Callowland Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Callowland Surgery on 19 May 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for older people, people with long term conditions, families with young children, working age people, those whose circumstances make them vulnerable and those suffering with mental health problems.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- The practice had policies and procedures in place to govern its activities.
- The practice was carrying out clinical audits to help them monitor and improve the quality of care given.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that 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.

Summary of findings

- 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.

We saw one area of outstanding practice:

- The practice had a carers' champion who assisted patients in many ways including accessing convenient appointment times and assisting carers with obtaining respite support.

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

Importantly the provider should:

- Document infection control audits and ensure all staff receive role specific infection control training.

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. The practice did not have a standardised reporting template but all the documentation we saw was clearly and comprehensively written. 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. Staff had been trained to recognise signs of abuse and were able to demonstrate how they put this into practice. Medicines and vaccines were stored appropriately and were safe to use. There were enough staff to keep patients safe.

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 and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Patients were referred to a local gym to help them with weight management. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams. Audits had been completed to improve the quality of care delivered by the practice.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice comparably to 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 for patients about the services available was easy to understand and accessible. The practice had an identified carers' champion to assist patients with caring responsibilities. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to

Summary of findings

secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had extended opening hours three days per week. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders. All staff had received equality and diversity training.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. The vision was documented in the practice leaflet and the staff handbook. 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 practice had a number of policies and procedures to govern activity. The practice held regular staff meetings and all staff members were encouraged to contribute to these. There were systems in place to monitor and improve quality and identify risk. The practice sought feedback from staff and patients, which it acted on. The practice did not have a patient participation group (PPG) but did act on feedback it received from patients. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. 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 dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

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 in chronic disease management and patients at risk of hospital admission were identified as a priority. There was a lead GP to support patients with diabetes. 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.

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 living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard 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 midwives and health visitors All staff had a knowledge of Gillick competencies. Pro-active chlamydia screening took place and there was a system to provide free condoms on request.

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

Summary of findings

care. Extended opening hours were available three days a week to enable attendance outside of working hours. 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.

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. It had carried out annual health checks for people 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.

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 regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

Patients completed CQC comment cards to provide us with feedback on the practice. We received 47 completed cards and they were all positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were caring and understanding. They said staff treated them with dignity and respect. Some of the cards mentioned staff members by name and gave examples of the good care they had received.

We spoke with five patients on the day of the inspection and they were all satisfied with the care they received from the practice.

The data from the National Patient Survey 2014 was reviewed. The practice scored well with 80% of patients stating the last GP they saw or spoke to was good at treating them with care and concern and 91% stated they had confidence and trust in the last GP they saw or spoke to.

Areas for improvement

Action the service SHOULD take to improve

Document infection control audits and ensure all staff receive role specific infection control training.

Outstanding practice

The practice had a carers' champion who assisted patients in many ways including accessing convenient appointment times and assisting carers with obtaining respite support.

Callowland Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector. The team included another CQC inspector, a GP and a practice manager acting as specialist advisors.

Background to Callowland Surgery

The Callowland Surgery provides a range of primary medical services to the residents of Watford. The practice was founded over 100 years ago and has been in its current purpose built location for 25 years.

The practice population is of mixed ethnic background and national data indicates that the area is one of lower deprivation. The practice has approximately 11000 patients and provides services under a general medical services contract (GMS).

There are five GP partners who run the practice, three female and two male and they employ three salaried GPs, all female. The nursing team consists of four practice nurses and a phlebotomist. There are a number of reception and administration staff led by a practice manager and deputy practice manager. The practice is a training practice and currently has one trainee GP.

The practice is open between 8am and 6.30pm Monday to Friday and offers extended opening on Monday until 8pm and from 7.20am Tuesday and Thursday.

When the practice is closed out-of- hours services are provided by Herts Urgent Care and can be accessed via NHS 111.

Why we carried out this inspection

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

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

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

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions

Detailed findings

- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 19 May 2015. During our visit we spoke with a range of staff including the practice and deputy practice manager, GPs, nurses, reception and administration staff. We spoke with patients who used the service and we observed how people were dealt with by staff during their visit to the practice. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and 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.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. This showed the practice had managed these 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. We reviewed records of 10 significant events that had occurred during the last year and saw this system was followed appropriately. Significant events was a standing item on the practice meeting agenda and a dedicated meeting was held annually to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

The practice did not have a standard significant event form. If an event was identified the staff member documented it and send to the practice manager. We viewed the documentation for significant events that had occurred in the past year. All of the events were documented in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared, for example a breach of confidentiality had resulted in additional staff training on confidentiality and responsibility. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were disseminated by the practice manager 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 practice 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. All the clinicians had laminated sheets with the contact details and they were recorded on a whiteboard in the reception area.

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil this role. Most of the staff we spoke with were aware who the lead was and who to speak within the practice if they had a safeguarding concern. Some of the reception staff were not aware of the lead's name but all said they would discuss concerns with a more senior member of staff. We saw evidence of a concern that a member of the reception team had raised, documentation had been completed and appropriate action had been taken to safeguard the patient.

There was a system to highlight vulnerable patients on the practice's electronic records. The records were maintained by the clinicians and required codes were entered to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. This included information to make staff aware of any relevant issues when patients attended appointments. There was active engagement in local safeguarding procedures and effective working with other

relevant organisations. We saw minutes of meetings where vulnerable patients were discussed. If children did not attend the practice for their immunisations the health visitor was informed to follow this up with the family.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms and on the practice web site. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff had been trained to be a chaperone. Reception staff acted as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. The reception staff undertaking chaperone duties had not received Disclosure and Barring Service (DBS) checks. (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). However we reviewed the chaperone policy and it clearly stated that the chaperone would not be left alone with the patient and would leave the room if the clinician did.

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 policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw evidence that the nurses had received appropriate training and been assessed as competent to administer the medicines referred to under a PGD. Two members of the nursing staff were qualified as independent prescribers and they received regular supervision and support in their role as well as updates in the specific clinical areas of expertise for which she prescribed.

Cleanliness and infection control

We observed the premises to be visibly 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.

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. Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. For example, reception staff informed us they wore disposable gloves when handling specimens, this was witnessed on the inspection. The nursing staff informed us that they used disposable aprons when treating patients. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The nursing staff were responsible for infection control within the practice. They had all received infection control training. One of the nurses informed us that they had recently carried out an infection control audit but there was no documentation of this. The nurse was able to describe her findings and we saw evidence of actions taken, for example, the removal of pillow covers and blankets and the introduction of disposable paper items instead. We also saw there was evidence that the practice was implementing good infection control practice, for example

elbow taps, pedestal bins and laminate flooring were in use in the clinical areas. We found that some practice staff had not received infection control training but when questioned they were all able to demonstrate an understanding of infection control pertinent to their role.

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

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients. The practice had undertaken a risk assessment for legionella in 2013 and carried out the actions that had been identified. An external company did a further risk assessment this year and no further actions were identified.

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 which was March 2013. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer. These had all been calibrated in May 2015.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We looked at five staff files and found they 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 the appropriate DBS checks.

The practice also had a locum appointment protocol to ensure the same checks were made for temporary staff. This protocol contained details of the locum pack that was issued that gave information about the practice and its procedures.

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. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. We were informed that most of the staff worked part time hours which enabled them to be flexible when covering for each other.

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. The practice manager showed us records to demonstrate that actual staffing levels and skill mix met 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 regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. The practice manager was identified as the health and safety representative. We saw there was a health and safety file for staff to refer to. This included information on accident and incident reporting and work station risk assessments.

There was no formal risk log but within the health and safety file areas of risk had been identified and mitigating actions recorded to reduce and manage these. The meeting minutes we reviewed showed risks were discussed at practice meetings.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When

Good

Are services safe?

we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date.

Emergency medicines were easily accessible to staff 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. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included floods, power failure and breakdown of telephone systems. It also identified temporary premises that could be used if needed. The document contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed and contact details of other GP practices within the local area. The plan was last reviewed in March 2015.

The practice had carried out a fire risk assessment in April 2015 that included actions required to maintain fire safety. Records showed that staff were up to date with fire training. It had been identified in the fire risk assessment that regular fire drills were required. In response to this the practice had recently carried out a fire drill and plans had been put in place for future 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 familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

We discussed with the GPs how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff. We saw minutes of clinical meetings which showed this was then discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They informed us that they used their clinical skills and experience to provide the patient with a range of treatment options. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed that this happened.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma. One of the GPs was also a qualified dentist and led in oral medicine. The practice nurses supported the work of the GPs and were trained to manage patients with long term conditions such as chronic obstructive airways disease (COPD) and diabetes. They were also trained to treat leg ulcers with compression bandaging, a skilled procedure to help improve circulation in the legs. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital their discharge letter was reviewed using the same tool to identify those with complex needs at risk of readmission. Any patients that required a care plan were referred to their GP for one to be implemented. The GPs would follow up all discharged patients with a telephone call, home visit or consultation as required ensuring that all their needs were continuing to be met.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Information about patients' care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice showed us five clinical audits that had been undertaken in the last year. Two of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. One of the audits was on the prescribing of a specific antibiotic. The practice had a higher than average prescribing rate for this antibiotic compared to other practices in the CCG area, but this had improved as a result of the audit. Learning had been identified; this included sharing local guidelines on prescribing with new GPs joining the practice. Another audit had been undertaken to ensure that all patients receiving a medication for the treatment of mental health conditions had received regular blood tests and reviews. We saw that an action plan had been put in place to increase the monitoring of these patients and a re-audit was planned to ensure the practice's improved

Good

Are services effective?

(for example, treatment is effective)

performance in this area. The practice had completed an audit to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and National Institute for Health and Care Excellence guidance.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures).

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets, It achieved 96% of the total QOF target in 2014, which was above the national average of 94%. Specific examples included:

- Performance for diabetes related indicators was similar to the national average.
- The percentage of patients with hypertension having regular blood pressure tests was similar to the national average
- Performance for mental health related and hypertension QOF indicators was similar to the national average.
- The dementia diagnosis rate was comparable to the national average
- The percentage of patients diagnosed with dementia who have had a face to face review in the previous 12 months was above the national average.

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 how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

The practice's prescribing rates were also similar to national figures. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. One of the GPs was a prescribing lead and managed medication alerts received by the practice and disseminated the information to the clinical staff. They informed us of a recent example of a medication administering device that had been recalled due to a fault in manufacture and the appropriate action that had been taken. The practice used an IT system that flagged up relevant medicines alerts when the GP was prescribing medicines.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. In addition to practice staff these meetings were attended by community nurses, health visitors and Macmillan nurses.

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups for example patients with learning disabilities and those with poor mental health. Structured annual reviews were also undertaken for people with long term conditions such as diabetes, asthma and COPD.

One of the GPs was a clinical lead in the local CCG and therefore the practice took part in all CCG initiatives. The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending essential training courses such as annual basic life support. We noted a good skill mix among the GPs with a number having additional diplomas in sexual and reproductive medicine, children's health, family planning and obstetrics. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented.

Good

Are services effective?

(for example, treatment is effective)

Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example the practice nurses had received training in cervical cytology and vaccine administration. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a GP partner throughout the day for support. We spoke with a trainee on the day of the inspection who was positive about the support they received.

Practice nurses had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles for example seeing patients with COPD and diabetes were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the NHS 111 service both electronically and by post. Staff informed us that letters received by post were scanned onto the electronic system on the day they were received. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues that arose from these communications. Out-of hour's reports, NHS 111 reports and pathology results were all seen and acted on by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actions taken on the day of receipt and all within five days of receipt. 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 worked well.

Emergency hospital admission rates for the practice were relatively low at 11% compared to the national average of 14%. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for acting on hospital communications was working well in this respect.

The practice held multidisciplinary team meetings every two weeks to discuss patients with complex needs. For example, those with end of life care needs or children on the at risk register. These meetings were attended by community nurses, health visitors and palliative care nurses and decisions about care planning were documented in a shared care record. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

Information sharing

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.

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency. The practice had also signed up to the electronic Summary Care Record (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours). Patients had access to the Summary Care Record online. Patients without internet access could attend the practice and ask for a printed copy of their record. The practice informed us of their plans to install a computer terminal in the waiting room for these patients to print their own summary if they wished.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. The practice had a consent policy that highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Good

Are services effective?

(for example, treatment is effective)

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. 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 the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, all patients needed to sign a consent form and have a discussion with the GP about possible complications such as scarring and pain. Documentation of the discussion and the consent form were kept in the patient's electronic record. We were shown an audit that confirmed the consent process for minor surgery had being followed in 99% of cases.

Health promotion and prevention

It was practice policy to offer a health check 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. We noted a culture among the GPs and nursing staff to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 15 to 25. The nursing staff informed us that condoms were provided on request to promote sexual health. We saw a system in place that enabled patients to hand in a yellow card which allowed them to request this service discreetly. The reception staff were trained to know what the cards meant and could provide the service preventing embarrassment to patients if the reception was busy.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 698 patients in this age group had taken up the offer of the health check.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had identified the smoking status of 97% of patients over the age of 16. The practice nurses were trained to give smoking cessation advice but due to staffing levels they did not have capacity to offer this service. They did however signpost patients to a local pharmacy for smoking cessation advice. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. One of the nurses informed us that they would refer obese patients to a local gym where they could get reduced subscription rates if the patient wished. They showed us how they had done this recently for one of their patients.

The practice's performance for the cervical screening programme was 76%, which was slightly below the national average of 81%. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was above average for the majority of immunisations where comparative data was available. For example:

- Flu vaccination rates for the over 65s were 74%, and at risk groups 55%. These were similar to national averages.
- Childhood immunisation rates for the vaccinations given to under twos ranged from 92% to 98% and five year olds from 88% to 93%. These were comparable to the CCG averages.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2014.

The evidence from this survey showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated above the national average for patients who rated the practice as good or very good. The practice was average for most of its satisfaction scores on consultations with doctors and nurses. For example:

- 90% said the GP was good at listening to them compared to the CCG average of 88% and national average of 87%.
- 91% said they had confidence and trust in the last GP they saw compared to the CCG average of 93% and national average of 92%.
- 78% said the GP gave them enough time which was below average compared to the CCG average of 86% and national average of 85%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 47 completed cards and they were all positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were caring and understanding. They said staff treated them with dignity and respect. Some of the cards mentioned staff members by name and gave examples of the good care they had received. In addition to the positive comments two of the cards remarked that they sometimes experienced difficulty in getting an appointment. We also spoke with five patients on the day of our inspection all of whom told us they were satisfied with the care provided by the practice. They said the GPs, nurses and reception staff were always polite and they were treated sensitively and with respect. One patient commented that they were given time during consultations to ask questions. Another patient informed us they were always offered a chaperone for intimate examinations.

On the day of the inspection we observed staff speaking with patients in a respectful way. We saw that the GPs and nurses came out of their consulting rooms into the waiting room to politely call the patients by name for their appointment.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private. The patient waiting area was visible to the receptionists but away from the front desk this again helped to maintain confidentiality. There was also an electronic check in system, available in different languages, for patients to bypass the reception desk. The reception staff informed us that there were two rooms available to take patients to if they requested to speak to someone in private. They also said that they would go round to the front of the reception desk to speak to patients using wheelchairs. Additionally, 88% of respondents to the national patient survey 2014 said they found the receptionists at the practice helpful compared to the CCG average of 88% and national average of 87%.

There was a clearly visible notice on the reception desk stating the practice's zero tolerance for abusive behaviour. Receptionists told us they would refer to this to help them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed the practice scored slightly below average on questions about patient's involvement in planning and making decisions about their care and treatment. For example:

- 72% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 82% and national average of 82%.

Good

Are services caring?

- 69% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 74% and national average of 75%.

However patients we spoke to on the day of the inspection and the comments cards we received indicated a more positive response with patients stating they were given time to ask questions about their treatments and their views about treatments were listened to. Patients described having choices and treatment options explained to them.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the consulting rooms informing patents this service was available. A signing service was also used for those patients with hearing difficulties.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients rated the practice slightly below average when responding to questions about the emotional support provided. For example:

- 79% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 83% and national average of 83%.
- 70% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 75% and national average of 78%.

The patients we spoke with on the day of our inspection and the comment cards we received were more positive. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, on the TV screen 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. Eighty patients within the practice had been identified as carers. There was a carers' notice board in the waiting area with information to ensure carers understood the various avenues of support available to them. The practice had a carers' champion who assisted patients in many ways including accessing convenient appointment times and assisting carers with obtaining respite support. We saw the practice had a carer's protocol and this identified who the carers' champion was.

Staff told us that if families had suffered a bereavement, their usual GP contacted them to offer support and direct them to bereavement support services. The GP would make a decision whether it was appropriate for the practice to send a condolence card. An alert was placed on the electronic notes of close relatives so if they needed to attend the practice they were treated sensitively.

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 patient'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 NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. The practice manager informed us that the practice was part of a cluster of practices in the local area that shared good practice and information. One of the GPs attended Local Medical Committee (LMC) meetings and gave feedback from these to the practice.

The practice did not have a patient participation group (PPG) and had not done any patient surveys recently. There was information on the practice website for patients to join an online patient reference group to provide feedback to the practice and participate in surveys. They informed us this was an area they were going to develop in the future. The practice did however have feedback forms available in the reception area for patients to complete. We saw in response to feedback from patients the practice had made changes to appointment times and availability. This helped reduce waiting times for patients in the practice and ensured those patients requiring a same day urgent appointment were either seen or had a telephone consultation.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities and those with long term conditions. These were identified by an alert on the electronic patient record informing the reception staff that a longer appointment was required. The practice population was of mixed ethnicity and access to translation services were available if they were needed.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties; there was a ramp and wide doors at the entrance and all the consulting rooms were on the ground floor. The practice manager informed us that they had applied for funding to have electronic doors fitted at the entrance. The application had been unsuccessful but the practice had installed a call bell on the door so patients could ring for assistance. The reception staff also informed us that they could see the front entrance from their desk and would assist patients as required. There were access enabled toilets and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence. In response to feedback from patients a 'buggy area' had been created for parents to leave pushchairs to avoid taking them into consulting rooms.

Staff told us that they did not have any patients who were of "no fixed abode" as these patients were directed to a local GP practice that provided focussed, specialist services for homeless and disadvantaged people. There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

The practice provided equality and diversity training. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months.

Access to the service

The surgery was open for appointments from 8am to 6.30pm Monday to Friday. It offered early morning appointments from 7.20am on Tuesdays and Thursdays and evening appointments until 7.20pm on Mondays. All patients contacting the practice for an emergency appointment before 11am would be seen and those contacting the practice after this time would be offered a telephone triage with a GP who would make an appointment for the patient the same day if required.

Comprehensive information was available to patients about appointments on the practice website. This included 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 and could be accessed via the NHS 111 service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse.

The patient survey information we reviewed showed how patients responded to questions about access to appointments and rated the practice below average in these areas. For example:

- 73% were satisfied with the practice's opening hours compared to the CCG average of 75% and national average of 76%.
- 62% described their experience of making an appointment as good compared to the CCG average of 76% and national average of 74%.
- 44% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 65% and national average of 65%.
- 62% said they could get through easily to the surgery by phone compared to the CCG average of 73% and national average of 72%.

The practice informed us that they had made changes to their appointment times in response to the survey and some staff members now had longer appointment slots to reduce the waiting times experienced within the practice.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be with their GP of choice. Routine appointments were available for booking six weeks in advance.

During the winter of 2014 the practice opened every Saturday morning. They applied for additional money from the Winter Pressure Fund (money made available by the government to relieve pressure on A&E services throughout the winter months). This enabled the practice to provide a service for patients who may otherwise have attended A&E.

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 system on the practice website and in the patient information booklet. There were also forms available in the reception area for patients to complete if they wished to make a complaint. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at 19 complaints received in the last 12 months and found they had been satisfactorily handled in a timely way. Apologies had been made to patients when necessary and learning and action points had been identified.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result. We saw from minutes of team meetings that complaints were discussed with staff.

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 within a safe and nurturing environment. We found details of the vision and practice values were documented in the patient information booklet. This was available online and could be viewed in the reception area. The practice vision and values included that they would treat all patients and each other with equality, dignity and respect. It also said they would strive to work in partnership with the patients and welcome their involvement to influence the practice's development

We spoke with 10 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these and had been involved in developing them.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff in a folder behind the reception area. We looked at 15 of these policies and procedures and noted they had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, a GP was the lead for prescribing and another GP was the lead for safeguarding. We spoke with 10 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 used the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice also 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, we saw audits relating to prescribing, minor surgery and emergency admissions. Evidence from other data from sources, including incidents and complaints were used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG.

The practice had arrangements for identifying, recording and managing risks. Risks and mitigating actions were documented within the policies and procedures. We saw from minutes of meetings that risks were discussed and learning shared within the practice.

The practice manager and the deputy practice manager were responsible for human resource policies and procedures. We reviewed a number of policies, including the disciplinary, induction and equal opportunities policies which were in place to support staff. We were shown the staff handbook that was issued to all staff on employment. This included information on the practice vision and values and informed staff of the policies in place to support them, for example, bullying and harassment and whistleblowing. Staff we spoke with knew where to find these policies if required.

Leadership, openness and transparency

The GP partners were visible in the practice and staff told us that they were approachable and always take the time to listen to all members of staff.

We saw from minutes that team meetings were held every six weeks and were attended by reception, administration and nursing staff. Two of the GP partners also attended these meetings. The practice manager informed us there was an open agenda that staff could contribute to. Staff confirmed there was an open culture within the practice and they had the opportunity to raise any issues at team meetings, felt confident in doing so and supported if they did.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. They had gathered feedback from patients through feedback forms and complaints received. The practice did not have a patient participation group (PPG) but there was information on the practice website for patients to join an online patient reference group to

Are services well-led?

Good

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

provide feedback to the practice and participate in surveys. No recent surveys had been completed however the practice informed us this was an area they were going to develop in the future.

We also saw evidence that the practice had reviewed their results from the national GP survey to see if there were any areas that needed addressing.

The practice had also gathered feedback from staff through appraisals and team meetings Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. The practice informed us they had a low turnover of staff and all staff we spoke with were happy in their roles.

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 five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff training days where guest speakers and trainers attended.

The practice was a GP training practice; they trained newly qualified doctors and GP registrars, experienced doctors undergoing additional training to become a GP.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients. We looked at minutes of meetings that confirmed this.