Coachmans Medical Practice

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Coachmans Medical Practice on 25 March 2015. Overall the practice is rated as good.

Coachmans Medical Practice provides services to people living in the covering the areas Crawley. At the time of our inspection there were approximately 10,100 patients registered at the practice with a team of six partners which included four GPs, the practice manager and the practice nurse manager. The practice was also supported by GPs, nurses, healthcare assistants and a team of reception and administrative staff. Coachmans Medical Practice is a GP training practice and at the time of the inspection was providing training and support to one registrar.

We visited the practice location at Coachmans Medical Practice, Lansbury Road, Broadfield, Crawley,

West Sussex, RH11 9JA

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

Our key findings were as follows:

- Staff understood their responsibilities to raise concerns, and to report incidents and near misses.
- Information about safety was recorded, monitored, reviewed and addressed.
- Risks to patients were assessed and well managed
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned.

Summary of findings

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment and urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management.
- The practice proactively sought feedback from staff and patients, which it acted on

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

In addition the provider should:

- Ensure that patients on certain medicines have their blood pressure regularly monitored as recommended by National Institute for Health and Care Excellence (NICE) guidelines.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs have been identified and planned. The practice was able to demonstrate that appraisals and personal development plans had taken place for all staff. Staff worked with local multidisciplinary teams to provide patient centred care. We reviewed records for patients receiving a certain medicine for behavioural problems. We noted that blood pressure reviews had not always taken place in the recommended time frames as required by National Institute for Health and Care Excellence (NICE).

Are services caring?

Good

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

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Patients reported good access to the practice and continuity of care, with urgent appointments available the same day. 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. There was evidence of shared learning from complaints with staff and patients. The practice had arrangements in place to support patients with disabilities. The layout of the building enabled patients with mobility problems to gain access without assistance. Home visits and telephone consultations were available.

Are services well-led?

Good

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

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older patients. Nationally reported data showed that outcomes for patients were positive for conditions commonly found in older patients. There were arrangements in place to provide flu and pneumococcal immunisation to this group of patients. Patients were able to speak with or see a GP when needed and the practice was accessible for patients with mobility issues. Clinics included diabetic reviews and blood tests. Blood pressure monitoring was also available. The practice offered personalised care to meet the needs of the older patients in its population. It was responsive to the needs of older people, and could offer home visits. The practice had a safeguarding lead for vulnerable adults. The practice had good relationships with a range of support groups for older patients.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had 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.Flu vaccinations were routinely offered to patients with long term conditions to help protect them against the virus and associated illness.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. Immunisation rates were relatively high for all standard childhood immunisations. Specific services for this group of patients included family planning clinics, antenatal clinics and childhood immunisations. The practice offered contraceptive implants. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly. Practice staff had received safeguarding training relevant to their

Summary of findings

role and knew how to respond if they suspected abuse. Safeguarding policies and procedures were readily available to staff. The practice ensured that children needing emergency appointments would be seen on the day.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age patients (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. Patients were able to request a GP to telephone them instead of attending the practice. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of patients whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances for example those with complex health needs. The practice ensured that patients classed as vulnerable had annual health checks. The practice offered longer appointments for patients when required. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. Translation services were available for patients who did not use English as a first language. The practice could accommodate those patients with limited mobility or who used wheelchairs.Accessible toilet facilities were available. The practice supported patients who were registered as a carer.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of patients experiencing poor mental health (including patients with dementia). Patients with severe mental health needs had care plans and new cases had rapid access to community mental health teams. The practice worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. The practice had sign-posted patients experiencing poor mental health to various support groups and local organisations. The practice worked with the local mental health team and consultants.

Summary of findings

What people who use the service say

Patients told us they were satisfied overall with the practice. Comments cards had been left by the Care Quality Commission (CQC) before the inspection to enable patients to record their views of the practice. We received 35 comment cards which contained positive comments about the practice. We also spoke with six patients on the day of the inspection.

We reviewed the results of the national patient survey from 2014 which contained the views of 102 patients registered with the practice. The national patient survey showed patients were consistently pleased with the care and treatment they received from the GPs and nurses at the practice. The survey indicated that 98% of respondents said their last appointment was convenient to them, 97% said they had trust and confidence in the last GP they saw and 98% say the last nurse they saw or spoke to was good at listening to them. All of these scores were well above the average local Clinical Commissioning Group results.

The practice provided us with a copy of the practice patient survey results from February 2014. The findings indicated 89% of respondents rated the practice as good, very good or excellent and 84% said they felt listened to and 87% said they were felt respected.

We spoke with six patients on the day of the inspection and reviewed 35 comment cards completed by patients in the two weeks before the inspection. The patients we spoke with and the comments we reviewed were positive. Comments about the practice included that patients felt listened to, cared for and respected. Comments also included that staff were friendly, caring and professional. Some of the patients had been registered with the practice for a number of years and we received comments in relation to the support the practice gave to them and their family members.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that patients on certain medicines have their blood pressure regularly monitored as recommended by National Institute for Health and Care Excellence (NICE) guidelines.

Coachmans Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector. The team included a GP and a Practice Manager specialist.

Background to Coachmans Medical Practice

Coachmans Medical Practice offers general medical services to patients. There are approximately 10,100 registered patients.

The practice is run by six partners which include four GPs, the practice manager and the practice nurse manager. The practice is also supported by practice nurses, healthcare assistants, a team of receptionists and administrative staff, a deputy practice manager, an IT manager, a building services manager, and a practice manager.

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

Services are provided from the location:

Lansbury Road, Broadfield, Crawley, West Sussex, RH11 9JA

There are arrangements for patients to access care from an Out of Hours provider through NHS 111.

The practice population has a significantly lower number of patients between 55-85 years of age than the national and local CCG average, with a significantly lower number of patients aged over 65 years of age. Patients aged 0-9 and 15-39 were above average, with a significant higher proportion 0-9 year old and 25-34 year olds than the national average. There are fewer patients with a long standing health condition and the percentage of registered patients suffering deprivation (affecting both adults and children) is slightly higher than the average for England.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme, under the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014

How we carried out this inspection

Before visiting the practice we reviewed a range of information we hold. We also received information from local organisations such as NHS England, Healthwatch and the Crawley Clinical Commissioning Group (CCG). We carried out an announced visit on 25 March 2015. During our visit we spoke with a range of staff, including GPs, nurses and administration staff.

We observed staff and patients interaction and talked with six patients. We reviewed policies, procedures and operational records such as risk assessments and audits. We reviewed 35 comment cards completed by patients, who shared their views and experiences of the service, in the two weeks prior to our visit.

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

Detailed findings

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

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

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

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

Good

Are services safe?

Our findings

Learning and improvement from safety incidents

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts, as well as comments and complaints received from patients. The staff we spoke to were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

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

Reliable safety systems and processes including safeguarding

The practice had a system for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred and we reviewed records from the last 12 months. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at meetings and felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We saw records for incidents were completed in a comprehensive and timely manner. We saw evidence of action taken as a result.

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

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. Staff were able to tell us of what they would do if there was a problem with a medicine refrigerator.

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

There was a comprehensive medicines management policy in. The duty doctor took ownership of patient repeat prescription requests and patient medicines reviews were organised in line with the National Prescribing Centre guidance. GPs maintained records showing how they had evaluated the medicines and documented any changes. Where changes were identified the practice liaised with the patient to describe why the change was necessary and any impact this may have. Blank prescription forms were stored securely and were tracked through the practice in accordance with national guidance.

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

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who could provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits and that any improvements identified for action were completed in a timely manner. We noted the last audit score was 100% and no actions were required.

Good

Are services safe?

An infection control policy and supporting procedures were available for staff to refer to including a policy for needle stick injury. This enabled staff to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff were able to describe how they would use these to comply with the practice's infection control policy.

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 all treatment and consulting rooms.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients and on the day of the inspection we note that an outside company was completing these checks.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers and blood pressure measuring devices.

Staffing and recruitment

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

Staff told us there were suitable numbers of staff on duty and that staff rotas were managed well. The majority of practice staff worked part time which allowed for some flexibility in the way the practice was managed. For example, staff were available to work overtime if needed and could be available for annual leave and sickness absence cover. 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 ensure patients were kept safe. We noted the practice had not required the use of locum doctors.

Monitoring safety and responding to risk

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

We saw that any risks were discussed at practice meetings and within team meetings. For example, the infection control lead had shared the recent findings from an infection control audit with the team.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For patients with long term conditions and those with complex needs there were processes to ensure these patients were seen in a timely manner. Staff told us that these patients could be urgently referred to a GP and offered double appointments when necessary.

Arrangements to deal with emergencies and major incidents

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

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

Good

Are services safe?

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included adverse weather, unplanned sickness and access to the building.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines. For example, the practice nurse manager was the lead for supporting the nurses and healthcare assistants.

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 by their GP according to need.

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

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

Management, monitoring and improving outcomes for people

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

The practice showed us clinical audits that had been undertaken. We were able to see completed audits where the practice was able to demonstrate the changes resulting since the initial audit. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit reviewing contraception and contraception advice given after prescribing a particular medicine. The audit had two cycles so that the practice could monitor if improvements had been made after the initial findings and recommendations. Following the second audit, it was noted that the clinical team have improved the rate of contraceptive advice given from 8% to 50% and improved the rate of contraception from 48% to 66%.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 100 % of patients with diabetes had received the flu jab and 94% had a record of retinal screening in the preceding 12 months. We also noted that 92% of patients with chronic obstructive pulmonary disease (COPD) had a review, undertaken by a healthcare professional in the preceding 12 months and 100% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the record, in the preceding 12 months. The practice met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF (or other national) clinical targets.

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

Good

Are services effective?

(for example, treatment is effective)

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

The practice provided an enhanced service to patients who were most likely to be subject to unplanned hospital admissions. Patients were highlighted on the practice computer system so that their care could be prioritised.

We reviewed records for patients receiving a certain medicine for behavioural problems. We noted that blood pressure reviews had not always taken place in the recommended time frames as required by National Institute for Health and Care Excellence (NICE). We bought this to the attention of the senior GP and practice manager. After the inspection the practice manager sent us an action plan regarding the concerns raised. The action plan ensured that all outstanding blood pressure reviews would be completed and the practice had updated their procedures to ensure that the medicine could not be repeat prescribed without the patient having a blood pressure review in the recommended time frame.

Effective staffing

We looked through training records for staff and noted that training was up to date. Staff had completed training in subjects such as basic life support, fire awareness and safeguarding children and adults. Staff we spoke with told us of the training they had completed. They told us that training for the whole practice happened four times a year and that guest speakers delivered the training. Staff told us they appreciated this method of training as it allowed for greater interaction with the trainers and a better understanding of the subject.

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff had annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example one staff members told us they were being supported to undertake a diploma in their field of work. As the practice was a training practice, doctors who were training to be qualified as GPs had access to a senior GP throughout the day for support. We received positive feedback about this from the registrar we spoke with.

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, travel health and cervical cytology. Those with extended roles, for example seeing patients with long-term conditions such as asthma and chronic obstructive pulmonary disease (COPD) were able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. Relevant staff were aware of their responsibilities 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. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

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

Information sharing

Good

Are services effective?

(for example, treatment is effective)

The practice used 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. The practice used a referral system for patients requiring specialist treatment and dedicated staff were used to ensure referrals were done in a timely manner. The GPs spoke with patients as to where they would like their consultation to be before organising the referral.

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

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 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. Staff we spoke with highlighted how patients should be supported to make their own decisions and how this would be documented in the medical notes. We saw evidence that the practice staff had received training for the Mental Capacity Act (MCA) 2005 and Deprivation of Liberties (DoLs) in February 2015

Care plans were used to support patients to make decisions regarding their care. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it. 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. The GPs demonstrated a clear understanding of Gillick competencies. (Gillick competencies 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 GPs we spoke with told us they always sought consent from patients before proceeding with treatment. GPs told us they would give patients information on specific conditions to assist them in understanding their treatment and condition before consenting to treatment. We noted there was a consent policy for staff to refer to. The policy referred to implied and expressed consent and how patients have the right to refuse consent at any time. Patients consented for specific interventions for example, birth control implants, by signing a consent form. Patient's verbal consent was also documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure discussed with the patient.

Health promotion and prevention

It was practice policy to offer a new patient health check with the health care assistant to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic smoking cessation advice to smokers.

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 long term conditions and offered an annual physical health check. The practice had also identified the smoking status of 86% of patients over the age of 16 and 97% of female patients who were prescribed an oral or patch contraceptive method in the last 12 months had also received relevant information in relation to methods of contraception. We noted that 100% of patients diagnosed with diabetes had received their flu immunisation.

The practice's performance for cervical smear uptake was 83%, which was comparable with other practices nationally. There was a mechanism of following up patients who did not attend such as telephone reminders for patients who did not attend for cervical smears.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. We reviewed our data and noted that 98% of children aged below 24 months had received their mumps, measles and rubella vaccination. There was a mechanism in place to follow up patients who did not attend screening programmes. Last year's performance for all immunisations was slightly above average for the Clinical Commissioning Group, and again there was a clear policy for following up non-attenders.

Health information was made available during consultation and GPs used materials available from online services to

Good

Are services effective?

(for example, treatment is effective)

support the advice they gave patients. There was a variety of information available for health promotion and prevention in the waiting area and the practice website referenced websites for patients looking for further information about medical conditions.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a survey of 249 patients undertaken by the practice's patient participation group (PPG). The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was above average for its satisfaction scores on consultations with doctors and nurses with 84% of practice respondents saying the GP was good at listening to them and 81% saying the GP gave them enough time.

We also spoke with six patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Patients said they felt the practice offered an excellent service and staff were friendly, considerate and caring. They said staff treated them with dignity and respect. Patients completed CQC comment cards to tell us what they thought about the practice. We received 35 completed cards and all were positive about the service experienced

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that 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. The practice switchboard was located away from the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. The practice had a queuing system at the front desk so that only one patient could come forward at a time. We also noted that music was played in the waiting area which all helped to protect patient privacy. Patients were able to book in using an electronic booking in system which also allowed for a patient confidentiality. Staff were able to give us practical ways in which they helped to ensure patient confidentiality. This included not having patient information on view.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 76% of practice respondents said the GP involved them in care decisions and 87% felt the GP was good at explaining treatment and results. Both these results were around average when compared to the local clinical commissioning group area.

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 also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

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

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The results of the national GP survey showed that 81% of patients said the last GP they saw or spoke to was good at treating them with care and concern and that 99% of patients said the nurses were also good at treating them with care and concern. 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.

Good

Are services caring?

Notices in the patient waiting rooms and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We noted an information board in the waiting area which contained information for carers to ensure they understood the various avenues of support available to them. The practice manager informed us that a carer support worker visited the practice on Monday afternoons

Staff told us that if families had suffered bereavement, their GP would contact them. Staff could also arrange a patient consultation at a flexible time and would give them advice on how to find support services.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The practice ran a duty doctor rota. The duty doctors' role was to ensure that patients received triage in a timely fashion, see emergency patients and review and sign repeat prescriptions. Their role was to also support staff and had an open door policy. Staff we spoke with told us that the duty doctor was always available to them. One member of reception staff told us that they had received a call from a parent wanting to book an appointment for their child. After talking to the parent the receptionist was concerned that the symptoms needed a more urgent appointment. They were able to speak with the duty doctor straight away, who spoke with the parent and offered an urgent appointment.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from patients. For example, the practice had received comments that patients waited a long time for calls to be answered during peak times of the day. In response to this the practice had increased staff numbers during these times to answer the phones and was monitoring calls coming into the practice to ensure demand was being met.

Longer appointments were available for patients who needed them and for those with long term conditions. GPs completed telephone consultations each day and home visits could be requested when necessary. Working age patients were able to book appointments and order repeat prescriptions on line.

The practice supported patients with complex needs and those who were at risk of hospital admission. The practice worked closely with the local proactive care team which included district nurses, health visitors and the palliative care team. Personalised care plans were produced and were used to support patients. Patients with palliative care needs were supported. The practice had a palliative care register and held regular internal as well as multidisciplinary meetings to discuss patient and their families care and support needs.

Patients with long term condition had their health reviewed in an annual review. The practice provided care plans for asthma, chronic obstructive pulmonary disease (COPD), diabetes, dementia and severe mental health. Childhood immunisation services were provided through dedicated clinics and administrative support to ensure effective follow up. Post natal and six week check were provided and the midwife held clinics each week at the practice.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The number of patients with a first language other than English was low. Staff knew how to access language translation services if these were required. The practice website also had the functionality to translate the practice information into 21 different languages. We noted that staff had received equality and diversity training and that there was a policy to support staff. The practice had a hearing loop for those patients with hearing impairments.

The premises and services had been adapted to meet the needs of people with disabilities. The practice was purpose built and situated over three floors, with the top floor being for staff only. There was a lift which allowed access for patients to the first floor. We noted patients had access to the front entrance of the practice via a slope and doors which had an automatic opening mechanism. Patients with restricted mobility could easily enter the practice and had level access to the reception desk. The waiting area was accessible for wheelchairs and mobility scooters. Accessible toilet were available for all patients attending the practice. The practice had a parent room for patients who had small babies. This could be used for feeding as well as including baby changing facilities. There was also an interview room where patients could speak privately to members of staff or could be used for patients who felt uncomfortable in the waiting room.

Access to the service

The surgery was open Monday to Friday 8am to 6:30pm. Appointments were available from 8:30am until 12:30pm and from 2pm to 6:30pm. Patients could book

Good

Are services responsive to people's needs?

(for example, to feedback?)

appointments up to four weeks in advance, with a number of appointments available on the day for patients who called. The practice operated a telephone triage service every morning and afternoon.

Comprehensive information was available to patients about appointments on the practice website and through a practice leaflet. This included how to arrange urgent appointments and home visits. 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.

Patients were generally satisfied with the appointments system. The practice operated a triage system for those patients calling the practice on the day for an appointment. Patients would be called back by the most appropriate clinical lead (or example a GP or nurse) and if needed a face to face appointment would be offered. Patients we spoke with confirmed that they could a see a doctor on the same day if they needed to. They told us they had been able to get appointments at a time convenient to them. Staff told us longer appointments were also available for patients who needed them for example, those with long-term conditions.

Data from the national patient survey indicated that 91% of respondents said the last appointment they got was convenient**.** On the day of inspection we asked staff when the next available appointment would be for a fasting blood test and a pre-bookable appointment with GP. We were given an appointment for the nurse for the fasting blood test for the following morning. The first available pre-bookable slot for the GP was in there weeks' time however, this did take in to account the long bank holiday in April. The receptionist did inform us that we could book a triage appointment if we wanted to speak to a GP rather than wait for three weeks.

Listening and learning from concerns and complaints

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

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

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

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values in their statement of purpose. The practice vision and values included to provide high quality, accessible health care to registered individuals and families without discrimination. The vision also included a focus on providing a safe and clean environment; that patients felt included in decision making and to operate in an approachable and friendly way where patients were proactively involved in providing feedback.

We spoke with 15 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. Staff spoke positively about the practice and thought that there was good team work. They told us they were actively supported in their employment and described the practice as having an open, supportive culture and being a good place to work. Many of the staff had worked at the practice for a number of years and all the staff we spoke with were positive about the open culture.

Governance arrangements

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

The practice had a business development plan which set out the practice's objectives for patients and the practice over the next year. For example, the plan indicated the continued importance of patient feedback and ensuring a good skill mix of staff with job satisfaction and regular training.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead for infection control and a GP partner was the lead for safeguarding. We spoke with 15 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, we saw audits for a specific medicine and liver function tests and an audit to identify if patients under 18 years had their weight checked if prescribed a certain medicine.

The practice had robust arrangements for identifying, recording and managing risks. The buildings manager and practice manager showed us risk assessments, which addressed a wide range of potential issues, such as infection control, fire and legionella.

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

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly and there were both management and clinical meetings. Staff told us that twice a day the team met for a coffee a break and would use that time to discuss patients, concerns, significant events or complaints. They told us that although these were also discussed formally it meant that they could be offered support or advice straight away. There was an open culture within the practice and staff told us they were happy to raise issues and felt encouraged to do so. For example, staff we spoke with told that the duty doctor was always available. The practice had a policy that unless the duty doctor was with a patient, staff were to knock and enter the duty room straight away. Staff told us that social events had been arranged by the practice. These events were used for senior staff members to thank staff for their work and provided an opportunity for reflection.

Are services well-led?

Good

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

We saw there were a number of human resource policies and procedures in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equal opportunities, stress management and grievance procedure. Staff were aware of the whistle blowing policy. They told us they knew it was their responsibility to report anything of concern and knew the practice and senior team members would take their concerns seriously and support them. Staff we spoke with knew where to find these policies if required.

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

The practice had a patient reference group (PRG). There were currently 72 patients who were members of the PRG and we were able to speak with two on the day of the inspection. They told us that they were a virtual group and that communication was via e-mail rather than meetings. One of the people we spoke with informed us they represented Coachmans Medical Practice at a practice wide meeting run by the local clinical commissioning group (CCG). They informed us they met with the practice manager to discuss findings from the CCG meetings and bring ideas to the practice. The PRG supported and advised the practice in areas such as, the on-line booking system, a separate phone line for cancelling appointments and creating an action plan from the patient survey. The practice manager showed us the analysis of the surveys completed and the reports and action plans agreed with the PRG were available on the practice website for patients to see. The practice had also gathered feedback from patients through patient surveys, comment cards and complaints received.

We looked at the results of the annual patient survey from January 2014. We saw that some patients had requested a texting service. We saw this service was now in operation for those patients who had consented. Regular reminders were sent to patients in relation to up and coming appointments.

The practice had gathered feedback from staff through staff discussion, meetings and appraisals. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. For example, the call centre for incoming calls was originally situated on the second floor. Staff had suggested this be moved to a ground floor room so that the team could also support the front desk receptionist. We saw this had been action and all staff thought this new arrangement was working well.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place which included reviews from colleagues and a personal development plan. Staff told us that the practice was very supportive of training and that they had regular training organised by the practice. We looked through training records for staff and saw that staff had completed training in basic life support, fire awareness, information governance, child protection and safeguarding vulnerable adults. A staff member told us they were being supported by the practice to attain further qualifications in their field of work. Two staff members, who had originally been employed as receptionists, had been encouraged to develop their roles within the practice. We noted that one was now a healthcare assistant and the other was the reception manager.

All staff received an induction when they first started work. Staff we spoke with told us they were given a buddy to work with and had one to one meetings with a senior staff member to discuss their progress. They told us they had a meeting after three months to ensure they felt competent in doing the role and could discuss any further training requirements. We saw the practice used an induction check list to record the dates that staff were signed off on various subjects. For example, after supplying the required recruitment information and after training had been provided.

The practice was a GP training practice and supported new registrar doctors in training. At the time of the inspection the practice had one registrar GP. Registrars were supported in their role by experienced, trained GPs and received supervision and mentoring throughout their period in the practice.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients and staff. For example, we noted that a significant event had

Are services well-led?

Good

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

highlighted the need to remove nail varnish from a patient in order to monitor their oxygen levels. Due to this event nail polish remover was now included in the practices' emergency box.