also available via the practice website.

We looked at the three complaints which had been received in the last 12 months and found these were satisfactorily handled in a timely way. We also received a complaint from a patient during our inspection details of which were passed to the practice to deal with in line with their complaints procedure.

Lessons were learned from individual concerns and complaints and action was taken as a result to improve the quality of care. For example, one complaint related to a patient not being happy that they had not been prescribed antibiotics. We saw that the learning was for GPs to explain more thoroughly the rationale for not prescribing antibiotics 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 had a clear vision to deliver high quality care and promote good outcomes for patients.

- The practice had a mission statement which was 'to improve the health, well-being and lives of our patients by providing high quality care in a traditional family GP practice'. This was displayed on the practice website. It was apparent from our discussions with staff that they acted in line with the statement.
- The practice had a clear strategy and supporting business plans which reflected the vision and values and were regularly reviewed.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas.
- Practice specific policies were implemented and were available to all staff. These were updated and reviewed regularly.
- A comprehensive understanding of the performance of the practice was maintained. Practice meetings were held monthly which provided an opportunity for staff to learn about the performance of the practice.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- We saw evidence from minutes of a meetings structure that allowed for lessons to be learned and shared following significant events and complaints.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care.

They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The partners encouraged a culture of openness and honesty. From the sample of documented examples we reviewed we found that the practice had systems to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support and truthful information.
- Incidents were reflected upon, reviewed and shared with relevant organisations.

There was a clear leadership structure and staff felt supported by management.

- The practice held a range of multi-disciplinary meetings including meetings with community nurses, district nurses, mental health facilitators and the local hospice to monitor vulnerable patients. GPs, where required, liaised with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings or informally and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported by each other and the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify and be involved in opportunities to improve the service delivered by the practice.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback from:

- patients through the patient participation group (PPG) and through surveys and complaints received. The PPG

Are services well-led?

Good 

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

met regularly and worked with the practice to improve services. For example as a result of comments made in a survey the practice trialled extended opening hours in an evening to accommodate working patients.

- the NHS Friends and Family test, complaints and compliments received.
- staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management and felt involved in how the practice developed and was run.

Continuous improvement

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. The practice were actively engaged with the local federation which consisted of 13 GP practices.

One of the GP partners had taken a lead role in the federation's involvement in a joint venture with the existing provider to provide the urgent care service locally which was now up and running.

Charnwood Surgery is a training practice but at the time of our inspection did not have any trainee GPs.

The practice took part in research and had also recently participated in a pilot scheme through the federation relating to C-reactive protein (CRP) point of care testing. This involved the practice using a machine to test levels of CRP in patients to determine whether it was appropriate to prescribe antibiotics with the purpose of reducing the unnecessary prescribing of antibiotics.