Lockfield 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?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Lockfield Surgery, with a visit to the branch site, Raynor Road Surgery on 12 May 2015. Overall the practice is rated as Good.

Specifically, we found the practice to require improvement for providing safe services. It was good for providing an effective, caring, responsive and well led service. It was also good for providing services for older people; people with long-term conditions; families, children and young people; working age people; people whose circumstances may make them vulnerable and people experiencing poor mental health.

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

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Patients' needs were assessed and the practice planned and delivered care following best practice guidance.
- The practice had a well-established and well trained team with expertise and experience in a range of health conditions. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- Lockfield Surgery was clean and hygienic and had arrangements for reducing the risks from healthcare associated infections. The practice had good facilities and was well equipped to treat patients and meet their needs.
- Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe, the practice did not have a process in place for the testing of fire alarms and fire drills and fire risk was not assessed in the practice.

Summary of findings

- The practice had identified that the branch site was no longer a suitable premises at which to deliver care and treatment and had plans in place to relocate during July 2015.
- Data showed patient outcomes were average for the locality.
- Information about services and how to complain was available and easy to understand.
- The practice had recognised that internal communication processes was an area which they needed to develop and improve.

The areas where the provider must make improvements are:

- Ensure fire risk is assessed and document fire risk assessments within the practice.

In addition the provider should:

- Ensure a consistent process is applied to recording fridge temperatures.
- Improve internal communication and consider introducing regular meetings involving the whole practice team, ensuring there are mechanisms in place to seek feedback from staff . This would provide opportunities to share information learning from significant events and complaints.
- Routinely document attendance and input at internal and external meetings.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong, lessons learned were not communicated widely enough to support improvement. We found that the logging of the fridges' temperature ranges were not consistent and there were some gaps in the temperature recording. We raised this with the practice on the day and staff told us they would address this by ensuring there was always a staff member on duty to take ownership of logging the fridge temperatures. Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. For example, the practice did not have a process in place for the testing of fire alarms and fire drills and fire risk was not assessed in the practice.

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 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 capacity and promoting good health. 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.

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.

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

Summary of findings

NHS England Area Team and Clinical Commissioning Group (CCG) to 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 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 with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a vision, strategy and a leadership structure in place. Staff told us they knew how to report concerns and who to report them to however, some staff told us they did not feel valued or supported at times. Staff we spoke with told us that they would like to have staff meetings on a regular basis rather than opportunistically, this was a theme we picked up throughout the day from various staffing areas. When the practice did host and attend meetings, agendas and minutes were not routinely produced to support the meetings; this included practice staff meetings, governance meetings and multidisciplinary meetings. The practice manager was aware that documenting the practice meetings could be improved and the practice had plans in place in order to start formally documenting their meetings. The practice sought feedback from patients and had an active patient participation group (PPG).

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

Requires improvement

The practice was rated as good for effective, caring, responsive and well led overall and this includes for this population group. The practice was rated as requires improvement in the domain of safe. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice is rated as requires improvement 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 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

Requires improvement

The practice was rated as good for effective, caring, responsive and well led overall and this includes for this population group. The practice was rated as requires improvement in the domain of safe. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice is rated as requires improvement for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management. 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

Requires improvement

The practice was rated as good for effective, caring, responsive and well led overall and this includes for this population group. The practice was rated as requires improvement in the domain of safe. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice is rated as requires improvement 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. Childhood Immunisation rates

were in line with regional immunisations rates. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were also available outside of school hours.

Working age people (including those recently retired and students)

Requires improvement

The practice was rated as good for effective, caring, responsive and well led overall and this includes for this population group. The practice was rated as requires improvement in the domain of safe. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice is rated as requires improvement 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. The practice offered a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Requires improvement

The practice was rated as good for effective, caring, responsive and well led overall and this includes for this population group. The practice was rated as requires improvement in the domain of safe. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice staff told us that they 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)

Requires improvement

The practice was rated as good for effective, caring, responsive and well led overall and this includes for this population group. The practice was rated as requires improvement in the domain of safe. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE. It had a system in place to

Summary of findings

follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Most staff had received training on how to care for people with mental health needs.

Summary of findings

What people who use the service say

All of the eight patients we spoke with on the day of our inspection were complimentary about the care and treatment they received. Patients told us the staff were efficient, caring and respectful. Patients told us that clinical staff listened well and gave good advice. Patients told us that their confidentiality was well maintained however some patients told us that they were sometimes interrupted by other staff members during nurse consultations.

We reviewed the 35 patient comments cards from our Care Quality Commission (CQC) comments box that had been placed in the practice prior to our inspection. We saw that most comments were positive. One comment card was completed by a long term patient from the practice who described the clinical care as outstanding. Three comments were less positive and commented that sometimes it could take a while to get through on the surgery phone line. The practice had recognised the need to free up the practice phone line for patients who wished to book an appointment and staff told us that the changes to the process for requesting repeat prescriptions had a positive impact for patients who needed to call the practice to make an appointment.

We spoke with representatives from two of the care homes that the practice provided primary medical services to. They told us that the practice responded quickly to a request for a patient to be seen at the home.

The results from the latest National Patient Survey, published in January 2015 showed that 73% of respondents said that their overall experience of the practice was good or very good.

Areas for improvement

Action the service MUST take to improve

Ensure fire risk is assessed and document fire risk assessments within the practice.

Action the service SHOULD take to improve

Ensure a consistent process is applied to recording fridge temperatures

Improve internal communication and consider introducing regular meetings involving the whole practice team, ensuring there are mechanisms in place to seek feedback from staff . This would provide opportunities to share information learning from significant events and complaints.

Routinely document attendance and input at internal and external meetings.

Lockfield Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The lead inspector was accompanied by a GP specialist advisor and a second CQC inspector.

Background to Lockfield Surgery

Lockfield Surgery is situated in Walsall. Lockfield Surgery has a branch surgery called Raynor Road Surgery which is situated approximately four miles away in Wolverhampton. We visited both sites during our inspection.

The historic roots of Lockfield Surgery date back for over 85 years, with the original practice starting well before 1920. The practice building is purpose built and occupies two floors, with treatment areas on the ground floor. The building has car parking, with allocated spaces and access for those with a disability. The practice joined with Raynor Road Surgery in July 2013 and has plans to relocate the surgery to nearby modern health centre which is more suited to people's needs and easily accessible for people who use the service, including people with disabilities.

There are just over 13,200 patients of all ages registered and cared for at the practice. Patients can be seen at Lockfield and Raynor Road surgeries and staff work consistently across the two sites.

The practice team consists of four female and three male GPs, a healthcare assistant and five nurses including three nurse practitioners, a senior nurse practitioner and prescriber. The administrative team take care of the day to day running of the practice and consist of a practice manager, a practice manager assistant and 18 reception/ secretarial team members.

The practice is a training practice for trainee GPs and medical students to gain experience and higher qualifications in General Practice and family medicine.

The practice opening times are 8am to 6.30pm on weekdays except for Wednesdays when the practice closes at 1.pm. The practice offers extended hours on Saturdays from 10am to 1pm twice a month. Patients can book appointment over the phone, online and in the practice. The practice does not routinely provide an out-of-hours service to their own patients but they have alternative arrangements for patients to be seen when the practice is closed.

The practice holds a General Medical Services contract with NHS England and has expanded its contracted obligations to provide enhanced services to patients. An enhanced service is above the contractual requirement of the practice and is commissioned to improve the range of services available to patients. The increased range of services provided includes minor surgery, insertion of contraceptive devices and phlebotomy (taking of blood samples).

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 the service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check

Detailed findings

whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

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

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

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

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

Before carrying out our inspection, we reviewed a range of information that we held about the practice and asked other organisations to share what they knew. Prior to our inspection we spoke with two representatives from two of the seven care homes where the practice provides care for older people.

We carried out an announced inspection on 12 May 2015 at the practice. During our inspection we spoke with a GP partner; an associate GP; a GP registrar; four nurses; a health care assistant and a pharmacist who worked with the practice. We also spoke with three receptionists and four administrative staff across the two sites, as well as the practice manager and eight patients. We spoke with two members of the patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. We observed how patients were cared for. We reviewed 35 comment cards where patients and members of the public shared their views and experiences of the service.

Requires improvement

Are services safe?

Our findings

Safe track record

We reviewed safety records and incident reports dating back to March 2014 to show that the practice had managed them consistently over time. The practice used a range of information to identify risks and improve patient safety including 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 an incident concerning confidentiality had occurred whereby a letter was sent to a patient and the label used to address the envelope contained the patient's date of birth and NHS number. We saw that appropriate action had been taken and the issue was raised as a significant event. The practice acted immediately by addressing the error with the staff member concerned and further steps were taken by providing some in house training to prevent any reoccurrence.

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 12 months and we were able to review these.

Staff told us that significant events were occasionally discussed on a regular basis and during practice meetings. However, the practice did not document their meetings and therefore were unable to evidence that significant events formed part of the agenda for practice meetings. Staff told us that learning from incidents and significant events were occasionally discussed during practice meetings however the practice did not produce minutes to support these meetings. The practice manager was aware that documenting the practice meetings could be improved and the practice had plans in place in order to start formally documenting the meetings moving forward.

Staff used incident forms on the practice's shared drive and sent completed forms to the practice manager. We tracked seven significant events 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 significant event concerning the administration of an incorrect vaccine had occurred at the practice. We saw that appropriate action had been taken and the issue was raised as a significant event. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken. We saw evidence on the significant event log to show that the incident in question had been discussed with the local hospital and findings shared with all clinical staff. The staff member concerned also attended further training.

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.

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 safeguarding concerns and how to contact the relevant agencies both in and out of normal working hours. Contact details were easily accessible and on display at Lockfield Surgery and at the branch site, Raynor Road Surgery.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained to an appropriate level to enable them to fulfil this role. All staff we spoke with were aware who these leads were 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.

The staff we spoke with could clearly demonstrate the action they would take if they had concerns in relation to a

patient who did not attend an appointment. For example, if a child did not attend for immunisations. We saw records that showed the practice had followed up patients in this group regularly.

There was a chaperone policy, which staff could access through their shared policy system. 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. Signs informing patients of their right to have a chaperone present during an intimate examination were on display at both Lockfield Surgery and at the branch site, Raynor Road Surgery. Nursing staff we spoke with told us they had received chaperone training during their nurse training. They clearly explained to us what their responsibilities were to keep patients safe from the risk of abuse. Reception staff would act as a chaperone if nursing staff were not available. Disclosure and Barring Service checks were in place for all staff members, including chaperones. Disclosure and Barring Service (DBS) checks – checks to 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. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

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, which described the action to take in the event of a potential failure. The practice staff followed the policy. We found that the logging of the fridges' temperature ranges were not consistent and there were some gaps in the temperature recording, staff we spoke with told us that this was due to a difference in staff shift patterns, we found that recordings were no't consistently made when one nurse was off duty. We raised this with the practice on the day and staff told us they would address this by ensuring there was always a staff member on duty to take ownership of logging the fridge temperatures.

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.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber and they received regular supervision and support in their role as well as updates in the specific clinical areas of expertise for which they prescribed.

All prescriptions were reviewed and signed by a GP before they were given to the patient. We found that the practice did not have a system in place to record and monitor prescription numbers. The practice addressed this on the day by implementing a process for tracking and recording prescription forms to ensure they were handled in accordance with national guidance and kept securely at all times.

Cleanliness and infection control

Cleanliness and infection control was observed at Lockfield Surgery and at the branch site, Raynor Road Surgery. At Lockfield Surgery 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 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. We saw evidence of infection control audits and that an action plan had been put in place.

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 at both sites for staff to use and 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 and staff knew the procedure to follow in the event of an injury.

Are services safe?

The practice had started to introduce steps to protect staff and patients from the risks of health care associated infections. We saw records that demonstrated that two clinical staff had received the relevant immunisations and support to manage the risks of health care associated infections. We saw that Legionella risk assessments had been completed for both sites in July 2014. We saw that appropriate action had been taken to address any risks identified. Legionella is a term for particular bacteria which can contaminate water systems in buildings. 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.

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. We saw records that demonstrated all portable electrical equipment had been tested in March 2015 to ensure they were safe to use. We saw records that demonstrated that all medical devices had been calibrated at Lockfield Surgery in March 2015 and at Raynor Road Surgery in October 2015. This included devices such as weighing scales and blood pressure measuring devices.

Staffing and recruitment

The practice had recently developed a recruitment policy as part of their new policy system. 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). These are checks to 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.

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 and to work across both the main practice and the branch site when required. 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 were in line with planned staffing requirements.

Monitoring safety and responding to risk

We saw policies in place to support health and safety, health and safety information was displayed for staff to see and staff were aware of how to report risks and who to report them to. However the practice did not have a process in place for the testing of fire alarms, fire drills and assessing health, safety and fire risk.

Staff at the practice had recently completed fire awareness training and health and safety training was annually updated online. The practice manager had appointed two fire marshals and assured us on the day of our inspection that plans would be implemented to commence fire alarm testing and fire drills with immediate effect. The practice manager was able to share records of fire alarm maintenance tests carried out by an accredited and approved fire alarm specialist to ensure that the fire alarm was in working order and that staff and patients were not at risk.

Staff told us that regular visual health and safety checks were conducted across both the main practice and the branch site. Prior to the inspection, the practice manager had identified the need to carry out formal checks and document a series of health and safety risk assessments in line with the practice's new health and safety policy.

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 (AED, 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

Requires improvement

Are services safe?

diabetes. 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 power failure, adverse weather, unplanned sickness and the loss of domestic services.

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 saw that the GPs and nurses used clinical templates in the management of patients' care and treatment. This assisted them to assess the needs of patients with long term conditions, older patients and patients experiencing poor mental health. 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, and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as asthma, diabetes, mental health and family planning. The advanced nurse practitioners (ANPs) and practice nurses supported this work which allowed the practice to focus on specific conditions. An advanced nurse practitioner is a nurse who has undergone further training; they work independently but in close collaboration with a GP. 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.

The practice had a register in place for all patients with long term conditions, this included patients with poor mental health, dementia, learning disabilities and patients with osteoporosis and rheumatoid arthritis. The practice offered annual reviews for all patients with long term conditions. The practice shared data with us which showed that annual reviews had been carried out for 87% of the practice's patients experiencing poor mental health and 82% of the practice's patients with dementia. The GPs we spoke with told us that the practice provided cognition testing for patients at risk of developing or displaying symptoms of dementia. We saw evidence to support this data on the day of our inspection as well as the templates used for cognition testing.

We saw practice records that showed annual reviews of medication were in place and we saw that for the year so far, medication reviews had been carried out for patients with asthma, dementia, diabetes and, cardiovascular disease. And chronic obstructive pulmonary disease (COPD) - the name for a collection of lung diseases, including chronic bronchitis and emphysema. Typical symptoms are increasing shortness of breath, persistent cough and frequent chest infections.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All the GPs we spoke with used national standards for the referral of patients with suspected cancers so that they were referred and seen within two weeks.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed within six weeks by their GP according to need.

The practice held registers of patients whose circumstances may make them vulnerable. An example was the register for 33 patients with learning disabilities. The practice carried out 23 full learning disability reviews which included a full health and social assessment as well as an assessment for the needs of their carers. One of the GP partners had a lead role in this area and other clinical staff at the practice would help to coordinate and support the care for this group.

All information about patients received from accident and emergency departments and the out-of-hours service was reviewed by the GPs. A GP told us this provided a clinical evaluation of the information and enabled the practice to assess if the patient would require any further follow up or support. They told us patients on the practice register for experiencing poor mental health who attended accident and emergency with a problem related to their mental wellbeing would be followed up by their own GP.

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, 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 had a system for completing clinical audits. The practice showed us four clinical audits that had been completed in the last two years. Where relevant the audits had been revisited to ensure that outcomes for patients had improved. For example, an audit of patients on nonsteroidal anti-inflammatory drugs (NSAIDs) had been carried out. The aim of the audit was to identify all patients on this medication with osteoarthritis, rheumatoid arthritis and anyone 45 years of age and older with chronic low back pain to ensure that a proton pump inhibitor (PPI) was also routinely co-prescribed in line with NICE guidance and for safe prescribing. The audit also highlighted a reduction in risk for patients on medication used to treat pain or inflammation caused by conditions such as arthritis, where cardiovascular disease was a risk. Where continued use of NSAIDs were required, the audit showed where the practice changed to ibuprofen or naproxen in line with Medicines and Healthcare products Regulatory Agency (MHRA) and NICE guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes. Other examples included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and NICE guidance.

Minor surgery was regularly undertaken at the practice by one of the GPs. The practice audited the effectiveness of minor surgery by looking at recognised complications of minor surgery. For example, excessive bleeding or infection rates. The practice also ensured patient consent was documented on the minor surgery audit proforma; this was cross referenced with the patient record to ensure consent obtained was documented and routinely checked. A GP told us that they were not aware of any issues and would report any occurrence such as post-operative infection as a significant event. No complaints or significant events had been raised in relation to minor surgery.

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). We looked at national data 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 e.g. diabetes and implementing preventative measures. The results are published annually. We saw that the practice level for prescribing antibiotics was in line with the national average.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 91% of patients with chronic obstructive pulmonary disease (COPD is the name for a collection of lung diseases, including chronic bronchitis and emphysema) and 72% of patients with asthma had received an annual review. These results were in line with the national target.

In addition the practice provided a level two diabetic clinic which was managed by the nurse practitioner, with support and input from a community specialist diabetic nurse clinic twice a month. The practice shared data with us to show that 56 reviews had taken place for 94 of the practices patients with diabetes, these patients were seen at the level two diabetic clinic and 7 of the patients were initiated on insulin. The practice also confirmed that 88% of their diabetic patients had received foot assessments.

The senior GP partner showed us data from the local CCG of the practice's performance for antibiotic prescribing, which was comparable to similar practices. The practice had also completed a review of case notes for patients with high blood pressure which showed all were receiving appropriate treatment and regular review.

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 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.

Good

Are services effective?

(for example, treatment is effective)

The practice had a palliative care register and staff told us that they held weekly multidisciplinary meetings with the integrated locality teams to discuss the care and support needs of patients and their families; however the practice did not produce minutes to support these meetings. Staff we spoke with were aware that documenting the practice meetings could be improved and the practice had plans in place in order to start formally documenting the meetings moving forward.

The practice also 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. This benchmarking data showed the practice had outcomes that were comparable to other services in the area.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. The practice had a wider team in place where they worked with the district nurses and a pharmacist, staff we spoke with told us that the wider team were also included in regular staff meetings.

We reviewed staff training records and saw that all staff were up to date with attending training courses such as basic life support. We noted a strong skill mix among the doctors with some having additional qualifications in clinical areas. For example, diabetes diagnosis and management of gynaecology in the community. 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 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.

The practice was an approved training practice and had provided training for trainee GPs to become qualified GPs for the last five years. We received positive feedback from the trainee we spoke with, the trainee was offered extended appointments and had access to a senior GP throughout the day for support.

Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example one nurse had been supported through training in Spirometry and use of a Spirometer (a spirometer measures lung function including the volume and speed of air that can be exhaled and inhaled and is a method of assessing lung function), as well as COPD and was also being supported with their application on the expert nurse practitioner pathway.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, childhood immunisations and cervical screening. Some nurses also had extended roles and saw patients with long term conditions such as asthma, diabetes and COPD. The practice was able to demonstrate that the nurses had appropriate training to fulfil these roles.

The practice health care assistant carried out a wide range of duties including dressings, ear syringing, blood pressure checks, spirometry, food checks for diabetes, phlebotomy (taking of blood), new patient checks and cryotherapy (Cryotherapy is the local or general use of low temperatures in medical therapy and is used to treat a variety of benign and malignant tissue damage, medically called lesions). The health care assistant also assisted with minor surgery once a week and had completed a wide range of training to support her daily duties as well as additional training such as electrocardiogram (ECG) reading. An electrocardiogram (ECG) is the equipment used to record electrical activity of the heart to detect abnormal rhythms and the cause of chest pain.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those 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 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 worked well.

The practice was commissioned for the new 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). The practice undertook a yearly audit of follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed.

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. Electronic systems were also in place for making referrals and the practice managed referrals through tasks on their electronic records system and also 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).

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. One GP showed us how straightforward this task was using the electronic patient record system, and highlighted the importance of this communication with A&E. The practice has 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).

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, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. Audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

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 in their practice. A recent talk was given to all staff at the practice which included a presentation by one of the GP partners, key points on consent, mental capacity and consent when chaperoning were also covered and we were able to see a copy of the presentation on the day of our inspection.

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 are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions). The practice had not needed to use restraint, but staff were aware of the distinction between lawful and unlawful restraint.

We saw care records that showed staff had applied the principles of the Mental Capacity Act 2005 when involving patients in decisions about the care they received. We saw there was a MCA 2005 policy in place to support staff in making decisions when capacity was an issue for a patient. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes. 82% of patients with dementia had received an annual physical health check.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, there was a formal consent form for patients to sign which demonstrated they were aware of the relevant risks, benefits and complications of the procedure. Consent forms were scanned into patients' notes. We saw an anonymised record where this had been completed. Consent was also listed for all surgical procedures and cross referenced by checking on the minor surgery audit proforma, we saw an audit that confirmed the consent process for minor surgery had been followed in all 151 minor surgery cases.

Health promotion and prevention

Patients over 75 years of age had a named GP to provide continuity of care. Childhood vaccinations and child development checks were offered in line with the Healthy

Good

Are services effective?

(for example, treatment is effective)

Child Programme. We saw data that demonstrated the practice was in line with the regional Clinical Commissioning Group (CCG) average in the uptake of childhood immunisations

There were systems in place to support the early identification of cancers. The practice carried out cervical screening for women between the ages of 22 and 70 years. We saw that the practice's performance for cervical screening uptake was 76%; however, this was below the national target of 81%. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend. There was also a named nurse responsible for following up patients who did not attend screening.

The practice provided a confidential chlamydia screening service for young people and saw this had been accessed by 13 patients since January 2015. They told us that one of the GPs specialised in family planning. All Advanced Nurse Practitioners (ANPs) and practice nurses provided contraceptive advice and offered sexual health screening at the practice. All clinical staff provided free contraception where appropriate.

The practice offered opportunistic advice to patients that may improve their health or the condition they experienced. For example patients with long-term conditions such as COPD were encouraged and supported to stop smoking. The practice nurses held smoking cessation clinics. Practice data showed that smoking cessation advice had been offered to 1769 patients over the last year and that 11% of these patients had stopped smoking following this support. Practice nurses described to us how they sign posted patients to weight loss clinics and completed exercise referrals for patients who needed to manage their weight.

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 for all immunisations was above average for the CCG. For example the latest available QOF data from 2013- 2014 showed that 99.3% of two year old children had received the measles, mumps and rubella (MMR) vaccination compared to the CCG average of 97.5%.

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 offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 4% of patients in this age group took up the offer of the health check. A GP showed us how patients were followed up if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The practice had a recent blood pressure reading recorded in 13% of patients of a working age. A practice nurse told us that any abnormal blood pressure findings were followed up with a GP. High blood pressure is a known risk factor in serious illnesses such as stroke, and coronary heart disease.

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. Practice records showed 70% had received a check up in the last 12 months.

Health promotion information was displayed on practice notice boards, we saw information and patient leaflets on alcohol advice, asthma, cancer and mental health.

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 during January-March 2014, published in January 2015. The evidence showed patients were generally satisfied with how they were treated however, respondents rated the practice 70% with regards to the GPs treating them with care or concern. This was below the national average of 85%. Respondents rated the practice as 89% for nurse care in terms of care and concern. This was above the national average of 85%. Overall, 73% of the responses were good or fairly good with regards to experience of the practice. However, the practice was significantly lower than the national average of 60% for patients being able to see or speak to a GP of their choice, the practice scored 27% for this indicator.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 35 completed cards and the majority were positive about the service experienced. The comment cards contained details of how the practice staff were efficient, caring and respectful and how clinical staff listened well and gave good advice. One comment card was completed by a long term patient from the practice who described the clinical care as outstanding.

We spoke with eight patients during our inspection. All patients had positive things to say about the practice, staff were described as caring, kind and respectful. All of the patients we spoke with said they had confidence in their care and that they were treated with dignity. Patients told us that their confidentiality was well maintained however some patients told us that they were sometimes interrupted by other staff members requesting to speak to the nurse during nurse consultations and also by staff members phoning through to the nurse during time with patients.

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 / 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. At Lockfield Surgery, the practice switchboard was located away from the reception desk and was shielded by partitions which helped keep patient information private. We spoke with a patient on the day who told us that sometimes it was difficult to speak with reception confidentially as patients would stand close to the reception desk. Staff told us that they would take patients to a private room if they wished to speak in private. There was a sign in reception informing patients that they can speak to staff away from the reception desk, the sign was not clearly visible or easy to see. Telephone calls were received in a room behind the switchboard. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained. At the branch site, Raynor Road Surgery, we found that the reception area did not cater to patients' needs in terms of privacy and confidentiality. The reception desk was open plan and patients could sometimes be overheard by people in the waiting room when speaking with reception. The practice had identified that the branch site was no longer a suitable premises at which to deliver care and treatment and had plans in place to relocate during July 2015.

There was a clearly visible notice in the patient reception areas stating the practice's zero tolerance for abusive behaviour. Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager.

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

Good

Are services caring?

care and treatment and generally rated the practice in line with national averages. For example, data from the national patient survey showed 71% of practice respondents said the GP involved them in care decisions.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They all told us that

staff treated them with dignity and respect, the GPs and nurses listened well during consultations and explained things clearly to make sure patients had a clear understanding during consultation. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language, some GPs spoke additional languages such as Punjabi and two staff members had completed British Sign Language courses and could carry out basic sign language. We saw notices in the reception areas informing patents of the translation services available.

Staff told us that the practice team had a long-standing, caring and trusting relationship with the patients. One staff member told us how she recognised behaviour differences in a regular patient whilst working on reception. The staff member had noticed the patient looking confused and disorientated. The staff member spoke with the GP on duty to highlight her concerns, as a result the patient was screened for dementia and has since been referred to a memory clinic.

We spoke with representatives from two care homes for older people. They told us that all the patients living there who were registered with the practice had a named GP and received regular medication reviews. They also told us that when a do not attempt cardio-pulmonary resuscitation (DNACPR) decision had been made regarding a patient, that the patient and their family were fully involved in those decisions. They told us the GPs reviewed these decisions at regular intervals with the patient and important others.

Patient/carer support to cope emotionally with care and treatment

The 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.

The practice had a very informative carer's board as well as notices in the patient waiting room, on the TV screen and patient website to inform patients on 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 were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Patients we spoke with who had had a bereavement said they had found the staff to be very kind and supportive. Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. The practice kept a confidential 'Rest in Peace' board to ensure staff did not contact relatives without them being aware.

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 practice offered extended appointments when reviewing patients who needed additional time. An example of this was patients with a learning disability. A GP told us this was to ensure they had sufficient time to discuss issues so the patient would not feel rushed, also to accommodate the assessment of health conditions that patients in this group were at a higher risk of developing. Home visits were available on request for patients who were housebound, terminally ill or too ill to attend the practice.

The practice provided care and support to several house bound elderly patients and patients living in local care homes. Patients over 75 years of age had a named GP to ensure continuity of care. We spoke with representatives from two of the care homes who told us that the practice responded quickly to a request for a patient to be seen at the home.

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 had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. We spoke with two members of the PPG who gave us examples of planned changes to working practice following feedback from patients and improvement suggestions. We spoke with two PPG members who told us how they had discussed ways of reducing queues in the waiting area by educating patients who were not confident in using the self-check-in appointment service. The PPG were also keen to address the attendance rates for patients who missed appointments without informing the practice, one member of the PPG spoke about how they had planned to educate patients on how to effectively use the free text messaging response service which allowed them to easily cancel their appointments via text message and open the appointment up for another patient.

Tackling inequity and promoting equality

The premises and services at Lockfield Surgery had been adapted to meet the needs of patient with disabilities. The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Doorways and corridors were wide enough to allow prams and wheelchairs to turn and access all rooms. We saw patients with walking aids mobilising through the practice without hindrance. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. Facilities for patients with mobility difficulties included disabled parking spaces; step free access to the electronic front door of the practice; disabled toilets and a hearing loop for patients with a hearing impairment.

The practice had a very proactive PPG, one member of the PPG told us about previous access problems in terms of car parking at the practice, some people were parking in spaces close to the practice which were intended for use by disabled people, the practice found that patients with disabilities were having to park in spaces further away from the surgery entrance. The practice worked with the PPG to address this problem, disabled spaces were officially marked and a polite notice was created to inform drivers of where to park. This had significantly reduced the problem and patients could now easily access the surgery.

We found the premises for Raynor Road Surgery were not easily accessible for people with disabilities. One consultation room was very small with two steps and therefore unable to accommodate wheelchair users and people with pushchairs. Visitors accessing the waiting room were also required to use steps which led down in to the waiting area. There were potential trip hazards due to broken flooring tiles in the surgery corridors and the reception area was fairly open and did not promote privacy for patients who wished to speak in confidence. The practice had plans in place to relocate the Raynor Road branch to a new location. We saw the business plan to support this and the practice told us that the move was to take place in July 2015.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice had access to translation services for patients who did not speak English as a first language, some GPs spoke additional languages such as Punjabi and two staff members had completed British Sign Language courses and could carry out basic sign language. We saw notices in the reception areas informing patents this service was available.

The practice provided care and treatment for a small travelling community. They told us that travelling families were supported to register as temporary residents with the practice

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.

Access to the service

Appointments were available from 8.30am to 6pm on all weekdays except for Wednesdays when the practice closed at 1pm, appointments were available from 7.30am to 12.30pm on Wednesdays. The practice offers extended hours on Saturdays from 10am to 1pm twice a month. Appointments could be booked in person, via telephone or online for patients who had registered their details for this method. Emergency cover was provided by an out out-of-hours service when the practice was closed, patients could access this service through 111 on weekdays and weekends. When the practice closed at 1pm on Wednesdays patients were signposted directly to a local out-of-hours provider until 6.30pm, after which they could contact the appropriate cover through the 111 service. Patients could also attend the local walk-in centre.

Comprehensive information was available to patients about appointments on the practice website and on the practice leaflet. 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 patients who needed them and those with long-term conditions. Home visits were made to several local care homes to those patients who needed one.

Patients were generally satisfied with the appointments system. They confirmed that 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. For example, one patient we spoke with told us how the practice was able to provide an urgent appointment for their child.

A survey of 104 patients was also undertaken by the practice's patient participation group (PPG) in February 2014. The evidence from all these sources showed patients were particularly satisfied with surgery opening hours, with 8 out of 104 responses being rated as dissatisfied. 102 responses highlighted that reception staff were helpful and 101 responses were satisfied with the cleanliness of the practice.

Patients completed CQC comment cards to tell us what they thought about the practice, three cards contained comments that sometimes it can take a while to get through on the surgery phone line. To tackle this problem, the practice had recently changed the process for ordering repeat prescriptions, instead of phoning through to the practice patients also had the choice of directly contacting the pharmacy for their prescription, ordering online, or ordering prescriptions face to face.

The practice manager told us that the practice had experienced a high number of patients who did not attend (DNA) booked appointments. The practice DNA rates were up to 100 missed appointments in one week. The practice had introduced text messaging reminders to be sent to patients and a free text messaging reply service where patients could also cancel an appointment by text message. The practice manager told us that sometimes the text messaging facility was not used correctly and patients were failing to cancel their appointments via text. The practice had planned to work with the PPG to educate patients on how to correctly use the text messaging reply service.

We spoke with a GP partner at the practice who told us that the practice was exploring new ways of working through

the planned use of an online tool. The practice had support from the CCG (Clinical Commissioning Group) and use of the software was to commence with a full training package in May 2015. The GP explained that the idea behind the initiative was to give patients the control they wanted through use of a user-friendly and personal service that they could access online. The GP told us that the plan was to increase GP productivity, allowing GPs to decide on the best course of action through fast, easy, personal and confidential services.

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. The practice manager worked with the GPs as the designated responsible person to handle all complaints in the practice.

We saw that information was available to help patients understand the complaints system. The practice displayed clear information on how to raise a complaint in the waiting room, practice booklet and on their website.

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 13 complaints received in the last 12 months and found that all of these complaints had all been dealt with in a timely and open way. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken. Staff told us that learning from complaints were occasionally discussed during practice meetings however the practice did not produce minutes to support these meetings. The practice manager was aware that documenting the practice meetings could be improved and the practice had plans in place in order to start formally documenting the meetings moving forward.

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.

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, continually improve the quality of its service and involve patients in shaping the delivery of its services. We found details of the vision and practice values were part of the practice's strategy and the practice improvement plan.

We spoke with seventeen members of staff and they all understood the vision and values and knew what their responsibilities were in relation to these.

The practice did not have regular routine meetings involving the whole team so did not have a structured route for sharing information with staff. Staff we spoke with told us that they would like to have staff meetings on a regular basis rather than opportunistically, this was a theme we picked up throughout the day from various staffing areas.

Governance arrangements

The practice had a range of policies and procedures and these were all available on the practice computer system where members of the team could access them. Most of the staff we spoke with were familiar with the practices policy system were able to direct us to a number of electronic policies and procedures. All of the staff we met understood their roles and responsibilities within the practice.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. 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 QOF data for this practice showed it was performing above national standards with a practice value of 98.4% compared with a national value of 94.2%.

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, an audit of patients on nonsteroidal anti-inflammatory drugs (NSAIDs) had been carried out. The aim of the audit was to identify all patients on this medication with osteoarthritis, rheumatoid arthritis and anyone 45 years of age and older with chronic low back pain to ensure that a proton pump inhibitor (PPI) was also routinely co-prescribed in line with NICE guidance and for safe prescribing. Other examples included audits 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 practice manager told us that clinical meetings took place with the GPs every two weeks, although the practice did not have a meeting agenda in place the practice manager told us that governance would be discussed during these meetings. The practice did not produce minutes to support these meetings. The practice manager was aware that documenting the practice meetings could be improved and the practice had plans in place in order to start formally documenting their meetings.

Leadership, openness and transparency

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead for safeguarding, minor surgery and also complaints. We spoke with seventeen members of staff and they were all clear about their own roles and responsibilities. Staff told us they knew how to report concerns and who to report them to however, some staff told us they did not feel valued or supported at times. Staff we spoke with told us that they would like to have staff meetings on a regular basis rather than opportunistically, this was a theme we picked up throughout the day from various staffing areas.

Staff told us they knew how to report concerns and who to report them to. The practice had a whistle blowing policy which was available to all staff to access by the practices new shared policy system. Whistle blowing occurs when an internal member of staff reveals concerns to the organisation or the public, and their employment rights are protected. Having a policy meant that staff were aware of how to do this, and how they would be protected.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment and induction procedures which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work

Seeking and acting on feedback from patients, public and staff

Are services well-led?

Good

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

Staff at the practice and members of the patient participation group (PPG) met every three months to discuss issues concerning the operation of services at the practice, we saw minutes to support these meetings. PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services. The PPG had 12 members, both male and female. The group had recognised that they were underrepresented for families, children and young people. One member of the PPG told us how they were exploring ways of encouraging young people to join as PPG members and that they hoped to approach and include the mother and baby population group at the practice.

The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website. The results of previous survey in 2014 were discussed and an action plan produced with the PPG to address issues raised. For example, helping to tackle appointment demand by introducing guidelines for patients when booking appointments online with the GPs, nurse practitioners, practice nurses and the healthcare assistant to ensure patients see the staff member who was most suited to deal with their needs.

The practice had recognised the need to free up the practice phone line for patients who wished to book an appointment and this was acted on by changing the way patients can request repeat prescriptions, giving them the option of phoning directly through to the pharmacy as well as face to face, online and through standard telephone requests. Staff told us that the changes to this process had already had a positive impact for patients who needed to call the practice to make an appointment.

Staff told us they knew how to report concerns and who to report them to however, some staff told us they did not feel valued or supported at times.

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

The practice was a training practice for medical students and trainee GPs to gain experience and higher qualifications in General Practice and family medicine. GP registrars are qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine. We spoke with one GP registrar on the day of our inspection. They told us they were well supported by the practice and described how they had been supported in their learning.

The practice had completed reviews of significant events and other incidents to ensure the practice improved outcomes for patients. Staff told us that significant events were discussed on a regular basis and during practice meetings. However, the practice did not routinely document their meetings and therefore were unable to evidence that significant events formed part of the agenda. Staff told us that learning from incidents and significant events was occasionally discussed during practice meetings however the practice did not produce minutes to support these meetings. The practice manager was aware that documenting the practice meetings could be improved and the practice had plans in place in order to start formally documenting their meetings moving forward.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Fire risks were not identified, assessed and managed relating to the health and safety of service users due to no fire risk assessment having been conducted Regulation 12 (2) (a).

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.