# Hampton Surgery

## Quality Report

Fentham Hall, Marsh Lane
Hampton-in-Arden
Solihull
West Midlands
B92 0AH
Tel: 01675 442510
Website: www.hamptonsurgery.co.uk

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

## Ratings

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

# Summary of findings

## Contents



## Overall summary

**Letter from the Chief Inspector of General Practice**

We inspected Hampton Surgery, Fentham Hall, Marsh Lane, Hampton-in-Arden, Solihull, West Midlands, B92 0AH on 11 November 2014 as part of a comprehensive inspection.

We rated the practice as good for safe, effective, caring, responsive and well-led . We also inspected the quality of care for six population groups these are, people with long term conditions, families, children and young people, working age people, older people, people in vulnerable groups and people experiencing poor mental health. We rated the care provided to these population groups as good. We rated the practice as good overall.

Our key findings were as follows:

- There were systems in place to ensure patients received a safe service.
- There was evidence of completed audit cycles undertaken to ensure patients care and treatment was effective and achieved positive outcomes.
- Patients were complimentary about the staff at the practice and said they were caring, listened and gave them sufficient time to discuss their concerns.
- The practice was responsive to the needs of the practice population. There were services aimed at specific patient groups including those with long term conditions. There were examples of outstanding practice when responding to the needs of vulnerable patients. For example,the practice recognised that patients from the traveller community were often transient and may experience difficulty accessing health services. The practice offered flexible appointments and all aspect of the patients medical health needs were assessed during routine appointments.
- There was strong and visible leadership with defined roles and responsibilities. The governance framework ensured clear lines of accountability and was well- led.

We saw an area of outstanding practice

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- There was evidence of outstanding practice in responding to the needs of vulnerable patient groups such as people from the traveller community and older people. There were joint working arrangements with local health services and charitable organisations in order to develop innovative and flexible ways to help vulnerable groups access the service and improve their health and wellbeing.

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

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**

Good

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

**Are services effective?**

Good

There was evidence of completed audit cycles to ensure patients care and treatment was effective and improved the quality of the service. There was a strong emphasis on evidence based practice which was referenced in patients care and treatment to ensure positive outcomes were achieved Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and demonstrated its use. The practice had joint working arrangements with other health care professionals and services which demonstrated a collaborative approach. There were effective arrangements to identify, review and monitor patients with long term conditions and those in high risk groups. The practice was an established undergraduate and postgraduate teaching practice and recognised in the education field and within Health education West Midlands for providing an effective teaching and learning environment for GP Registrars (fully qualified doctors who wish to become general practitioners), Foundation Year Doctors and medical students. It was also an advanced training practice for struggling GP Registrars.

**Are services caring?**

Good

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

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

Good

The practice had arrangements in place to respond to the needs of the practice population. The service was accessible to a variety of

# Summary of findings

patients with different health needs including vulnerable patients. There were joint working arrangements with local health services and charitable organisations in order to develop innovative and flexible ways to help vulnerable groups access the service reducing barriers to health care. For example, the practice recognised that patients from the traveller community were often transient and may experience difficulty accessing health services.The practice responded by offering flexible appointments and ensuring all aspect of their medical health needs were assessed during routine appointment as it may be some time before they accessed the service again. The practice was in the process of recruiting a community support worker to support and be a champion for the older person, offering holistic wellbeing support within the home while promoting access to medical care through the practice. This was in response to practice staff identifying that this patient group would benefit from one to one support and advice on their health and wellbeing. The practice was responsive to complaints with evidence demonstrating that the practice acted on issues raised in a proactive manner.

**Are services well-led?**

Good

The practice had a clear vision and was working towards delivering this. Staff were aware of their responsibilities in delivering a good service. There was strong and visible leadership with roles and responsibilities clearly defined. The practice had a number of policies and procedures to govern activity and these were regularly reviewed and updated as necessary. There were robust systems in place for assessing and managing risks and monitoring the quality of service provision. There was evidence of improvements made as a result of audits and feedback from patients and staff. The practice had a patient participation group (PPG) that was proactive in engaging with patients and passionate about improving the quality of the service.

# Summary of findings

## The six population groups and what we found

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

**Older people**

Good

The practice had a slightly older practice population in comparison to the national average. All patients over 75 years of age had a named GP to ensure they received co-ordinated care. Vulnerable older patients with complex care needs had been identified by the practice in order that appropriate care plans could be created and kept under review.

Patients over the age of 75 years were offered health checks There were also arrangements to review patients in their own home if they were unable to attend the practice. The practice had identified and responded to the needs of older patients by initiating a 'Fragility Project' jointly with the local village trust. The aim of the project was to employ a community support worker to support and be a champion for the older person, offering holistic wellbeing support within the home while promoting access to medical care through the practice.

**People with long term conditions**

Good

Patients with long term conditions were reviewed by the GPs and the nurses to assess and monitor their health condition so that any changes to their treatment could be made. These reviews were done on an appointment basis allowing more flexibility and responsiveness to patients individual needs. There was an active recall system to ensure patients were invited to attend the practice to support the management of their long term condition. Health checks and medication reviews took place and repeat prescriptions were accessible. These arrangements would help to minimise unnecessary admissions to hospital.

There was evidence of multi-disciplinary working with relevant health care professionals to deliver effective and responsive care.

**Families, children and young people**

Good

Antenatal care was provided by the midwife who undertook clinics at the practice. The post natal check was completed by the GPs to ensure a holistic assessment of a women's physical and mental wellbeing following child birth. Women were offered cervical screening and there were systems in place to audit results. A range of family planning services were available with referral system in place for specialist services.

Children under the age of 5 years had access to the Healthy Child Programme. The six week check for babies was undertaken by the

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GPs and children were offered childhood vaccinations. The practice had an allocated health visiting team and our discussion with them demonstrated a good working relationship and systems in place for information sharing. Safeguarding procedures were in place for identifying and responding to concerns about children who were at risk of harm.

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

Good

The practice was open extended hours on Tuesdays between 6.30pm to 7.30pm to accommodate the needs of working age patients. Patients were able to book non urgent appointments and order repeat prescriptions around their working day by telephone or on line. Telephone advice was available so that patients could call and speak with a GP or a nurse where appropriate if they did not wish to or were unable to attend the practice.

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

**People whose circumstances may make them vulnerable**

Good

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

The practice had arrangements in place which enabled people without a permanent address to register at the practice, this also included people living in vulnerable circumstances. The practice demographics included patients from the traveller community. There was evidence of joint working arrangements and flexibility in the delivery of the service ensuring access to healthcare for vulnerable groups.

**People experiencing poor mental health (including people with dementia)**

Good

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

# Summary of findings

who were stable were also offered a review to ensure their care and support needs were monitored. Systems were in place to identify and support patients with dementia and they were invited for an annual health review.

Staff worked closely with local community mental health teams to ensure patients with mental health needs were reviewed, and that appropriate risk assessments and care plans were in place. An in-house mental health counsellor was available at the practice for patients to be referred to.

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## What people who use the service say

We looked at results of the most recent national GP patient survey. Out of the 257 surveys sent 115 were completed and returned. Findings of the survey were based in comparison to the average for other practices nationally. The results of the national GP survey highlighted the practice was average in most areas in comparison to other practices nationally. This included patients experience of getting through to the practice by phone and making appointments.

We reviewed comments made on the NHS Choices website to see what feedback patients had given. There were only two comments posted on the website, one in February 2012 and the other in March 2013. Positive feedback on the NHS choices website included being treated with dignity and respect and the number of patients who would recommend the practice to others. An area for improvement included ensuring confidentiality in the patient waiting area. The practice had replied to both of the comments in a constructive manner which showed that practice took the opportunity to engage and listen to patient feedback to improve the quality of the service.

As part of the inspection we sent the practice comment cards so that patients had the opportunity to give us feedback. We received 73 completed cards, of these 69 contained positive feedback. On the day of the inspection we spoke with seven patients including three members of the patient participation group (PPG). PPGs are a way in which patients and GP surgeries can work together to improve the quality of the service. Patients described a good service and said staff were caring, considerate and respected their privacy and dignity. Patients were fully aware that the practice was a teaching practice. However, four patients felt that this impacted on the continuity of care they received.

## Areas for improvement

## Outstanding practice

- There was evidence of outstanding practice in responding to the needs of vulnerable patient groups such as people from the traveller community and older people. There were joint working arrangements with local health services and charitable organisations in order to develop innovative and flexible ways to help vulnerable groups access the service and improve their health and wellbeing.

# Hampton Surgery

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

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

## Background to Hampton Surgery

Hampton Surgery is a registered provider of primary medical services with the Care Quality Commission (CQC) and has one registered location (practice).This is Hampton Surgery, Fentham Hall, Marsh Lane, Hampton-in-Arden, Solihull, West Midlands, B92 0AH.

The practice is in the village of Hampton in Arden and well established in the surrounding villages of Bickenhill and Barston with a registered patient list size of approximately 2900 patients. The practice also serves around 300 temporary residents in three local sites for travellers.

The practice is a training practice for GP registrars (fully qualified doctors who wish to become general practitioners), Foundation Doctors and for medical students.

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

The practice is open Mondays, Tuesdays, Wednesday and Fridays between 08:30am and 1pm and 2.30pm until 6pm. The practice is open on Thursdays from 0830am to 1pm. However, patients have access to a GP via a mobile number during core hours. There is extended opening hours on Tuesdays between 6.30pm to 7.30pm which would benefit working age patients. The practice has opted out of providing out-of-hours services to their own patients. This service is provided by 'Badger' the external out of hours service contracted by the Clinical commissioning Group (CCG).

There are two GPs working at the practice who are also GP partners (both male). The practice employs a practice nurse (female) an advance nurse practitioner (ANP) (female) and a phlebotomist. There are also five administrative staff and a practice manager.

We reviewed the most recent data available to us from Public Health England which showed that the practice is located in one of the least deprived areas in Solihull though it has amongst its patient population a large local deprived traveller community. The practice has an above average patient population who are aged 65 years and over and an above average patient population with caring responsibilities in comparisons to other practices across England. The practice achieved 99.8 points for the Quality and Outcomes Framework (QOF) for the last financial year 2012-2013. This was above the average practice score nationally. The QOF is the annual reward and incentive programme which awards practices achievement points for managing some of the most common chronic diseases, for example asthma and diabetes.

# Detailed findings

## Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. This provider had not been inspected before and that was why we included them.

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

## How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we held about the service. We also asked other organisations and health care professionals to share what they knew about the service. We sent the practice a box with comment cards so that patients had the opportunity to give us feedback. We received 73 completed cards where patients shared their views and experiences of the service. We carried out an announced inspection on 11 November 2014. During our inspection we spoke with a range of staff including the practice manager, clinical and non clinical staff. We spoke with patients who used the service.

Good

# Are services safe?

## Our findings

### Safe track record

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

The practice 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 who we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. Staff told us that they received feedback following incidents during meetings.

### Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. This included significant event analysis (SEA). A significant event is any event thought by anyone in the team to be significant in the care of patients or the conduct of the practice. We saw that nine significant events had been recorded over the last year and we were able to review these. There was evidence to demonstrate good learning and reflection of significant events. Findings were recorded, discussed and shared with staff in meetings.

National patient safety alerts were disseminated by the practice manager following discussion with the GPs. These were then actioned where appropriate and shared with staff and there was evidence to support this. Patient safety alerts are issued when potentially harmful situations are identified and need to be acted on.

### Reliable safety systems and processes including safeguarding

There were arrangements in place for ensuring patient safety, this included the contact numbers for local safeguarding teams and safeguarding policies and procedures for staff to refer to should they have any concerns. There was a lead GP for children's safeguarding. Staff had received training in safeguarding vulnerable adults and children. Clinical staff had completed children training at the appropriate level for their role. There was alert system on the patient record system to highlight vulnerable adults and children to staff. A recent referral had been completed by a GP at the practice following concerns about a child. This demonstrated concerns were identified and acted on in line with local safeguarding procedures.

Safeguarding was a regular agenda item in practice meetings to ensure staff were kept up to date with current practice and any safeguarding concerns were shared with staff.

Some of the staff acted as chaperones and had received training in this area so they had the competencies required for the role. Staff who we spoke with were aware of their role and responsibilities when undertaking this duty. A policy was in place to provide additional guidance for staff. 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.

### Medicines management

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

The practice routinely used electronic prescribing. Where a paper prescription was used a system was in place so that the prescriptions could be accounted for.

There were robust arrangements in place for repeat prescribing so that patients were reviewed appropriately to ensure their medications remained relevant to their health needs. There was an alert system which informed patients and staff that medication reviews were due. A pharmacist from the local Clinical Commissioning Group (CCG) was attached to the practice. A CCG is an NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services. This enabled medicine management systems to be monitored and reviewed such as repeat prescribing audits. The most recent data available to us showed that the practice prescribing rates for some medicines for example Non-Steroidal Anti-Inflammatory were in line with the national average and prescribing rates for antibacterial prescriptions were better than the national average.

Good

# Are services safe?

## Cleanliness and infection control

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

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

The general environment was cleaned by an external cleaning contractor. There were cleaning schedules in place that included daily, weekly and monthly tasks which were signed to demonstrate that the cleaning had taken place consistently. There was evidence that the practice manager monitored the standard of cleaning by undertaking spot checks.

An infection prevention and control self-assessment audit had been completed by the practice in August 2014. The practice had an overall score of 96%. Some of the actions identified had been acted on but other actions, such as training for staff, were still in progress.

There had been no legionella testing on the water supply at the practice. Legionella is a term for particular bacteria which can contaminate water systems in buildings. The GPs told us that this was because the practice was a low risk environment. A risk assessment had been undertaken to determine the level of risk and included actions to minimise any risks such as regular flushing of all water outlets.

## Equipment

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

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

## Staffing and recruitment

The registered patient list size was approximately 2900 patients. There were two permanent GPs. The practice manager confirmed that most of the staff had worked at the practice for a number of years which provided stability within the staff team and ensured patients received continuity in their care. The practice employed a practice nurse and an advance nurse practitioner (ANP), a phlebotomist. There were also five administrative staff and the practice manager.

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

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

Both of the GPs at the practice were senior GP trainers and appraisers with teaching and training commitments outside the practice. The GPs told us that the current registered patient list size meant that the patient to GP ratio was adequate, and this enabled the GPs to work opposite shifts, covering each other's leave. In addition the practice had GP Registrars. The practice manager told us that they rarely used locum GPs. However, in the event this was required regular locums who were GP trainers were employed and they were made aware that they would be supervising GP Registrars. We looked at the file of one GP Registrar and saw that appropriate documentation was sought prior to them working at the practice.

We looked at three staff files, including clinical and non clinical staff and the file of the most recent member of staff employed at the practice. There was evidence that appropriate pre-employment checks were completed as part of the recruitment procedure. This included photographic identity, references and details of professional registration. The practice manager told us that new members of staff received an induction on commencement of their post and we saw evidence to support this. However, we were unable to see the outcome of DBS checks for the staff. The practice manager told us

that they visually checked the outcome of the DBS checks completed for staff before returning the document to them. However, they did not document any of the details such as the DBS reference number or the outcome of the DBS check, this made it difficult for us to confirm the details. The practice manager recognised that the system should be improved so that the relevant information was recorded and could be easily accessible when required.

### Monitoring safety and responding to risk

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

Fire alarms, equipment and emergency lighting were checked to ensure they were in good working order. Staff had received training in fire safety and there were policies to provide guidance to staff on what to do in the event of a fire. However, no formal fire drills took place to ensure staff were prepared in the event of a fire emergency. We discussed this with the practice manager at the time of our inspection and they told us that this would be addressed.

### Arrangements to deal with emergencies and major incidents

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

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The clinicians who we spoke with including the GP registrars were able to describe and demonstrate how they accessed and implemented guidelines based on best practice such as National Institute for Health and Care Excellence (NICE). NICE provides national guidance and advice to improve health and social care. The GP registrars described the GPs at the practice as being very knowledgeable about evidence based practice. The CCG had recently installed 'Map of Medicine' this system allowed the practice to access evidence-based care pathways and referral guidance.

The practice did not have specific clinics to review patients with long term conditions such as diabetes, asthma, hypertension and heart disease as they found these were not effective. The practice identified and recalled patients during normal surgery time, this allowed patients more flexibility.

We saw that there were 13 patients registered at the practice with a mental health need. A system was in place to ensure these patients could be easily identified. Patients who previously had serious mental health problems and were stable were also offered a review as it was recognised that these patients often suddenly deteriorated. We saw evidence that care plans were in place and reviews were detailed and well documented**.** There were arrangements to refer patients to an in-house mental health counsellor who attended the practice as well as secondary care services for additional support. Patients with a diagnosis of dementia were also identified on a register and invited for a review. We saw examples of reviews which were personalised and included a holistic assessment of the person's individual needs including a discussion with their carers. Data that we reviewed showed that the practice was comparable to other practices nationally for indicators relating to mental health.

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

There were arrangements to review patients in their own home if they were unable to attend the practice and included a phlebotomy service (taking of blood) for diagnosis and medication monitoring purposes.

### Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included, prescribing and the management of diabetes. Most audits were completed cycles which showed improvements made to patients care and treatment and demonstrated good learning and reflection. For example, following an audit, some patients were prescribed an alternative more effective medicine for their health condition based on NICE guidance.

The childhood vaccination programme was undertaken by the practice nurses. The most recent data available to us showed that the percentage of children receiving some of the childhood vaccinations was below the average for the CCG area. For example, the Meningitis C vaccination for children aged 12 months and the Infant Meningitis C vaccination for children aged 5 years. We discussed this with the GPs at the time of the inspection. The GPs explained that the practice population included around 300 temporary residents in three local sites for travellers. This patient group were often transient and could be difficult to engage. However, there was an effective recall system for children that did not attend for their vaccination. We also saw information about the childhood vaccination programme was displayed in the patient waiting area and in the practice newsletter to raise awareness of the importance.

GPs in the practice undertook minor surgical procedures in line with their registration. The staff were appropriately trained and kept up to date. They also regularly carried out clinical audits on the results and used this in their learning.

### Effective staffing

Both GP's were GP trainers and appraisers working with Health Education West Midlands and universities to support GP Registrars and medical students

Good

# Are services effective?

## (for example, treatment is effective)

and recognised as senior educators and fellows of The Royal College of General Practitioners (RCGP). Fellowship is the highest level of membership given in recognition of a significant contribution to medicine. The GPs attended regular Vocational Training Schemes (VTS) to ensure they kept their knowledge and skills up to date. Alongside their education role the GPs had also completed training to understand the needs of their practice population. This included a RCGO certificate in 'Practitioner Health', 'Bronze National Clinical Excellence Award' and continuing professional development course looking at 'Remote & Rural Medicine'. This involved working in a remote area to understand how people living in isolated areas accessed healthcare services.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We saw training records that showed staff were able to maintain their skills and knowledge. Staff had undertaken training in areas such as long term conditions and cytology as well as core training in areas such as infection control, safeguarding and fire. We identified that not all of the staff such as the nurses had received formal training in the Mental Capacity Act (2005). There was a training log to ensure training needs could be easily identified and addressed.

Staff were also given the opportunity and supported to develop specialist knowledge and expertise. For example, one of the nurses had completed a post graduate certificate in diabetes; another nurse had completed a masters degree in long term conditions which was partly funded by the practice. One of the nurses was the sexual health development lead for the CCG.

New staff received induction training to help prepare them for their role. We saw that there were good arrangements to support new registrars working at the practice. This included a detailed clinical induction programme, information packs and 'survival' guides. GP registrars spoken with commented positively on the induction process.

The practice had systems in place for annual appraisals for all staff including the GPs and we saw evidence of completed appraisals.

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

### Working with colleagues and other services

Multidisciplinary working was in place, meetings were held with health care professionals such as the district nurses and Macmillan nurses as part of the Gold Standard Framework (GSF) for end of life care. The GSF helps doctors, nurses and care assistants provide the highest possible standard of care for all patients who may be in the last years of life. The practice was part of the 'Virtual ward' staff scheme. A virtual ward is a method of providing support in the community to people with the most complex medical and social needs. Virtual wards use the systems and staffing of a hospital ward, but without the physical building: they provide preventative care for people in their own homes.

There was a national recall system in place for cytology screening (smear test) in which patients were invited to attend the practice. Cytology screening was undertaken by the practice nurse. This ensured women received this important health check including their results in a timely manner and findings were audited to ensure good practice was being followed.

The practice provided antenatal and post natal care for women, the midwife undertook regular clinics at the practice and our discussion with them suggested that there was a good working relationship with the GPs with effective communication systems in place.

There were systems in place to ensure that the results of tests and investigations were reviewed and actioned as clinically necessary by the GPs.

### Information sharing

Our discussions with health care professionals such as health visitors and district nurses suggested that there effective systems in place to share information via informal arrangements as well as formal meetings such as meetings with the pharmacist. The practice engaged positively with specialist services such as the support worker who worked with the traveller community in the local area. There were also joint consultations with the local substance misuse service to review patients as part of an enhanced service. This was supported by feedback we received from them.

Good

# Are services effective?

## (for example, treatment is effective)

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

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

### Consent to care and treatment

Not all of the staff had received formal training on the Mental Capacity Act (2005). However, the staff who we spoke with demonstrated their understanding of capacity assessments and how the principles would be applied in clinical practice. Both of the GPs were aware of the Mental Capacity Act (2005) as they had received training as part of their educational roles and the GP registrars working at the practice had completed training in previous jobs. The Mental Capacity Act (2005) is a law that protects and supports people who do not have the ability to make decisions for themselves. Clinical staff were also able to demonstrate understanding of Gillick competency and Fraser guidelines when assessing children under the age of 16.

The GPs undertook some minor surgery procedures and we saw evidence that consent for minor surgery had been obtained and recorded on a consent form. However, we noted that written consent for repeat procedures was not documented on the consent form. One of the GPs told us that this was because it was ongoing treatment within a short time frame and so only verbal consent was obtained. However, they acknowledged that good practice would be to obtain written consent for all procedures and told us that this would be implemented.

### Health promotion and prevention

Information leaflets and posters were available in the patient waiting area relating to health promotion and prevention. There was also information that signposted patients to support groups and organisations such as services for people who were carers. The practices website had links to patient information on various health, conditions and diseases and advice on choosing the most appropriate service for effective treatment and advice. Health information was also included in the regular Patient Participation Group (PPG) newsletter which provided the opportunity to promote health campaigns such as flu vaccinations.

The practice offered advice and support in areas such as smoking cessation, weight management, family planning and sexual health referring patients to secondary services were necessary. NHS health checks were available for people aged between 40 years and 74 years and the practice offered a range of health promotion and screening services which reflected the needs of this patient group. Flu vaccinations were offered to high risk groups.

The practice had a procedure in place for new patients registering with the practice. This included completing a new patient medical assessment and a health check with the GP.

Good

# Are services caring?

## Our findings

### Respect, dignity, compassion and empathy

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

The layout of the patient waiting area meant that patient's confidentiality was not always maintained. Patients approaching the reception desk could be overheard when talking to staff. Staff taking incoming calls could also be heard. A comment made on the NHS choices website identified this as an area for improvement. However, we observed that there were arrangements in place to maintain confidentiality. There was a poster informing patients that they could discuss any issues in private, away from the main reception desk. The practices confidentiality statement was also displayed in the patient waiting area raising patient's awareness of the issue. We observed staff were careful in what they discussed with patients approaching the reception desk. Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room and that patients privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations.

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

Patients were offered a chaperone for intimate examinations and procedures and our discussions with staff demonstrated that they were aware of the importance of maintaining patient's dignity and respect during such procedures. 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.

There were no permanent female GPs working at the practice. However, there was a female GP Registrar and a female practice nurse to ensure patients could access services such as sexual health and family planning. This also gave patients the option of receiving gender specific care and treatment. There were also arrangements in place for patients to receive a specific family planning services at an alternative practice.

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

The results of the most recent national GP survey showed that 95% of patients surveyed said the last GP they saw or spoke to was good at involving them in decisions about their care and 93% said the last nurse they saw or spoke to was good at involving them in decisions about their care.

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

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

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

We asked staff about bereavement support for patients. They told us that clinical staff attended regular meetings with relevant professionals and agencies to discuss and review patients who were receiving end of life care based on the national gold standard framework (GSF). The GSF helps doctors, nurses and care assistants provide the highest possible standard of care for all patients who may be in the last years of life. As part of the process carers were identified and supported following bereavement. We spoke with healthcare professionals who worked with the practice, they told us that there was a good working relationship with the GPs and they worked well in supporting patients and their families with end of life care. The GPs told us that in the event of an unexpected death they would ring the family member or carer to offer support. However, we did not see any information available on bereavement services in the patient waiting area.

We saw that there was a carer's information board in the patient waiting area with information on local services. Feedback from comments card included positive

Good

# Are services caring?

comments about support given to carers. The practice also had a system for identifying people who were carers to ensure their needs were identified and support could be offered.

The practice was based in the village of Hampton in Arden and well established in the surrounding villages of Bickenhill and Barston. This enabled the GPs to develop good links with the local community including Parish Vicar, the village trust and village pharmacy to identify and support vulnerable people including carers.

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 understood its patient population very well. The GPs, practice manager and staff were able to demonstrate insight into the needs of their patients and the challenges they faced. There was evidence that the practice was proactive in responding to the needs of vulnerable groups by joint working arrangements, ensuring flexibility and developing innovative ways to help them access the service.

The practice had arrangements in place which enabled people without a permanent address to register at the practice. The practice list included around 300 temporary residents from three local sites for travellers. We spoke with a support worker who worked with the traveller community in the local area. They told us that one of the GPs at the practice had established a good link with this patient group and provided excellent feedback on how the GP was supportive and engaged positively with them. They told us that the GP and other staff provided person centred care to accommodate the needs of this vulnerable group who may have poor access to health care. For example, flexibility in appointments and recognising that some patients in this patient group may have difficulty with reading and writing that could impact on their ability to access services. Staff spoken with told us how they addressed this issue by calling patients and not sending letters for appointments. An alert system was also place on their records to highlight this to all of the staff. The GPs told us that this patient group were often transient and they had trained the Registrars to look at all aspect of their medical needs during routine appointments as the patient might not attend the practice again. There were examples of the GPs sign posting and referring patients to other services for their care and treatment needs.

The practice responded to the needs of older patients by initiating a 'Fragility Project' jointly with a local charity to employ a community support worker to support and be a champion for the older person, offering holistic wellbeing support within the home while promoting access to medical care through the practice. We saw evidence that the recruitment process for the community support worker was nearly complete. The idea was developed as a result of a member of staff attending a local day service for older people to offer the flu vaccination. They identified that this patient group would benefit from one to one support and advice on other aspects of their health and wellbeing.

Our discussions with the GPs showed a commitment to understanding their patient population and responding to their needs effectively by increasing their knowledge and awareness. One of the GPs had completed training in 'Practitioner Health' as they had identified that the practice population included a high percentage of medical staff and they felt this would enable them to understand this group better. Another GP had undertaken continuing professional development course looking at 'Remote and Rural Medicines'. This enabled them to spend time working in a remote area understanding how people living in isolated areas accessed healthcare services. The GP was considering how the learning could be implemented to benefit patients registered at the practice who lived in isolated areas in the local village.

The practice also delivered core services to meet the needs of the main patient population they treated. For example, screening services were in place to detect and monitor the symptoms of long term conditions such as heart diseases and chronic obstructive pulmonary disease (COPD). There were nurse led services such as asthma and diabetes. There were vaccination clinics for babies and children and women were offered cervical screening. Patients over the age of 75 years had a named GP to ensure their care was co-ordinated.

The practice followed the gold standards framework for end of life care (GSF). The GSF helps doctors, nurses and care assistants provide the highest possible standard of care for all patients who may be in the last years of life. There was a palliative care register and regular multidisciplinary meetings to discuss patients and their families care and support needs.

The practice was registered with the National Association for Patient Participation. We saw that the practice had an active and engaged patient participation group (PPG). PPGs are a way in which patients and GP surgeries can work together to improve the quality of the service. The practice in conjunction with the PPG devised a survey in the year 2014 for patients based on the work that the PPG and the practice had done over the last two to three years. The survey looked at areas such as patients awareness of the PPG and to obtain general feedback. As a result of the

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

patient survey the newsletter was utilised to promote the PPG, a picture board of the GP registrars was put up in the patient waiting area so that they were easily identifiable as patients wanted to be familiar with new staff working at the practice. The PPG had also raised concerns around the access to services for young people and how this could be addressed. One of the actions was to introduce a 'C Pack' which was a pack with information around a young person's rights regarding confidentiality and information on sexual health and contraception. The pack included information about services available to young people at the practice and locally. We saw a poster in the patient waiting areas informing young people that this pack was available.

The PPG had recognised the need to recruit new members who were reflective of the practice population. They did this by engaging with local schools to encourage young people to join. The PPG had its own newsletter which was circulated to everyone in the local village in conjunction with the local parish council and was also available on the practice website.

### Tackling inequity and promoting equality

The practice was engaging with vulnerable groups to reduce barriers to health and promote equality. For example recognising the needs of older 'frail' patients and those from the traveller community.

The premises was leased from a local village trust, this limited the changes that could be made. There were no allocated disabled parking although there were sufficient parking spaces to accommodate patients. The practice was on ground level and there was a ramp access and a handrail leading from the car park into the practice. There were no automatic doors on entering the practice however, a poster was displayed informing patients to ring the bell if they required assistance. There were disabled toilet facilities and all of the surgery doors were wide enough for wheelchair access. The practice had not completed a Disability Discrimination Act (DDA) audit to show compliance with the Disability Discrimination Act (1995). This act ensures providers of services do not treat disabled people less favourably, and must make reasonable adjustments so that there are no physical barriers to prevent disabled people using their service. The practice manager acknowledged this would enable them to better assess access for patients with a disability.

The practice had a loop induction system and information on the practice website was available in an audio format to support people with hearing impairments. The PPG newsletter was available in large print.

There was no designated area for baby changing but patients could access a baby changing mat at reception. There were toys in the patient waiting area and the waiting area was large enough to accommodate push chairs.

### Access to the service

The practice was open Mondays, Tuesdays, Wednesday and Fridays between 08:30am and 1pm and 2.30pm until 6pm. The practice was open on Thursdays from 0830am to 1pm. However, patients had access to a GP via a mobile number during core hours. There was extended opening hours on Tuesdays between 6.30pm to 7.30pm which would benefit working age patients. The practice had opted out of providing out-of-hours services to their own patients. This service was provided by 'Badger' the external out of hours service contracted by the Clinical Commissioning Group (CCG).

We looked at results of the most recent national GP patient survey. The results showed that overall the practice performance in most areas relating to access was in line with the national average. This included making appointments, phone access and the proportion who stated that they always or almost always saw or spoke to the GP they preferred.

The practice was a teaching and training practice this meant that there was a constant flow of new GP Registrars working at the practice (fully qualified doctors who wish to become general

practitioners). This information was made clear to patients both on in the patient waiting area, on the practice website and information leaflet. However, a small proportion of patients told us they wanted to see a regular GP and felt they could not always do this. We discussed this with the GPs and practice manager who told us that patients did not have to see a registrar and in most cases when they did the GP would oversee the consultation process, they explained that patients could always see a GP of their choice although this could mean a longer waiting time. They recognised that they needed to educate patients to help them understand the process more clearly.

We looked at the appointment system at the practice. We saw that appointments were available approximately four

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

weeks in advance. When these appointments were booked, urgent appointments were released each day. Home visits were undertaken for those patients who were unable to attend the practice. Telephone consultations were available so that any patients who had urgent queries could speak to a GP or a Practice Nurse. Patients had the opportunity to book a double appointment if they required additional time.

We saw that the practice had around 40 patients each month who did not attend their appointments (DNA) and action had been taken to try and reduce the DNA rates. This included sending letters to patients to raise their awareness on the importance of cancelling appointments, a poster displayed in the patient waiting area and information in the PPG newsletter highlighting the issue. We were told that mobile text reminders were sent to patients reminding them of their appointments

### Listening and learning from concerns and complaints

There was an accessible complaints system with evidence demonstrating that the practice recorded and responded to issues raised. The practice had a system in place for handling complaints and concerns. We saw that there had been one complaint made in the last 12 months and this was still in progress, so the action had not yet been completed. There was a complaints log that enabled themes and trends to be identified and acted on. Sharing of lessons learnt and discussions with staff following a complaint were included in staff meetings.

We saw that the complaints poster was on display in the patient waiting and informed patients to contact the practice manager with any complaints, concerns, but it did not include contact details of organisations that patients could escalate complaints to. We discussed this with the practice manager who agreed to include this information on the poster to ensure it was accessible to patients.

# Are services well-led?

Good

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

## Our findings

### Vision and strategy

The practice had developed a vision statement which was accessible to patients and staff. The aim was to provide excellent healthcare by understanding and meeting the needs of their patients, encouraging them to participate in the decision making process and enabling them to make informed healthcare choices. It also included providing staff with necessary training and facilities to provide an exemplary service. Staff who we spoke with demonstrated the vision for the practice and a commitment to improving the quality of the service for patients.

The GP partners had plans to develop and expand service provision for the future to further meet the needs of the local population although these plans had not been formally documented. The plans reflected the needs and capacity of the local population. Our discussion with them demonstrated a commitment to improving the quality of the service for patients through the process of engaging with patients and responding to their needs. We identified an area of outstanding practice in relation to how the practice responded to the needs of vulnerable patient groups which supported their vision, aspiration and potential.

### Governance arrangements

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

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

The GPs at the practice had various lead roles in areas such as mental health and safeguarding. One of the nurses was the sexual health development lead for the CCG. This provided the opportunity for staff to develop specialist knowledge and expertise and for other staff to obtain support and advice. There were also regular staff meetings held which provided the opportunity to discuss significant events, complaints and share good practice. There were systems in place to monitor and review the practice performance for Quality and Outcomes Framework (QOF). Data that we reviewed showed that the practice was working to achieve its QOF target for the current financial year 2014 to 2015.

The GP partners at the practice attended meetings with the local CCG to ensure they were up to date with any changes. Feedback we received from the CCG and NHS England suggested that the practice engaged well with them and staff members attended and led on meetings such as those held for practice managers**.** The practice was also chosen to test pilot projects for the CCG before these were rolled out to other practices for example, the introduction of the Friends and Family test (FFT).

### Leadership, openness and transparency

The aims and values of the service were clearly set out, and these were shared with the staff members. Staff were committed to providing a high quality service. They described the culture of the organisation as supportive and open. All of the GP Registrars (fully qualified doctors who wish to become general practitioners) who we spoke with were very positive about the learning environment. They told us that they felt extremely well supported and had no hesitation in approaching the GPs if they were unsure about anything. Staff said they felt that the service was well-led, and that the practice manager and GP partners provided supportive leadership.

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

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

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

There was evidence that the practice worked alongside the PPG and acted on patient feedback which had resulted in changes being made. Newsletters provided the opportunity

# Are services well-led?

Good

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

for the practice and PPG to engage with patients. The practice manager and a GP partner attended PPG meetings to ensure they remained fully involved and aware of feedback from patients.

The practice gathered feedback from the staff generally through appraisals, meetings and informal discussions. Staff who we spoke with told us that they felt listened to and gave examples such as ideas to develop service provision for older patients.

### Management lead through learning and improvement

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

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

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

Both GP's were GP trainers and appraisers working with Health Education West Midlands and universities to support GP registrars and medical students.This was reflected in the delivery of care and treatment which was evidence based.