# Arun Medical Group

## Quality Report

Arun Medical Group
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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 undertook a comprehensive inspection of Arun Medical Group on the 21st January 2015.

The practice has an overall rating of good.

Arun Medical Group provides primary medical services to people living in Littlehampton. The practice boundary encompasses the River Ward and Ham Ward districts. At the time of our inspection there were approximately 7060 patients registered at the practice with a team of two GP partners and a nurse partner. The practice was also supported by three salaried GPs, nurses, an associate practitioner, a healthcare assistant and a team of reception and administrative staff. Arun Medical Group is a training practice.

The inspection team spoke with staff and patients and reviewed policies and procedures. The practice understood the needs of the local population and engaged effectively with other services. There was a culture of openness and transparency within the practice and staff told us they felt supported. The practice was committed to providing high quality patient care and patients told us they felt the practice was caring and responsive to their needs.

Our key findings were as follows:

- GPs had their own patient lists and where possible encouraged continuity of care by patients seeing their named GP.
- Patient feedback about the practice and the care and treatment they received was very positive.
- The involvement of patients in the development of the practice was positive and inclusive.
- There was evidence the practice was listening to its patients and responding to any concerns or suggestions in a timely and effective manner.
- Infection control audits and cleaning schedules were in place and the practice was seen to be clean and tidy.
- The practice had systems to keep patients safe including safeguarding procedures and means of sharing information in relation to patients who were vulnerable.
- Learning from incidents was apparent and we saw good examples of changes made as a result of learning.
- There were a range of appointments to suit most patients' needs.
- Patients with palliative care needs were supported using the Gold Standards Framework.

# Summary of findings

- The practice had the appropriate equipment, medicines and procedures to manage foreseeable patient emergencies.

**Professor Steve Field (CBE FRCP FFPH FRCGP)**
Chief Inspector of General Practice

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe. Emergency procedures were in place to respond to medical emergencies and there was evidence that medical emergencies were reviewed and procedures updated as necessary. The practice had policies and procedures in place to help with continued running of the service in the event of an emergency. The practice was clean and tidy and there were arrangements in place to ensure appropriate hygiene standards were maintained.

**Are services effective?**

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing mental capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs have been identified and planned. The practice was able to demonstrate that appraisals and personal development plans had taken place for all staff. Staff worked with local multidisciplinary teams to provide patient centred care. Patients had a named GP which allowed for continuity of care.

**Are services caring?**

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. During the inspection we witnessed caring and compassionate interactions between staff and patients. Patients had access to local groups for additional support.

# Summary of findings

**Are services responsive to people's needs?**

Good

The practice is rated as good for providing responsive services. Patients reported good access to the practice and continuity of care, with urgent appointments available the same day. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and patients. The practice had arrangements in place to support patients with disabilities. The layout of the building did not enable patients with mobility problems to gain access without assistance, however this was being addressed with plans in place to move the practice to more suitable premises in 2016. Home visits and telephone consultations were available.

**Are services well-led?**

Good

The practice was rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management.The priority for the practice was provision of a high quality, safe service for its patients. The leadership, management and governance of the practice assured the delivery of high quality, patient centred care. The service was proactive and effectively anticipated and responded to change. There were systems in place to monitor and improve quality and identify risk. The practice sought feedback from staff and patients and this had been acted upon. Staff were encouraged to make suggestions for improvement and we saw evidence suggestions were acted on. There was an open culture and staff knew and understood the lines of responsibility and accountability to report incidents or concerns.Staff we spoke with felt valued and were supported through regular meetings with managers, team meetings and appraisals.

# Summary of findings

## The six population groups and what we found

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

**Older people**

Good

The practice is rated as good for the care of older people. Patients had a named GP which allowed for continuity of care. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. Patients were able to speak with or see a GP when needed and although the practice was not always accessible for patients with mobility issues, home visits were available. The practice had a housebound register and those patients had annual reviews. The practice identified patients at risk including those at risk of hospital admissions. Patients living in nursing or care homes were included on the practice admission avoidance register and had an admission avoidance care plan in place. Multidisciplinary meetings were held to discuss patients and the practice worked closely with the proactive care team to plan care accordingly. Clinics were held twice a month where advanced nurse practitioners would visit patients at home and review their condition. Patients over the age of 75 were visited and reviewed following discharge from hospital. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in diabetic and end of life care. It was responsive to the needs of older people, and offered home visits and telephone appointments for patients who found it difficult to get into the surgery. The practice also provided a service to the local nursing homes and provided individual patient reviews according to need. There were arrangements in place to provide flu and pneumococcal immunisation to this group of patients. Clinics included diabetic reviews and blood tests. Blood pressure monitoring was also available.

**People with long term conditions**

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles and were trained in chronic disease management, including asthma, chronic obstructive pulmonary disease (COPD), and diabetes. The practice worked closely with the community diabetic specialist nurse who ran a joint clinic with the practice nurses. Patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. Patients

with palliative care needs were supported and monthly multidisciplinary meetings with the palliative care nurse were held to discuss patients at the end of life. Flu vaccinations were routinely offered to patients with long term conditions to help protect them against the virus and associated illness.

**Families, children and young people**

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children who were at risk. Immunisation rates were relatively high for all standard childhood immunisations. Specific services for this group of patients included family planning clinics, antenatal clinics, post natal checks, teenage sexual health clinics and childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with health visitors at clinical meetings to discuss concerns and child protection issues. Practice staff had received safeguarding training relevant to their role and knew how to respond if they suspected abuse. Safeguarding policies and procedures were readily available to staff and processes to follow were clearly visible on notice boards in staff areas. The practice ensured that children needing emergency appointments would be seen on the day.

**Working age people (including those recently retired and students)**

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. Extended access appointments were available each morning, as were telephone consultations. 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. The practice offered a travel clinic for advice and vaccinations and NHS health checks were offered to patients aged 50-55, having previously offered health checks to the 45-50 age group. Patients could be referred to smoking cessation services and could be supported within the practice by a healthcare assistant. A weight management service was also available.

**People whose circumstances may make them vulnerable**

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. GPs carried out annual health

checks for people with a learning disability and where necessary the practice offered longer appointments for vulnerable patients. Clinical staff had attended training from the locality learning disability health facilitator to better support patients with a learning disability. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. Translation services were available for patients who did not use English as a first language. The practice could not always accommodate patients with a physical disability due to issues with the premises although alternative arrangements could be made, including home visits and plans were in place to move the practice to more suitable premises in 2016. Carers and those patients who had carers were flagged on the practice computer system and when registering with the practice were signposted to the local carers support team. Patients who might have hearing or visual disability were identified when accessing services and signing interpreters were available.

**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). Patients with dementia were flagged on the practice's computer system and had an annual review. Patients with severe mental health needs had care plans where both physical and mental health were assessed as well as annual reviews. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. The practice worked closely with local counsellors, the mental health team and consultants. There were referral processes in place for counselling services and child and adolescent mental health services.

# Summary of findings

## What people who use the service say

Patients told us they were satisfied overall with the practice. Comments cards had been left by the Care Quality Commission (CQC) before the inspection to enable patients to record their views on the practice. We received 42 comment cards which contained positive comments about the practice. We also spoke with three patients on the day of the inspection.

We reviewed the results of the national patient survey from 2013 which contained the views of 109 patients registered with the practice. The national patient survey showed patients were consistently pleased with the care and treatment they received from the GPs and nurses at the practice. The survey indicated that 91% of respondents found the receptionists helpful, 90% were able to get an appointment to see or speak to someone the last time they tried and 96% had confidence and trust in the last GP they saw or spoke to.

The practice had results from a patient survey conducted in 2014/2015 published on their website. The findings indicated that 91% of respondents would recommend the practice to their friends and family and 100% of respondents stated that reception staff were as helpful as they could be.

We spoke with three patients on the day of the inspection and reviewed 42 comment cards completed by patients in the two weeks before the inspection. The patients we spoke with and the comments we reviewed were positive. Comments about the practice included that patients felt that staff were efficient, caring and helpful and that they felt listened to, cared for and respected. Comments also included that reception staff were good and generally appointments were timely and staff would do what they could to accommodate individual needs.

# Arun Medical Group

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector and included a GP specialist advisor, a practice nurse specialist advisor and a practice manager specialist advisor.

## Background to Arun Medical Group

Arun Medical Group offers general medical services to people living in Littlehampton, East Preston, Climping, Lyminster, Wick, Rustington, Kindston Gorse, and Poling, West Sussex. The practice is involved in the education and training of doctors, practice staff and other healthcare professionals. There are approximately 7061 registered patients.

The practice is run by two partner GPs and a nurse partner. The practice was also supported by three salaried GPs, nurses, healthcare assistants a team of receptionists and administrative staff. At the time of our inspection there was no business manager in post, the previous business manager having left their post earlier in the month prior to the inspection.

The practice runs a number of services for its patients including asthma clinics, child immunisation clinics, diabetes clinics, a weight management group, new patient checks and holiday vaccinations and advice.

Services are provided from:

Littlehampton Surgery,18 – 20 East Street, Littlehampton, West Sussex, BN17 6AW

The practice has opted out of providing Out of Hours services to their patients. There are arrangements for patients to access care from an Out of Hours provider.

The practice population has a higher number of patients between 60 and 85 years of age than the national average although on a par with the CCG average. There are a marginally higher number of patients with long term health conditions although this is significantly lower than the previous year. The number of patients with health related problems in daily life is significantly higher than both the national and CCG average.

## 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 was 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 the practice we reviewed a range of information we hold. We also received information from local organisations such as NHS England, Health watch and the NHS Coastal West Sussex Clinical Commissioning Group (CCG). We carried out an announced visit on 21 January 2015. During our visit we spoke with a range of staff, including GPs, practice nurses, healthcare assistants and administration staff.

# Detailed findings

We observed staff and patients interaction and talked with five patients. We also spoke with the chair of the patient participation group (PPG). We reviewed policies, procedures and operational records such as risk assessments and audits. We reviewed 42 comment cards completed by patients, who shared their views and experiences of the service, in the two weeks prior to our visit.

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

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

Good

# Are services safe?

## Our findings

**Safe track record**

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example we saw that a needle stick injury had been reported and this led to a review of policy and reinforcement of practice for all staff.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. The practice had managed incidents and risks consistently over time and so could show evidence of a safe track record over the long term.

**Learning and improvement from safety incidents**

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these. Significant events were a standing item on the clinical meetings agenda. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. For example we saw that a medical emergency that had occurred in the practice had been evaluated with key staff involved, learning from this had led to a review of practice and staff training, for example for administrative staff in accessing emergency equipment.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We tracked four incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result, for example we saw that a review of resuscitation guidelines had been undertaken and that staff had attended cardiopulmonary resuscitation training with an external training provider.

National patient safety alerts were disseminated by the senior nurse via email to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at clinical meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

**Reliable safety systems and processes including safeguarding**

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible and information on action to be taken were visible in office areas.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role (level 3 safeguarding children training). All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern.

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

There was a chaperone policy, which was visible in consulting rooms. A chaperone is a person who can offer support to a patient who may require an intimate examination. The practice policy set out the arrangements for those patients who wished to have a member of staff present during clinical examinations or treatment. All nursing staff, including health care assistants, had been trained to be a chaperone. Some receptionists had also undertaken training and understood their responsibilities when acting as chaperones. All staff undertaking these

duties had received a criminal records check through the Disclosure and Barring Service. We saw there were posters on display within the waiting room which displayed information for patients.

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system, which collated all communications about the patient including clinical summaries, scanned copies of letters and test results from hospitals.

**Medicines management**

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures.

The practice had processes to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. There were no controlled drugs stored at the practice. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse.

There were comprehensive medicines management policies in place. GPs took ownership of their own patient repeat prescription requests and patient medicine reviews were organised in line with the National Prescribing Centre guidance. GPs maintained records showing how they had evaluated the medicines and documented any changes. Where changes were identified the practice liaised with the patient to describe why the change was necessary and any impact this may have. Blank prescription forms were stored securely although there were no formal written processes for recording serial numbers and how they were distributed.

Vaccines were administered by nurses using directives that had been produced in line with legal requirements and national guidance. We saw up to date copies of directives and evidence that nurses had received appropriate training to administer vaccines.

**Cleanliness and infection control**

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. The practice had a contract with an external cleaning company which specified the cleaning requirements and frequencies. We observed that this was checked on a regular basis and any issues that had arisen had been brought to the attention of the cleaning company.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits for each of the last three years and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury, which we saw had been followed when an incident occurred.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms although the sink in one of the treatment rooms where procedures were carried out was not suitable as it was small and part of a vanity unit.

**Equipment**

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. We saw evidence of calibration of relevant equipment and pat testing had last been completed in the past 12 months.

Records showed essential maintenance was carried out on the main systems of the practice. For example, fire alarm systems were serviced in accordance with manufacturers'

instructions. Panic alarms were installed in all consulting and treatment rooms in case of emergency and audible alerts had been added to the computer system so that staff would be aware of emergencies. All staff would respond if a call was raised.

**Staffing and recruitment**

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment requirements policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. Staff showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

**Monitoring safety and responding to risk**

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment.

We saw that any risks were discussed within team meetings. For example, we viewed meeting minutes where a significant event had been discussed.

**Arrangements to deal with emergencies and major incidents**

The practice had arrangements in place to manage emergencies. Records showed that staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, staff shortage and access to the building. We saw that methods to manage risks included the use of multi sites and relocation of services and the use of a 'practice buddy' system so that other practices in the area could be used in an emergency. Senior staff within the practice had copies of business continuity plans at home so that these could be implemented out of hours if necessary.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment**

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were generally familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence and from local commissioners. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines generally, and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

There was an effective system in place for the effective management of patients requiring cervical smear tests. Patients were invited to book an appointment. A system was in place for dealing with abnormal results that included contacting the patient and arranging a follow-up appointment with a GP. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. We saw that learning from educational meetings attended by individual staff was cascaded at practice meetings or through printed information available in staff areas.

The practice used computerised tools to identify patient groups who were on registers. For example, carers, patients with learning disabilities or patients with long term conditions. We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

**Management, monitoring and improving outcomes for people**

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input and review, scheduling clinical reviews and medicines management.

The practice had a system for completing clinical audit cycles. Examples of clinical audits included medication audits that monitored the number of patients who had received appropriate blood tests when on specific medication. We also saw that the practice had audited patient attendance at accident and emergency and had increased the number of emergency appointments available at the practice as a result.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 93.6 % of patients with diabetes had a record of a dietary review by a suitably competent professional in the preceding 12 months. We also noted that 97.1% of patients with rheumatoid arthritis had a face-to-face annual review in the last 12 months and 92.2% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the record, in the preceding 12 months. The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31March who have been reviewed not earlier than 10 days after and not later than 35 days after the date of diagnosis was 63%. The practice met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF (or other national) clinical targets.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed, as a group how they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around quality improvement.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions

Good

# Are services effective?

## (for example, treatment is effective)

such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had a palliative care register and had regular internal as well as monthly multidisciplinary meetings to discuss the care and support needs of patients and their families. There was a lead GP for end of life care and staff were alerted to a patient being on the register so that if the patient contacted the surgery they could respond appropriately. There was also a system in place to ensure up to date patient information and patient wishes was shared with the out of hours service.

The practice provided an enhanced service to patients attending the practice who may require a more multi-disciplined service of care. For example, patients who were most likely to be subject to unplanned hospital admissions. The practice worked closely with the local pro-active team and created care plans with the patient. Patients were also highlighted on the practice computer system so that their care could be prioritised.

The practice also participated in local benchmarking run by the CCG, including benchmarking around dementia, accident and emergency attendance and referral rates. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area.

### Effective staffing

Practice staffing included GPs, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support and safeguarding training. A good skill mix was noted amongst the GPs. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

The nurses at the practice had the necessary skills, qualifications and experience to carry out their role. They were given time to undertake their continuous professional development to enable them to keep up to date with their skill levels. Nurses and healthcare assistants had received appropriate specialist training in delivering the services provided. These included managing patients with long term conditions such as asthma or diabetes, providing immunisations for children and adults, cervical smear testing and smoking cessation advice.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. For example, a healthcare assistant informed us they had increased their hours and had undertaken additional training in phlebotomy, ear syringing and carrying out electrocardiograms (ECGs).

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties.

### Working with colleagues and other services

The practice worked with other service providers to meet patient needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place generally worked well.

The practice held multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs, a cancer diagnosis or children on the at risk register. These meetings were attended by district nurses, health visitors, social workers, and palliative care nurses. Staff felt this system worked well.

Good

# Are services effective?

## (for example, treatment is effective)

### Information sharing

The computerised patient record system was used to record all relevant details about patients on their records. This ensured all staff at the practice had timely information about a person's care and treatment.

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made referrals last year through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

We found that information was being shared appropriately between other healthcare providers and the practice in relation to their patients. The practice used a referral system for patients requiring specialist treatment. Dedicated staff were used to ensure referrals were done in a timely manner and this included the work of a medical secretary in typing up referral letters. We saw an example of a referral letter being sent to a specialist where the patient was then seen nine working days later.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient, System One to record to coordinate, document and manage patients' care. All staff were fully trained on the system.

### Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. They gave examples of how a patient's best interests were taken into account if they did not have capacity to make decisions or understand information. We saw an example of a Deprivation of Liberty Safeguard application in place for a patient who lived in a local nursing home. The practice had drawn up a policy to help staff. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in patient notes.

Patients with a learning disability and those with dementia were recorded on a register and monitored regularly. We saw they were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it). One of the GPs had participated in the year of care course in 2014 where personalised care plans are developed with the individual patient's involvement. We viewed an example of a care plan completed for a patient who lived in a local care home. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting patient consent. The policy provided guidance for staff in relation to the different kinds of consent (implied and expressed), how patients are able to change their mind, where written consent was required and how staff need to ensure patients are aware of the relevant risks, benefits and complications before they consented to treatment. There were forms within the practices computer system which prompted GPs to obtain consent. The consent could then be used when creating care plans and ensuring that shared information was relevant and up to date.

### Health promotion and prevention

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. The practice also offered NHS Health Checks to all its patients aged 40-75. GPs we spoke with told us that regular health checks were offered to those patients with long term conditions and those experiencing mental health concerns. We also noted that medical reviews took place at appropriate timed intervals.

We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, the practice held weight management clinics and pre-diabetic clinic for patients at risk of developing diabetes. The practice would

Good

# Are services effective?

## (for example, treatment is effective)

provide smoking cessation advice on a one to one basis. There were services in place for patient's to be referred to smoking cessation clinics outside of the practice and we saw information about these on posters in the waiting area.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and invited them to yearly annual reviews. The practice had also identified the smoking status and alcohol consumption of patients with a physical or mental health condition. For example, 97.8% of patients with schizophrenia, bipolar affective disorder and other psychoses had a record of their alcohol consumption in the preceding 12 months.

The practice offered a full range of immunisations for children, and flu vaccinations in line with current national guidance. We reviewed our data and noted that 96.6% of children aged below 24 months had received their mumps, measles and rubella vaccination. The practice's performance for cervical smear uptake was 89.2%, which was comparable with other practices nationally. There was a mechanism in place to follow up patients who did not attend screening programmes.

Health information was made available during consultation and GPs used materials available from online services to support the advice they gave patients. There was a variety of information available for health promotion and prevention in the waiting area and the practice website referenced websites for patients looking for further information about medical conditions.

Good

# Are services caring?

## Our findings

**Respect, dignity, compassion and empathy**

Patients completed CQC comment cards to tell us what they thought about the practice. We received 42 completed cards and all were positive about the service experienced. Patients said they felt the practice offered a caring service and staff were efficient, helpful and took the time to listen to them. They said staff treated them with dignity and respect. We also spoke with three patients individually on the day of our inspection and we met with a member of the PPG (patient participation group). All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

We reviewed the most recent GP national survey data available for the practice on patient satisfaction. The evidence from the survey showed patients were satisfied with how they were treated and this was with compassion, dignity and respect. Data from the national patient survey showed that 84% of patients rated their overall experience of the practice as good. 93% of practice respondents saying the GP was good at listening to them and 92% said the last GP they saw or spoke to was good at giving them enough time. We also noted that 96% of patients had responded that they had confidence and trust in the last GP they saw or spoke to and 94% said the same about the last nurse they saw. We also saw that 72% of patients would recommend the practice.

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

We observed staff were careful to follow the practice's confidentiality policy when discussing patient treatment in order that confidential information was kept private. The reception area and waiting room were separate which allowed for greater privacy for patients. We also noted that telephone calls were taken away from the reception desk so staff could not be overheard. Staff were able to give us practical ways in which they helped to ensure patient confidentiality. This included not having patient information on view and asking patients if they wished to discuss private matters away from the reception desk.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

**Care planning and involvement in decisions about care and treatment**

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 88% of practice respondents said the GP involved them in care decisions and 92% felt the GP was good at explaining treatment and results.

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. We saw that patient's with learning disabilities had an annual review. Patients we spoke with 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.

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

**Patient/carer support to cope emotionally with care and treatment**

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The results of the national GP survey showed that 93% of patients said the last GP they saw or spoke to was good at treating them with care and concern and that 87% of patients said the nurses were also good at treating them with care and concern. Patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Good

# Are services caring?

Notices in the patient waiting room and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We saw information was available for carers to ensure they understood the various avenues of support available to them. Staff told us they were made aware of patients or recently bereaved families so they could manage calls sensitively and refer to the GP if needed. We were informed that their usual GP would contact the family and when appropriate advice on how to access support services would be given.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting people's needs**

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from patients. For example, the practice had increased the number of emergency appointments available and had made changes to the way information was communicated as a result of feedback. .

GPs had their own patient lists which enabled good continuity of care. Longer appointments were available for patients who needed them and those with long term conditions. GPs completed telephone consultations each day and home visits could be requested when necessary. Working age patients were able to book appointments and order repeat prescriptions on line. The practice had early morning and evening surgeries for GP and nurse appointments.

Patients experiencing poor mental health were supported by the GPs and local mental health teams. A mental health lead clinician oversaw patients with a diagnosis of depression or severe mental health problems. We saw that the practice had a system of assessing mental capacity and deprivation of liberty safeguards on admission to nursing homes and we viewed one example of this. Patients could be referred to 'time to talk' counsellors as needed and staff were aware of the availability of crisis assessments at the local urgent treatment centre.

The practice had a housebound register. The register ensured the practice was aware when these patients had medicine requests, required home flu jabs, annual reviews or care planning. The practice also supported patients at several care homes. The practice organised a review for each patient on first moving into a local care home and subsequent annual reviews. Named doctors were involved in the day to day provision of care. Staff from two homes the practice supported told us the service they received was good. One staff member told us that GPs would visit patients in the home when asked.

The practice supported patients with either complex needs or who were at risk of hospital admission. The practice worked closely with the local proactive care team which included district nurses, community matron, physiotherapists, occupations therapists and pharmacists. Personalised care plans were produced and were used to support people to remain healthy and in their own homes. Patients with palliative care needs were supported using a multidisciplinary approach. They had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patient and their families care and support needs.

Patients with long term conditions had their health reviewed in one annual review. This provided a joined up service working with the patient as a whole rather than just their individual condition and worked with community matrons, district nurses and proactive care team to provide support. The practice provided care plans for asthma, chronic obstructive pulmonary disease (COPD), coronary heart disease, diabetes, dementia and severe mental health.

Childhood immunisation services were provided through dedicated clinics and administrative support to ensure effective follow up.

**Tackling inequity and promoting equality**

The practice had recognised the needs of different groups in the planning of its services. The number of patients with a first language other than English was low. Staff knew how to access language translation services if these were required.

The practice provided equality and diversity training through an on-line training programme. The practice had policies for equality and diversity and we saw that the service was planned to meet the needs of individuals.

The premises did not meet the needs of people with disabilities. Some patient areas within the practice were situated on the first floor of the building and we observed one patient attempting to take children and a buggy up the stairs. However, we viewed plans for the practice to move premises in 2016 and we saw that patients had been consulted on this and that detailed plans were available in the waiting area of the practice for patients to view. Patients unable to attend the practice were able to be visited by a GP at home.

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

**Access to the service**

Appointments were available from 8.00am to 6.30pm on weekdays. Pre-bookable appointments were available from 7.30am for patients who required earlier appointments. Requests for urgent appointments were dealt with by a telephone triaging system where patients could call from 8am. We were told that appointments via this route were usually gone quickly but that if a patient called with an urgent problem after this then an appointment would be made available to them in person or via the telephone.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for people who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits could be arranged and GPs visited several local care homes for people with dementia, learning, sensory and or physical disabilities.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

We noted data from the national patient survey indicated that 90% of respondents said were able to get an appointment to see or speak to someone the last time they tried and 90% of respondents said the last appointment they got was convenient**.** On the day of inspection we saw that appointments could be booked a few weeks in advance.

**Listening and learning from concerns and complaints**

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

We saw that information was available to help patients understand the complaints There were posters in the waiting room to describe the process should a patient wish to make a compliment. Information was also advertised on the practice website. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at complaints received in the last 12 months and found these were all discussed, reviewed and learning points noted. We saw these were handled and dealt with in a timely way. We noted that lessons learned from individual complaints had been acted on. Staff we spoke with knew how to support patients wishing to make a complaint and told us that learning from complaints was shared with the relevant team or member of staff. The culture of the practice was that of openness and transparency when dealing with complaints and the practice tried to encourage patients to share their opinions. We saw that the patient participation group (PPG) were involved in supporting the practice in evaluating issues raised from concerns and complaints.

# 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 be recognised as a practice that provides high quality holistic patient centred care in a safe, happy and family friendly environment for staff and patients. We found details of the vision and practice values in their statement of purpose. The practice vision and values included the provision of high quality clinical care by suitably skilled and qualified staff and for patients to be treated with dignity, respect and honesty.

We spoke with 9 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. Staff spoke positively about the practice and thought there was good team work with a good level of active support from senior staff. Staff described the culture of the practice as being supportive, positive and open to their suggestions and ideas.

**Governance arrangements**

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. There were paper copies of policies kept. We looked at some of these policies and procedures and found these had been reviewed annually, were up to date and contained relevant information for staff to follow. This included recruitment, medicine management, whistleblowing, complaints, business continuity, chaperoning and infection control.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a GP partner was the lead for safeguarding. We spoke with 9 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, audits in the preceding 12 months included attendance at accident and emergency and medicine audits to ensure the relevant reviews and tests were being carried out.

The practice had robust arrangements for identifying, recording and managing risks. We saw risk assessments, which addressed a wide range of potential issues, such as infection control and fire safety.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. QOF data was discussed at monthly team meetings to maintain or improve outcomes. The practice held regular meetings. We looked at minutes from the most recent meetings and found that performance, quality and risks had been discussed. Clinical audits and significant events were regularly discussed at meetings. Meetings were held which enabled staff to keep up to date with practice developments and facilitated communication between the GPs and the staff team.

**Leadership, openness and transparency**

We saw from minutes that team meetings were held regularly and there were regular management / clinical meetings. Staff told us there was an open culture within the practice and they were happy to raise issues and felt encouraged to do so. There were three practice away days held each year where partners would meet to review the business plan and discuss issues.

We saw there were a number of human resource policies and procedures in place to support staff, including equality and diversity, complaints and whistleblowing. Staff were aware of the whistle blowing policy. They told us they knew it was their responsibility to report anything of concern and knew the GP partners would take their concerns seriously and support them. Staff we spoke with knew where to find these policies if required. The business manager had left their post just prior to our inspection and a replacement had yet to be appointed.

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

The practice had gathered feedback through patient surveys, complaints and feedback. There was an active patient participation group (PPG) in operation. The PPG included representatives from a number of population groups and they met four times a year. A representative from the group told us they had been actively involved in discussions about the relocation plans for the practice. They told us they had participated in gaining the views of patients and fundraising for equipment for the practice.

# Are services well-led?

Good

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

The PPG had been involved in the analysis of patient surveys. We looked at the results of the annual patient survey from March 2014. The survey had been completed by 67 patients. We noted that 91% of patients who completed the survey would recommend the practice to their friends and family. There were comments received about the shortage of nurses in the practice. The practice addressed this issue by recruiting a new chronic disease nurse and training up another new nurse to become a practice nurse.

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

**Management lead through learning and improvement**

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place and included personal development plans. Staff told us that the practice was very supportive of training and that they had regular training either organised with the local clinical commissioning group or by the practice.

The practice was a GP training practice and supported new final year medical students and foundation doctors.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients and staff. For example, we noted that staff across a range of roles had been involved in reviewing practice and policy following a medical emergency in the practice.