Bennfield Surgery

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Bennfield Surgery on 22 July 2015. Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for the 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, and people experiencing poor mental health (including people with dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Opportunities for learning from internal and external incidents were maximised.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the treatment choices available to them.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).
- 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.
- The practice had a well-established and well trained team and had expertise and experience in a wide range of health conditions.
- The practice had a clear vision which had quality and safety as its top priority. A delivery plan for the next 12 months was in place, was monitored and regularly reviewed and discussed with all staff. High standards were promoted and owned by all practice staff.

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 report incidents and near misses. The practice provided opportunities for the staff team to learn from significant events and was committed to providing a safe service. Information about safety was recorded, monitored, appropriately reviewed and actioned. Clinical staff held regular meetings to discuss safety concerns. The practice assessed risks to patients and managed these well. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the area. Patients' care and treatment was delivered using the guidelines issued by the National Institute for Care and Health Excellence (NICE). Patients had their needs assessed and received care that was planned and delivered in line with current legislation. The practice was proactive in the care and treatment provided for patients with long term conditions and regularly audited areas of clinical practice. All patients with long term conditions were reviewed at least annually. There was evidence that the practice worked in partnership with other health professionals. Staff received training appropriate to their roles and the practice supported and encouraged their continued learning and development.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients told us they were treated with compassion, dignity and respect. They were involved in decisions related to their care and treatment. Accessible information was provided to help patients understand the care available to them. We saw staff treated patients with kindness and respect and were aware of the importance of confidentiality. The practice provided advice, support and information to patients, particularly those with long term conditions and to families following birth and bereavement.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice was aware of the needs of their local population and engaged with the NHS Area Team and the Coventry and Rugby Clinical Commissioning Group (CCG) to obtain service improvements where these were identified. Patients told us there was good access to the practice and said they would always be seen

Summary of findings

on the same day in an emergency. There were good practice facilities and the premises were well equipped to treat patients and meet their needs. There was a clear complaints system with evidence demonstrating that the practice responded quickly to issues raised. The practice had a positive approach to using complaints and concerns to improve the quality of the service.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision which was promoted amongst patients and staff and was regularly reviewed. Quality and safety were highly prioritised. High standards were promoted and owned by all practice staff and teams worked together across all roles. Governance and performance management arrangements had been introduced and dates set for them to be reviewed. They took account of current models of best practice. Staff had received inductions, regular performance reviews and attended staff meetings and events. Minutes of staff meetings needed to consistently record decisions taken and identify staff responsible for completing actions. The practice proactively sought feedback from patients and had an active Patient Representative Group (PRG).

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

This practice is rated as good for the care of older patients. Patients over the age of 75 had a named GP and were included on the practice's avoiding unplanned admissions list to alert the team to patients who may be more vulnerable. Those most at risk had a care plan in place. GPs and practice nurses carried out visits to patients' homes if they were unable to travel to the practice for appointments. Flu vaccinations and blood tests were also carried out at patients' homes if required. Patients who received palliative care were given support to stay in their own homes if they wished to do so. The practice worked in conjunction with the Macmillan nursing team and district nursing team. Carers were actively identified and notes placed on patient records to identify them. Patients were signposted to voluntary organisations for additional support when appropriate, for example, AGE UK and Rugby Dementia Support Group.

People with long term conditions

Good

This practice is rated as good for the care of patients with long term conditions, for example asthma, COPD and diabetes. The practice had effective arrangements for making sure that patients with long term conditions were invited to the practice for annual reviews of their health. Medication reviews were carried out at the same time. Clinics were held for a range of long term conditions, including diabetes, arthritis and chronic obstructive pulmonary disease (COPD). Members of the GP and nursing team at the practice ran these clinics. Patients most at risk of unplanned hospital admissions had care plans in place. Patients whose health prevented them from being able to attend the surgery received the same service from one of the practice nurses as home visits were arranged. Patients told us they were seen regularly to help them manage their health.

Families, children and young people

Good

This practice is rated as good for the care of families, children and young people. The practice held weekly childhood vaccination clinics and its rates of immunisation for children was above average for the Coventry and Rugby Clinical Commissioning Group (CCG). Twice-weekly antenatal and baby and children's clinics were held. Regular child at risk meetings were held with relevant professionals, including social services and health visitors. All clinical staff had received child safeguarding training. Following the Coventry Serious

Summary of findings

Case Review published in September 2013, the practice started to actively follow up all children who failed to attend appointments at the practice or at hospital. The practice also provided cervical screening and a family planning service.

Working age people (including those recently retired and students)

Good

This practice is rated as good for the care of working age patients, recently retired people and students. The practice provided extended opening hours on Saturday mornings. The practice maximised the use of telephone consultations for patients who worked when clinically appropriate to avoid them having to take time off work to visit the practice. NHS health checks were carried out for patients aged 40-75. Smoking cessation support was available for patients who smoked.

People whose circumstances may make them vulnerable

Good

This practice is rated as good for the care of patients living in vulnerable circumstances. Regular reviews were carried out by a GP partner who was the learning disability (LD) lead. This GP was also trained to use Makaton sign language. The practice had an LD register. All patients with learning disabilities were invited to attend for an annual health check. Staff were aware of safeguarding procedures and all clinical staff had undertaken safeguarding for adults training. GPs told us how alerts were placed on the records of potentially vulnerable patients.

People experiencing poor mental health (including people with dementia)

Good

This practice is rated as good for the care of patients experiencing poor mental health (including people with dementia). The practice had a register of patients at the practice with mental health support and care needs and invited them for annual health checks. Staff described close working relationships with the community mental health team, consultant psychiatrists and social services staff. A therapist from Improving Access to Psychological Therapies (IAPT) visited the practice weekly to work with patients. These teams worked with the practice to identify patients' needs and to provide patients with counselling, support and information. Patients were also signposted to voluntary organisations for additional support when appropriate, for example, AGE UK and Rugby Dementia Support Group. The practice carried out dementia screening and planned to give all dementia patients a care plan by April 2016. It was already some way through this exercise.

Summary of findings

What people who use the service say

We gathered the views of patients from the practice by looking at 34 CQC comment cards patients had filled in and by speaking in person with eight patients. Two patients we spoke with were involved with the Patient Representative Group (PRG). The PRG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

All patients we spoke with and those who completed comment cards were satisfied with the service provided by Bennfield Surgery. Patients said GPs and practice nurses treated them with dignity and respect, were caring and compassionate and gave them the time they needed.

The 2014 GP National Patient Survey revealed that 93% of patients described their overall experience of this practice as good, against an average for the Coventry and Rugby CCG of 84%; 78% of patients said they were satisfied with the practice opening hours, compared to 75% for the CCG and 93% of patients said the last GP they saw or spoke with was good at listening to them; this was above the average for the CCG of 88%.

Most of the patients we spoke with and those who completed comment cards said they could easily obtain appointments at the practice. Eight patients said it could be difficult to get through on the telephone at times. Data gathered during the 2014 GP National Patient Survey showed that 44% of patients found it easy to get through to the practice by telephone, below the 74% average for the CCG and 76% of patients found their experience of making an appointment to be good compared to 71% for the CCG.

Bennfield Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector. The inspection team also included a GP specialist advisor, a practice manager specialist advisor and an expert by experience (a person who has experience of using this particular type of service, or caring for somebody who has).

Background to Bennfield Surgery

Bennfield Surgery is located on the outskirts of Rugby town centre. It began in 1988 as Warwick Street Surgery and moved to its current location in 2004 when it was renamed Bennfield Surgery. There are currently just under 7800 patients registered at the practice. It is located in a building shared with another GP practice and other non-NHS organisations.

The practice is located in an area which has some localised pockets of deprivation. There is a large number of eastern European patients registered at the practice and a high number of patients with alcohol dependency.

Bennfield Surgery offers patients a range of NHS services. This includes family planning, minor surgery, an antenatal clinic run by a community midwife, physiotherapy and smoking cessation advice. It is also a training practice and regularly hosts trainee GPs.

The practice has five GP partners (a mix of male and female), one advanced nurse practitioner (who is able to issue prescriptions), three practice nurses and one healthcare assistant. The clinical team are supported by a practice manager, a patient services and reception manager and a team of administrative and reception staff.

There is a chaperone service available for patients who would like to use it. This is advertised inside the practice waiting room and within consultation rooms.

This was the first time the Care Quality Commission (CQC) had inspected the practice. Based on information we gathered as part of our intelligent monitoring systems we had no concerns about the practice. Data we reviewed showed that in most areas the practice was achieving results that were average or in some areas above average with the Coventry and Rugby Clinical Commissioning Group.

The practice does not provide out of hours services to their own patients. Patients are provided with information about local GP out of hours services which they can access by using the NHS 111 phone number.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

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.

Detailed findings

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

Before this inspection, we reviewed a range of information we held about Bennfield Surgery and asked other organisations to share what they knew. These organisations included Coventry and Rugby Clinical Commissioning Group (CCG), NHS England area team and Healthwatch. We carried out an announced inspection on 22 July 2015. During the inspection we spoke with a range of staff (GPs, nurses, practice manager, reception and administrative staff). We spoke with eight patients who used the service, two of whom were members of the Patient Participation Group (PPG).

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

Bennfield Surgery used appropriate methods to identify any potential risks patients might face and to improve safety for patients and staff. During our inspection, we examined previously reported incidents and national patient safety alerts. We also looked at comments and complaints the practice received from patients. Staff we spoke with had a full understanding of the responsibilities they had to raise concerns. They clearly explained how they would report incidents and near misses. This was confirmed by the practices' safety records, incident reports and minutes of meetings where these had been discussed. We looked at these records for the last 15 months and examined two in detail. The records demonstrated all concerns raised had been investigated, discussed in staff meetings and learning points identified and actioned. This showed Bennfield Surgery had managed these consistently over time and demonstrated evidence of a longer term safe track record.

We looked at one example where a patient had collected their prescription from the practice and found another patient's prescription was attached to it. The patient returned the incorrect prescription to the practice. We saw all GPs were immediately informed of the error and all staff who give out prescriptions were reminded of the correct procedure and of the need to be extra vigilant.

During our inspection of Bennfield Surgery, we saw records to demonstrate that information gained from clinical audits and health and safety audits were assessed with patient safety in mind. For example, an audit of significant events was carried out after a GP discovered a patient had not been issued with a medicine that had been prescribed two years earlier. The patient was called in for a review and was found to be well. The practice took appropriate action to ensure that this had been a one-off occurrence.

Learning and improvement from safety incidents

There were procedures in place at Bennfield Surgery to ensure significant events, incidents and accidents were correctly reported and recorded. We looked at the record of significant events that had occurred over the previous 15 months. One incident concerned a patient who was given a vaccination that was out of date by a few days. The practice sought medical advice and was told to repeat the vaccination in 4 weeks' time and confirmed there would have been no risk to the patient. The patient was contacted by telephone and returned for the vaccination at the appointed time. All other medicine stocks held within the practice were immediately checked and all were within date. This incident was reviewed with all clinical staff, procedures were reviewed and re-iterated and we saw evidence of a discussion that took place about ways to ensure the error was not repeated.

Complaints were also reviewed in the same way. We also saw that concerns identified by GPs were also investigated. A GP noticed during a patient consultation that the practice did not seem to know about a recent visit the patient had made to the out of hours service. An electronic fault was discovered which was rectified by the out of hours provider. The practice then received a number of missing reports and entered the details onto all of the relevant patient records within 48 hours. A GP came into the practice on a day off to carry out the bulk of this work.

During our inspection, we saw evidence the practice had learned from significant events and complaints and the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff knew how to raise an issue that needed to be discussed at meetings.

National patient safety alerts were discussed in staff meetings with practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. Staff we spoke with also told us alerts were discussed during staff meetings to ensure they were aware of any that were relevant to the practice and where they needed to take action. Minutes of meetings also confirmed this.

Reliable safety systems and processes including safeguarding

Bennfield Surgery had appropriate procedures to identify, manage and review risks to vulnerable children, young people and adults. The vulnerable adults policy was based on the Warwickshire Inter-Agency Safeguarding Vulnerable Adults Policy, issued by the Warwickshire Safeguarding Adults Partnership, of which the practice was a member.

We looked at training records which demonstrated all staff had received relevant role specific training on safeguarding. We asked members of clinical and administrative staff about their training and examined training records and certificates. Staff we spoke with knew how to recognise signs of abuse in all population groups. Staff were also

aware of their responsibilities, knew how to share relevant information, properly record safeguarding concerns and how to contact the relevant agencies. Contact details for relevant agencies were easily available to staff.

A GP partner was the designated safeguarding lead and had received appropriate training. A deputy had also been appointed and trained to act in their absence. Staff at the practice knew who this lead was and of their responsibility to raise any safeguarding concern with this GP. The lead safeguarding GP was aware of vulnerable children and adults who were registered at the practice and records demonstrated good liaison with partner agencies such as the local authority. GPs told us safeguarding alerts were placed on the records of vulnerable patients.

There was a patient chaperone policy in place. (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.) This was promoted in the patient waiting room and in consulting rooms. Records showed that nursing staff had been trained to be a chaperone and those we spoke with understood the requirements of this task.

The practice also had procedures in place to identify and act on areas of concern. For example, to identify children, vulnerable and elderly patients with a high number of accident and emergency attendances.

Medicines management

During our inspection of Bennfield Surgery, we examined medicines stored in the treatment rooms and medicine refrigerators. They were securely stored and could only be accessed by authorised staff. We saw there was a policy in place to ensure medicines were kept at the correct temperature and the action that should be taken if for example, the refrigerator failed. Procedures were in place to check medicines were within their expiry date and therefore suitable for use. We checked a selection of medicines and found all were within their expiry dates. Staff also explained to us how expired and unwanted medicines were disposed of according to waste regulations.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, changes to blood thinning medication guidelines. For medicines management, the practice received support and advice from Coventry and Rugby Clinical Commissioning Group (CCG) medicines management team. (A CCG is a group of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.) The practice also received regular visits from a CCG pharmacist. Bennfield Surgery's levels of antibiotic prescribing were below the average for the CCG. This meant the practice performed well within this area. Within the last 12 months, 94% of patients who received four or more medicines had received a medicines review at the practice. GPs told us the practice had joined a local prescribing quality scheme which examined elderly people who received eight or more medicines. At the time of our inspection, the practice was waiting for full details and a start date for the programme. The practice was currently the best performing practice for prescribing data within Rugby and was placed 36 out of 75 in the CCG.

Bennfield Surgery had Patient Group Directions (PGD) in place. These gave guidance to nursing staff for the administration of vaccines. A PGD is a written instruction from a qualified and registered prescriber, such as a doctor, for a nurse or appropriately trained person to administer a medicine to groups of patients without individual prescriptions. We saw the PGDs had been signed by all the nurses who administered the vaccines and authorised by a manager. This meant that staff and managers were informed of any changes to the instructions. There was also a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance.

Prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance and kept securely at all times. We saw the procedure for issuing prescriptions had been reviewed within the last 12 months. The practice used the electronic prescription service.

Cleanliness and infection control

We saw Bennfield Surgery was visibly clean and tidy. There were cleaning schedules in place and cleaning records were kept. We also saw information and guidelines about the Control of Substances Hazardous to Health (COSHH). The practice used a contract cleaner and we saw a contract and service level agreement was in place. The contractor was responsible for cleaning the whole building.

Bennfield Surgery had lead staff members for infection control. The role was shared between a practice nurse and

a healthcare assistant. They had received further training which equipped them to provide advice on the practice infection control procedures, undertake infection control audits and give appropriate training to staff. We saw that all staff received infection control training as part of their induction and also received regular updates. The infection control leads carried out regular infection control audits. The most recent had been completed in May 2015, which we examined. No major concerns had been raised as a result of this audit, but a storage area was identified as needing clearing out. This was promptly done. We saw any improvements identified for action following infection control audits were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

The practice had an infection control policy with supporting procedures available for staff to refer to. This enabled staff to organise and implement measures to control infection. They included the safe use and disposal of sharps; use of personal protective equipment (PPE); spills of blood and bodily fluid and needle stick injury. Notices about hand washing techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

There was also a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). The latest legionella risk assessment had been carried out in July 2015. We saw records to demonstrate the practice carried out annual checks in line with this policy to reduce the risk of infection to staff and patients.

Procedures were in place to ensure the safe disposal of clinical waste and sharps, such as needles and blades. We saw evidence that their disposal was arranged through an appropriate company.

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. There was a testing schedule in place. All portable electrical equipment was routinely tested and those we examined displayed stickers indicating the last testing date, July 2015.

Staffing & Recruitment

The practice management demonstrated how they ensured there were appropriate numbers of suitably qualified, skilled and experienced staff on duty within Bennfield Surgery every day. Some administrative and clinical staff were part time and able to work additional hours to provide staff cover if a staff member was unexpectedly absent. We saw a selection of policies and procedures in place to support this, including staff sickness, and planned absences. Practice management explained how they monitored their staffing levels and made changes when needed to ensure predicted patient demand was met.

Bennfield Surgery had a business continuity plan in place. This included action to be taken if an unexpected shortage of staff occurred, for example the use of locum GPs. Some locums used previously were directly employed, others were employed through an agency and service level agreements were in place for this. This would help to ensure sufficient availability of GPs to continue the primary care service provision to patients.

There was a comprehensive recruitment policy in place. This listed the pre-employment checks to be carried out before a new staff member could start work at Bennfield Surgery. This included an identity check, references and a criminal record check with the Disclosure and Barring Service (DBS). These were checks to identify whether a person had a criminal record or was on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. All staff were DBS checked. We saw these checks were also applied to locum GPs who worked at the practice. We looked at a number of recruitment files for GPs, administrative staff and nurses. They demonstrated that the recruitment procedure had been followed.

Bennfield Surgery was also a training practice for doctors and regularly hosted trainee GPs. We saw how they were given appropriate training and supervision within the practice.

Monitoring safety and responding to risk

Relevant procedures to manage and monitor risks to patients, staff and visitors to the practice were in place. This included regular checks of the building, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for

Good

Are services safe?

staff to see and there was an identified health and safety representative who had received appropriate training for the role. A regular fire safety check was also carried out; the latest date was in May 2015. A risk log was maintained for all identified risks.

Staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. GPs explained how patients with long term medical conditions were monitored and appropriate alerts were placed on patients' medical records.

Arrangements to deal with emergencies and major incidents

Bennfield Surgery had processes to manage emergencies. This included the treatment of cardiac arrest and anaphylaxis (an allergic reaction). Records showed that all staff had received training in basic life support. There was emergency equipment available. This included oxygen and an automated external defibrillator (AED). This is a portable electronic device that analysed life threatening irregularities of the heart including ventricular fibrillation and was able to deliver an electrical shock to attempt to restore a normal heart rhythm. Emergency medicines were available and were securely stored. 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.

There was a business continuity plan to deal with a range of emergencies that may impact on the daily operation of the practice. Management confirmed copies of this were kept at the homes of GPs and practice management. Risks identified included power failure, adverse weather including flooding and access to the building. If the practice building was unavailable, we saw arrangements were in place for the use of the neighbouring practice.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

We were satisfied that Bennfield Surgery assessed the needs of its patients and planned and delivered care and treatment in line with their individual needs and preferences. All patients we spoke with were satisfied with the care they received at the practice and with any follow-up needed once they had obtained an appointment. GPs told us how they used the templates issued by the National Institute for Health and Care Excellence (NICE) for the diagnosis and treatments of illnesses. This ensured the care given by the practice was based on the latest guidelines and medical evidence and was of the best possible quality. This resulted in patients receiving up to date tests and treatments for their disorders.

Clinical staff were responsible for managing the care and treatment of patients with long term conditions, such as asthma, diabetes and chronic obstructive pulmonary disease (COPD), the name for a collection of lung diseases including chronic bronchitis and emphysema. Typical symptoms are increasing shortness of breath, persistent cough and frequent chest infections. Procedures were in place to ensure patients with long term conditions were reviewed annually, or more frequently if required. During the last 12 months, 87% of patients with COPD and 83% of patients with asthma had been reviewed. The most vulnerable patients (2% of the patients registered at the practice) had care plans in place to avoid unnecessary admittance to hospital. Within the last 12 months, all patients with suspected bowel cancer (559 patients) and breast cancer (52 patients) were referred and seen by secondary health care within the two week target. Of patients with drug (118 patients) or alcohol dependency (109 patients), 92% had been seen in the last 12 months.

Patients who required palliative care (palliative care is a holistic approach to care for patients with incurable illnesses and their families) were regularly reviewed. A palliative care meeting was held every three months. This included district nurses and Macmillan nurses. Details of patients who received palliative care were passed to the out of hours practice each weekend to ensure care would continue when the practice was closed. In the last 12 months, all patients who received palliative care, a total of 18, had been reviewed.

Following the Coventry Serious Case Review published in September 2013, the practice started to actively follow up all children who failed to attend appointments at the practice or at hospital.

Management, monitoring and improving outcomes for people

Bennfield Surgery had a system in place for completing clinical audit cycles. Examples of completed clinical audits included minor surgery procedures, the treatment of fungal nails and significant events. We examined the clinical audit for minor surgery procedures. This was first carried out in November 2013 and revealed that out of 14 procedures carried out during a six month period, minor complications had been reported for two, however both of these were unavoidable. The practice did identify however, that post-operative instructions had only been placed on the notes of two patients – 14.3% of the total. The partner GP responsible for the procedures and the audit identified that they needed to increase their level of vigilance with patient notes.

The audit was repeated in November 2014 and examined the nine procedures carried out during the previous six months. Only one patient had reported complications (again, these were to be expected). Eight patients (a total of 88.9%) had post-operative instructions placed on their notes. It was planned to repeat this audit again in November 2015.

Some of this monitoring was undertaken as part of the Quality and Outcomes Framework (QOF). QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions e.g. diabetes and implementing preventative measures. The results are published annually. The practice's performance was above average in some areas for the Coventry and Rugby Clinical Commissioning Group (CCG) for QOF. (A CCG is a group of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.) The practice had a total QOF score of 98.4% for 2013-2014, the latest full year available at the time of our inspection. This was above the average for the CCG of 94.1%. In some areas, the practice performed at 100%, for example, for dementia where the average for the CCG was 92.8% and cancer where the average for the CCG was 96.1%.

Good

Are services effective?

(for example, treatment is effective)

We also saw evidence that the practice attended training events hosted by other local practices to identify and discuss best practice. This had recently included developments in the prevention and treatment of yellow fever, which was attended with representatives from the neighbouring GP practices.

Effective staffing

Staff in post at the Bennfield Surgery included clinical, managerial and administrative staff. We looked at staff training records and saw all staff were up to date with attending courses such as annual basic life support and safeguarding. 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).

We saw that all staff had annual appraisals and any learning needs identified through this process were actioned appropriately. Management told us that due to pressures on time, staff appraisals had fallen behind and a plan was in place to complete those still outstanding. Staff we spoke with confirmed the practice actively provided opportunities for training and development. As the practice was a training practice, trainee doctors based there had access to senior GPs for support when needed.

Nursing staff had clearly defined duties which were outlined in their job description and were able to demonstrate that they were trained to fulfil these duties. For example, in the administration of vaccines. We were shown certificates to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

Bennfield Surgery worked with other service providers to meet people's needs and manage complex cases. The practice received blood test results, x-ray results, and letters from the local hospital. This included discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. Policies were in place to provide guidance on the responsibility of staff to action such correspondence. All staff we spoke with understood their roles.

The practice held a weekly practice meeting for GPs, the nurse practitioner and practice manager. We saw evidence that clinical updates, difficult cases, significant events and emergency admissions to hospital were discussed and actions identified. There was a monthly meeting for all clinical staff and a further monthly meeting for all practice staff, this included administrative staff. A quarterly palliative care meeting was also held; this included a selection of clinical staff from the practice, a Macmillan nurse and district nurse.

There was a close working relationship with the community midwife service, the community mental health team and community drug teams. Clinics were held for blood testing, hypertension (high blood pressure), diabetes and minor surgery amongst others, to which patients were referred when appropriate.

There was a large range of information leaflets about local services in the waiting room. Most of this information was in English, but other languages were available on request. Relevant information was also displayed on a screen within the patient waiting room.

Information sharing

Bennfield Surgery used electronic systems to communicate with other healthcare providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made most of its referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patient care. All staff were fully trained on the system.

Consent to care and treatment

There were processes to seek, record and review patient consent decisions. We saw there were consent forms for patients to sign agreeing to minor surgery procedures. We saw that the reason for the surgery and the risks involved had been clearly explained to patients. An interpretation service could be used if patients did not have English as a first language. We also saw evidence that audits of consent for minor surgery were carried out as part of the minor surgery audits completed in November 2013 and

Good

Are services effective?

(for example, treatment is effective)

November 2014. This demonstrated that appropriate consent had been carried out for all patients who received minor surgery. The audit was due to be repeated again in November 2015.

We looked at the process in place to obtain signed consent forms for children who had received immunisations. The practice nurse was aware of the responsibility to obtain parental consent and of the action that needed to be taken if a parent was unavailable. We saw information for parents which informed them of potential side effects of immunisations. GPs and nurses that we spoke with had a clear understanding of the importance of determining if a child was Gillick competent especially when providing contraceptive advice and treatment. A Gillick competent child is a child under 16 who has the legal capacity to consent to care and treatment. They are capable of understanding the implications of the proposed treatment, including the risks and alternative options.

Clinical staff understood the requirements of the Mental Capacity Act 2005 and were knowledgeable about best interest decisions for patients who lacked capacity. Mental capacity is the ability to make an informed decision based on understanding a given situation, the options available and the consequences of the decision. People may lose the capacity to make some decisions through illness or disability.

The practice used an interpretation service when required to ensure patients understood procedures if their first language was not English.

Health Promotion & Prevention

Bennfield Surgery offered all new patients a consultation with a practice nurse or healthcare assistant when they first registered with the practice. If any medical concerns were found, the patient was referred to the GP or another healthcare professional if more appropriate. The practice also offered NHS health checks to all its patients aged 40-75. In the last 12 months, the practice had given cervical screening to 74% of eligible patients and smoking cessation support to 70% of patients who smoked. Out of the patients who were given smoking cessation support, 33% had stopped smoking within four weeks. Patients with drug or alcohol problems were referred to the Rugby Recovery Partnership for support and advice. Patients were also referred to Rugby Food Bank for practical support and advice when appropriate. Rates of immunisation for children were above average for the CCG.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

A range of patients spoke with us on the day of our inspection or completed comment cards beforehand. All were satisfied with the care they received from Bennfield Surgery and also with any follow up needed after their initial appointment. Patients told us they were treated respectfully and with dignity by all of the staff team. Patients said GPs and nursing staff were always professional and listened clearly during consultations in person and over the telephone.

During our inspection we saw how staff were helpful, polite and understanding with patients. Staff we spoke with emphasised the importance of maintaining patient confidentiality and treating patients in an appropriate way. In consultation rooms there were curtains which could be drawn around treatment couches. This would ensure patients' privacy and dignity was maintained if anyone else entered the room during their examination or treatment.

The 2014 GP National Patient Survey revealed that 93% of patients felt the last GP they saw or spoke with was good at listening to them. This was above the average for the Coventry and Rugby Clinical Commissioning Group (CCG) of 88%. (A CCG is a group of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.)

Care planning and involvement in decisions about care and treatment

We examined patient choice and involvement at the practice. GPs explained how patients were involved with discussions before their treatment started and how they determined what each patient needed by taking into account their individual needs. Clinical staff told us they discussed any proposed changes to a patients' treatment or medication with them before any change was made. Some patients we spoke with confirmed this. GPs described treating patients with consideration and respect and said they kept patients fully informed during their consultations and subsequent investigations. Patients we spoke with confirmed this and told us decisions were clearly explained and options discussed when available.

In the 2014 GP National Patient Survey, a total of 91% of patients said the last GP they saw or spoke with was good at explaining tests and treatments. The average for the CCG was 85%. We spoke with some patients who had long term conditions. They told us they were seen regularly.

Patient/carer support to cope emotionally with care and treatment

For this inspection, we did not speak with or receive any comment cards from patients who were also carers. However the GP and staff described the support they provided for carers. This was detailed in a Carers Identification Protocol. This ensured carers were clearly identified, for example, their details were noted on the records of the patients they cared for as well as on their own. The practice had links to refer patients to appropriate organisations, including a counselling service for professional support and to social services for a carer's needs assessment if this was felt to be appropriate. The practice also signposted patients and family members to a bereavement counselling service when appropriate.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Bennfield Surgery responded to the needs of its patients and had appropriate systems in place to maintain the level of service required. The needs of the practice population were understood, particularly within the context of the local area and systems were in place to address identified needs in the way services were delivered. For example, the practice had a large number of patients from eastern Europe. The practice had identified a high level of alcohol abuse within this population and had links with Rugby Recovery Partnership to provide support and advice. At time of our inspection, there were no travellers registered with the practice. GPs told us as the practice was close to the town centre; they rarely had travellers registered there.

The practice planned services to meet the level of demand from the local population. We saw minutes of meetings that illustrated capacity and demand was discussed in staff meetings. The 2014 GP National Patient Survey revealed that 78% of patients were satisfied with the practice opening times, this compared with an average of 75% for the Coventry and Rugby Clinical Commissioning Group (CCG). A CCG is a group of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

We asked GPs about patient capacity and demand. GPs told us they faced increased demands due to changes in GP boundaries which had resulted in some practices being unable to accept new patients from particular areas. We were also told that an increase in the migrant population, particularly from eastern Europe had placed additional demands upon the practice.

Bennfield Surgery had an established Patient Representative Group (PRG). This was a group of patients registered with a practice who work with the practice to improve services and the quality of care.

This ensured that patients' views were included in the design and delivery of the service. We saw how the PRG played an active role and was a key part of the organisation. Regular meetings were held. We saw how the PRG had been involved with discussions on practice boundary changes within Rugby and promoting on-line services to patients.

Tackling inequity and promoting equality

The majority of patients who used the practice spoke English, most of those who did not have English as a first language, spoke a variety of eastern European languages. For those who did not have English as a first language, practice staff could use a translation service and printed information could be provided in other languages when required.

There was an induction loop to assist people who used hearing aids and staff could also take patients into a quieter private room to aid the discussion if required. Notices to say this were displayed in the waiting room. The ground floor of the practice was fully wheelchair accessible. Patients who were unable to manage stairs were able to use the lift by special arrangement as this was located in part of the building used by other organisations. This was secured to ensure the privacy and security of the practice was maintained at all times.

Access to the service

The practice opened from 8am to 6pm every weekday. Appointments were available from 8.30am to 5.30pm. In addition, a GP was on-call from 6pm to 6.30pm. An extended hours service was provided on Saturday mornings when the practice opened from 8.30am to 11.30am. Outside of surgery times, a GP out of hours service was provided by another organisation and patients were advised to call the NHS 111 service to access it. This ensured patients were able to obtain medical advice outside the practice's opening hours.

All patients who needed same day or emergency appointments were seen on the same day in line with the practice policy. Telephone consultations were also carried out when appropriate. Patients could make appointments up to six weeks ahead. Appointments could also be booked on-line and repeat prescriptions could be ordered the same way. Home visits were carried out for patients who were unable to get to the practice.

The 2014 GP National Patient Survey also disclosed that 95% of patients said the last GP appointment they were given was at a time convenient to them. This was above the CCG average of 91%. A total of 44% of patients found it easy to get through to the practice by telephone, compared to an average for the CCG of 74%.

GPs and management at the practice told us they experienced a very high level of demand over the

Good

Are services responsive to people's needs?

(for example, to feedback?)

telephone and in person as soon as the practice opened. This reduced later in the morning. To attempt to manage this, the practice advised patients to telephone after 10.30am unless they required an urgent same-day appointment or a home visit. This was also contained within the practice information guide. There had also been an increased number of patients register for on-line services. The practice continued to monitor telephone demand and management was confident patient survey results would now improve.

Listening and learning from concerns & complaints

There was a clear process for handling complaints and concerns at Bennfield Surgery. This reflected the recognised guidance and contractual obligations for GPs in England. The practice manager handled all complaints received by the practice. During our inspection, we looked at how patients' concerns were listened to and acted upon. We saw information about how to complain displayed in the waiting area and in a leaflet produced by the practice.

The complaints procedure identified how complaints would be dealt with and outlined the timescales for responding to and dealing with complaints. The practice had a complaints summary which summarised the complaints for each year. This was used to identify any trends.

During our inspection, we looked to see if Bennfield Surgery adhered to its complaints policy. Since April 2014 the practice had received 13 complaints. Two of those complaints were about other NHS providers and the practice forwarded them to the appropriate organisations and informed the patients accordingly.

There were no themes within the complaints and none related to safety incidents. We examined two complaints in detail and saw complaints had been dealt with appropriately and within the timescales set out in the practice's complaints policy. Patients were given a detailed explanation and when appropriate, an apology.

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

Bennfield Surgery had a clear vision to provide a high standard of medical care and be committed to patients' needs. GPs we spoke with discussed how the practice kept up to date with research and governance recommendations and related these to all staff. We examined how the GP partners investigated and reviewed significant events, devised, led and reviewed clinical audits and oversaw the management of related policies. GPs and staff we spoke with understood the vision and values of the practice and how their role related to this. During our inspection we noted the entire practice staff demonstrated an intention to give a safe and caring service where patients were treated with dignity and respect. Staff we spoke with told us GPs were open and approachable and the practice, including staff, were very well managed.

The GP partners held regular meetings outside of surgery opening times, to discuss important issues such as forward planning, aims and objectives, future direction and vision. These were frequently reviewed at staff meetings.

Governance Arrangements

Each GP partner had a lead role and a specific field of interest and expertise. This included clearly defined lead management roles and responsibilities. The practice held a regular meeting of clinical staff which included discussions about any significant event analyses (SEAs) that had been done. All of the clinical staff attended these meetings and where relevant, other staff also took part in the discussions about SEAs. This helped to make sure that learning was shared with appropriate members of the team.

Bennfield Surgery used information from a range of sources. This included their Quality and Outcomes Framework (QOF) results. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions e.g. diabetes and implementing preventative measures. The results are published annually. The practice's performance placed them in the top 10% of practices within the Coventry and Rugby Clinical Commissioning Group (CCG), with a score of 98.4% for 2013-2014, the latest complete year for which figures were available. This was above the average of 94.1% for the CCG. (A CCG is a group of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.)

We saw examples of completed clinical audit cycles, such as for minor surgery. This demonstrated the practice reviewed and evaluated the care and treatment patients received.

Leadership, openness and transparency

The practice had a team of five partners, some of whom had worked together over a number of years to provide stable leadership. They were supported by a practice manager who was described by clinical and other staff as being an excellent manager. GPs and staff told us there was an excellent working relationship within the practice, there was completely open communication and when together, they liked to laugh a lot. Our discussions with staff and interactions we saw between staff and GPs confirmed this.

Practice seeks and acts on feedback from users, public and staff

Bennfield Surgery had a Patient Representative Group (PRG). This was a group of patients registered with the practice who work with the practice to improve services and the quality of care. This resulted in patient views being included in the design and delivery of the service. We saw minutes of previous PPG meetings and saw how the PRG has been fully involved in initiatives such as promoting on line patient services.

The practice asked patients who used the service for their views on their care and treatment and these were acted on. This included the use of the GP National Patient Survey to gather the views of patients who used the service. We saw that there were systems in place for the practice to analyse the results of the survey. Issues identified were addressed and discussed with all staff members. For example, to reduce the waiting time for patients who telephoned the practice, patients with non-urgent queries were asked to telephone after 10.30am. This would reduce the patient demand during the early morning peak.

All the patients we spoke with on the day of our inspection told us they received a high quality service from the practice. It was clear patients experienced the quality of service that met their needs.

Are services well-led?

Good

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

Management lead through learning & improvement

We saw evidence at Bennfield Surgery that the practice was focussed on quality, improvement and learning. Training records we examined demonstrated that staff training was up to date and regularly reviewed. Staff we spoke with told us they received annual appraisals, during which training needs were identified, discussed and plans implemented. The practice also had sessions each month for 'protected learning'. This was used for training and to give staff the opportunity to develop their skills together.