Barton Hills Medical Group

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 an announced comprehensive inspection at Barton Hills Medical Group on 15 December 2014. Overall the practice is rated as good.

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

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of those relating to recruitment checks for staff who act as a chaperone.
- 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.
- Patients said they were treated with 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.
- 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 areas of practice where the provider needs to make improvements.

Importantly the provider should:

- Replace the chair used for phlebotomy or ensure that the ripped arms are replaced.

Summary of findings

- Ensure that all reception staff have DBS checks if the GP partners decide they are to undertake chaperone duties.
- Undertake a formal risk assessment of long serving reception staff who have not had DBS checks.
- Introduce a system or process to ensure the secure storage of clinical waste and cleaning substances.
- Carry out a new legionella risk assessment.

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 although some reception staff acting as chaperones had not received criminal records checks. There was no formal assessment of the risk of long serving reception staff not having undergone these checks. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff and staff worked with multidisciplinary teams.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Although patients said they

Summary of findings

found it difficult at times to get through on the telephone to make an appointment, they did report that if they needed to see a doctor on the day they could. 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.

Are services well-led?

Good

The practice is 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 practice had a number of policies and procedures to govern activity and held regular meetings which incorporated governance and quality issues. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were 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.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. 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.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients with a learning disability and had carried out annual health checks for these patients. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Patients experiencing poor mental health were offered an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

During our inspection we spoke with patients and reviewed comment cards we had left at the practice for patients to complete. We also spoke with a member of the patient participation group (PPG). A PPG is a group of people who represent the views of patients at the practice and work in partnership with the practice to improve services. We looked at the 11 comment cards that had been completed and all of these contained positive comments about the practice. Patients commented on the efficient, caring and helpful staff and how they were treated with dignity and respect. We spoke with six patients on the day of our inspection, three of whom expressed that on occasions getting an appointment could be difficult, although if they needed to see a doctor urgently they would be seen.

We also looked at the results of the national patient survey and noted that 72% of patients who responded reported being able to see the GP of their choice compared to the CCG average of 50% and 96% reported they had confidence and trust in the last GP they saw. However, only 48% of patients who responded reported finding it easy to get through to the practice on the telephone.

Areas for improvement

Action the service SHOULD take to improve

Replace the chair used for phlebotomy or ensure that the ripped arms are replaced.

Apply for DBS checks for the four remaining reception staff if the GP partners decide they are to carry out chaperone duties.

Undertake a formal risk assessment on long serving reception staff who have not had DBS checks.

Introduce a system or process to ensure the secure storage of clinical waste and cleaning substances.

Carry out a new legionella risk assessment.

Barton Hills Medical Group

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP and another CQC inspector.

Background to Barton Hills Medical Group

Barton Hills Medical Group practice is located in Luton and provides primary medical services to approximately 6,860 patients living in a specific boundary within the area of Barton Hills. The practice provides the services of three GPs, a nurse practitioner, two practice nurses, a health care assistant and a practice manager supported by a number of administration and reception staff. There are two male GP partners and one female GP who hold a general medical services (GMS) contract. They are a training practice supporting new doctors in gaining experience of general practice.

The CQC intelligent monitoring had not identified any specific areas of concern and had been rated as Band 6. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

When the practice is closed, out of hours services are provided by the '111' service.

Why we carried out this inspection

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

We carried out this inspection 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 surgery 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.

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

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people

Detailed findings

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 15 December 2014. During our inspection we spoke with a range of staff including, GPs, nurses, reception and administrative staff and the practice manager and we spoke with patients who used the service. We also observed how staff dealt with patients and carers who attended the practice. We spoke with the local clinical commissioning group (CCG) and NHS England and reviewed comment cards where patients and members of the public shared their views and experiences of the service. We also spoke with a member of the patient participation group (PPG).

Good

Are services safe?

Our findings

Safe track record

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 with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses and we looked at the significant event folder and saw that incidents had been reported and actioned.

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

Learning and improvement from safety incidents

We saw that the practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last two years and we reviewed these. Significant events were discussed at the practice meetings which were held weekly and administration and nursing staff also discussed these monthly during their learning sessions when required. When we looked at the significant events we saw that there was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration and they 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 looked at incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result for example, there had been an issue with prescribing and the practice investigated it and had taken action in line with guidance, implemented changes and notified the patient.

National patient safety alerts were disseminated by the practice manager to a clinical team member in the practice who determined what action should be taken. Staff confirmed that they received alerts where appropriate and the practice manager told us they also utilise the computer system message facility to communicate any issues which could not wait until the next meeting.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. The clinicians had received safeguarding level 2 and 3 training and the reception staff level 1 and we asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly document safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed a dedicated GP as the lead in safeguarding vulnerable adults and children. They had been appropriately trained in safeguarding to enable them to fulfil this role. Not all staff we spoke with were aware who the lead was but were able to demonstrate the appropriate actions if they had a safeguarding concern. The practice had a safeguarding policy that contained contact details of who to make referrals to.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans had an icon placed on their electronic record to highlight that a plan was in place.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. The practice reception staff had not had any formal external training to act as a chaperone but told us that the clinicians had trained them in-house and informed them what was required of them to undertake this role including where to stand to be able to observe the examination.

We noted that not all reception staff who carried out chaperoning duties had a DBS check. The practice manager told us that all new reception staff had received DBS checks since the new requirements but four staff had

been long term employees and had been informally risk assessed. They told us that they were not frequently asked to carry out this role as it is generally done by the practice nurses. However, we fed back to the practice that it was a requirement that any member of staff that carries out chaperone duties must have a DBS check. Following this feedback the practice manager advised us that they would either apply for DBS checks for the four receptionists or only call upon the other reception staff who had DBS checks, dependent on the decision of the GP partners.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy and were able to describe the action they would take in the event of a failure

We saw that there was a system in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

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

There was a protocol for repeat prescribing in line with national guidance and was followed by staff in the practice. We saw evidence that two members of the reception staff had received training in medicines management which enabled them to facilitate this process. The staff members were able to describe the checks they made to ensure repeat prescriptions were managed appropriately and safely. All 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 as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place but no cleaning records were kept; however we were informed the nursing staff oversee the cleanliness of the surgery and identify if further action is needed. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. 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 an infection control audit in the past two months and some improvements were identified for action. Minutes of practice meetings showed that the findings of the audit were discussed. These included the need for the clinical waste to be kept in a locked cupboard and the carpets in the clinical rooms required changing to wipe clean flooring around the treatment areas. We noted that a chair used for taking blood had tears in it and required replacing or repairing as this posed an increased risk to infection.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. There was also a policy for needle stick injury,

We saw that notices regarding hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice did not have a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). The practice manager told us that a new boiler had been installed in 2011 and they had carried out a risk assessment and the likelihood of the contamination was low.

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Are services safe?

We noted that although there was a secure keypad lock on the door to the stairwell where cleaning and clinical waste was stored, this was not locked during our inspection and meant that clinical waste and cleaning materials were not securely stored and were accessible to unauthorised people. We highlighted this to the practice manager during feedback from our inspection and they agreed to keep this locked.

Equipment

Staff we spoke with told us they had sufficient 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 and the blood pressure monitor had been tested in November 2014.

Staffing and recruitment

We looked at the recruitment records of three members of staff who had joined the practice within the past year. The records 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 DBS certificate for one of the staff members was missing at the time of the inspection and feedback was given that a copy of this was needed to be kept on file. All clinical staff had had DBS checks but some of the reception staff who had been in employment for many years had not and we did not see evidence of a risk assessment. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and skill mix of staff needed to meet patients' needs. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. We looked at staff records and saw that newly appointed staff had this expectation written in their contracts.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. They stated that it could be busy but they had a manageable workload.

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. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

We saw records of serious adverse event reporting. All events were logged and investigated with findings and actions discussed at the practice meetings. We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. Reception staff were able to describe the actions they would take if a patient's condition deteriorated, for example escalating to a GP on duty or calling 999 for an emergency ambulance if no one was immediately available. A patient we spoke with gave an account of when a receptionist had advised them and dealt appropriately with an emergency.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used 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 and anaphylaxis. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of

Good

Are services safe?

the practice. A copy of the plan was on the staff noticeboard for reference. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed, the water and gas supplier and all staff contact numbers.

The practice employed an external company to carry out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practiced regular fire drills. The most recent fire drill had been in December 2014. The practice had a fire safety policy outlining actions to take in the event of a fire.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We spoke with GPs and nursing staff who could clearly outline the rationale for their approaches to treatment which were conventional and in line with best practice. Discussions with GPs demonstrated that they were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where a wide range of clinical discussions took place, for example two week cancer referrals and surgical referral pathways.

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. Clinical staff in the practice discussed difficult referral decisions to share learning and improve care and examined and reviewed their referral rates. The staff we spoke with and the evidence we reviewed confirmed that the GPs actions ensured that each patient received support to achieve the best health outcome for them.

The GPs told us they lead in specialist clinical areas such as palliative care, heart disease and all areas of the QOF 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 they supported all staff to continually review and discuss new best practice guidelines for the management of all conditions. Our review of the clinical meeting minutes confirmed that this happened.

The practice engaged with the local CCG and locality and compared the practice's performance for antibiotic prescribing. They told us that historically they had higher prescribing costs, but that this had been examined, analysed and actioned and was now comparable with other practices in the area.

The practice had reviewed of case notes for patients with conditions such as high blood pressure and carried out audits to ensure appropriate treatments and regular review. The practice were considering using a specific software which identified patients with complex needs who had multidisciplinary care plans documented in their case notes but this had not yet been implemented.

The practice had a process in place to review patients recently discharged from hospital. Correspondence to the GPs regarding the discharge was reviewed and any medication changes or follow up were actioned as necessary. The practice showed us this process and we saw these were all up to date and had been actioned appropriately.

We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

During our inspection we noted that discrimination was avoided when making care and treatment decisions. Discussions with all clinical staff indicated 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. Translation services were available to ensure that patients whose first language was not English were not disadvantaged by a language barrier.

Management, monitoring and improving outcomes for people

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

The practice showed us three clinical audits that had been undertaken in the last year. One of these was a completed audit where the practice was able to demonstrate the changes resulting since the initial audit. None of these audits identified poor care but led to improvements and changes such as identification of patients with low vitamin B12 levels and subsequent appropriate treatment. We also saw an audit regarding the prescribing of anti-coagulation therapy in a response to a change in NICE guidance.

The GPs told us clinical audits were often linked to medicines management information, or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP

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Are services effective?

(for example, treatment is effective)

practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures).

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Patients with diabetes had an annual medication review, and the practice and had achieved the maximum QOF target level for all clinical areas including diabetes, asthma, chronic obstructive pulmonary disease (lung disease)

We saw from the minutes of clinical meetings that the practice was making use of clinical audit data and reports and these were discussed to share lessons learnt. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

There was a protocol for repeat prescribing which was in line with national guidance. The system required each request for a repeat prescription to be approved by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. Discussions with the GPs and evidence we saw of systems in use confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area for example referral rates, A&E attendances and prescribing.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff records of the nurse practitioner and practice nurse and saw that they were up to date with attending mandatory courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England). Each GP within the practice had an interest in specific areas such as women's health, ear nose and throat and palliative care.

All staff undertook annual appraisals that identified learning needs from which personal development plans were developed and documented and we saw staff files which confirmed this. Staff we spoke with told us that the practice was proactive in providing training and supported them in development such as cervical smear training. The practice had recently been approved as a training practice and had a new trainee GP had commenced two weeks prior to our inspection and we noted there was a notice informing patients in the waiting room. The trainee was not at the practice during our inspection therefore we were not able to speak with them.

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 and cervical cytology. The advance nurse practitioner was also a nurse prescriber and told us they were supported in this role. There was also a nurse with additional training in chronic obstructive pulmonary disease (COPD) and asthma. The practice provided a phlebotomy service which was delivered by the health care assistant who had been trained in this task.

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. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and

Good

Are services effective?

(for example, treatment is effective)

felt the system in place worked well. We looked through all significant events over the last year here were no instances identified of any results or discharge summaries that were not followed up appropriately.

The practice had committed to provide the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the practice were discussing A&E attendances and care home reviews at clinical meetings

The practice held multidisciplinary team meetings monthly to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses and palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals and the practice made referrals through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

The practice had signed up to the electronic Summary Care Record which provided faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours.

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

Consent to care and treatment

We found that all clinical staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it and received training in this. All the clinical staff we spoke with demonstrated an understanding of the key parts of the legislation and were able to describe how they implemented it in their practice.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it. The practice told us that they had plans to extend this care and try to reach those patients who did not attend for review. The practice was able to provide an example of where a patient's best interests were taken into account when a patient did not have capacity to make a decision and a good outcome had been achieved for the patient.

All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, family planning and childhood immunisations.

Health promotion and prevention

The practice had met with the CCG to discuss the implications and share information about the needs of the practice population. This information was used to help focus health promotion activity.

The practice offered a health check with the health care assistant to all new patients registering with the practice. There was a protocol linked to new patients' incoming notes summaries which allowed the staff to know when to consult the GP regarding patients undergoing a health check. The GP was informed of all health concerns detected and these were followed up in a timely way.

We noted that the practice was engaged with health promotion and used their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and to all women who were attending for consultations for oral contraception. The

Good

Are services effective?

(for example, treatment is effective)

practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Staff at the practice told us that they had identified some conditions as a result of NHS health checks, for example, diabetes.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and all patients were offered an annual physical health check.

Smoking cessation support was offered by the health care assistant and this was well advertised. There was support available for patients suffering with obesity and patients were referred for hospital services if necessary. Cervical screening was offered in line with the national programme and the practice had achieved 80% uptake.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG at all stages of the immunisation programme. The practice were also offering the shingles vaccine to patients in specific age groups.

The practice had regular contact with the midwife and health visitor from the local health care team. The midwife held antenatal clinics at the surgery and provided advice and support to women during pregnancy. We saw that the health visitor details were on the notice board for patients to access and health visitor attended the multi-disciplinary meetings. Child health medical examinations were offered at eight weeks of age at the time of the first immunisation.

We spoke with the practice nurses who demonstrated a systematic approach to the management of long term conditions such as diabetes, COPD, asthma and heart disease. Patients with diabetes were referred to other services for their annual foot check and the practice hosted the mobile retinal screening facility in the car park annually.

Older patients had an identified named GP responsible for their care and had personalised care plans and these patient received home visits as appropriate. Patients suffering with dementia received an annual review and patients suffering with poor mental health were able to access the mental health link worker who attended the practice weekly.

There was a variety of health promotion materials in the waiting room for patients to access and information regarding additional support groups and services. For example the drug and alcohol advisory group and the carers support group.

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 we also looked at minutes from the patient participation group meetings. 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 that 85% of respondents reported that the last GP they saw was good at listening to them and 82% said the GP gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 11 completed cards and all were positive about the service they received. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. All comment cards told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Some patients we spoke with during our inspection told us that getting an appointment was difficult at times and we saw from PPG minutes that this had been discussed and the practice were working with the PPG and exploring ways to improve this. For example, they were considering telephone triage.

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 and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. We also saw that there was a sign notifying patients regarding the availability of a chaperone if required and there was also a choice of male and female GPs for patients who may have expressed a preference.

We noted from the minutes of meetings that the PPG had raised concern regarding advertising the availability of a private room to talk with the reception staff if necessary and that this was to be advertised on the electronic Jaytex board in the waiting room. We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff. We saw that there was a visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

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 72% of practice respondents said the GP involved them in care decisions and 83% felt the GP was good at explaining treatment and results. The results from the practice's own satisfaction survey showed that 87% of patients said they felt involved in making decisions about their care.

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. The patient feedback we saw on the comment cards we received was also positive and aligned with these views. Some patients we spoke with gave us specific examples of when the GP had offered referral to other services but had respected the patient's wishes when they declined. They also reported the benefits of getting additional support from GPs with complex problems they had experienced and never feeling hurried during consultation.

Sixty-nine percent of the registered patients were of white British ethnic origin; however, staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection expressed satisfaction with how staff at the practice helped them to cope and understand their care and treatment and this was confirmed in the results of the patient survey. The reception staff told us that if a family had suffered bereavement the GP would contact them if appropriate to offer support. For example, some patients we spoke with reported being supported by their GP through bereavement and life limiting conditions their families had experienced.

We saw notices in the patient waiting room informing patients where they could get support and advice on issues such as the drug and alcohol service and CHUMS the child bereavement, trauma and emotional well-being service. The practice's computer system alerted GPs if a patient was also a carer. We saw in the waiting room there was a 'carer's board' showing information available for carers to ensure they understood the various avenues of support available to them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The practice told us that they engaged with the local clinical commissioning group (CCG). Once a month the practice manager and lead GP attended a meeting with the CCG and representatives from other practices to discuss local needs and service improvements that needed to be prioritised. For example, open access for new patients and paediatric referrals. They also undertook peer to peer review. We saw from minutes of the practice meetings that areas were discussed where developments could be made.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example we saw from the practice action plan that they had committed to train the nurse practitioner in telephone triage to help to address problems with access and had changed the appointment system to provide booking on the day appointments.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example patients with a learning disability were reviewed yearly and the practice had a GP lead for patients needing palliative care. The practice offered occasional Saturday clinics for flu vaccination when necessary to increase the uptake of this service.

The practice had access to a translation service which could be booked when required. There were also two members of staff who spoke different languages. Equality and diversity training through e-learning had been undertaken by all clinical staff and the practice manager told us that the other members of the team would be undertaking this.

The premises and services had been adapted to meet the needs of patient with disabilities. All services were provided on the ground floor and there were wide opening doors into the reception area which was arranged in a way to allow easy access for patients using wheelchairs, mobility aids or prams.

Accessible toilet facilities were available for all patients attending the practice including baby-changing facilities.

Access to the service

Appointments were available from 8am to 7.30pm on Mondays and 7.30am to 6pm Tuesday and Thursdays and 8.00am to 6.00pm on Fridays. Appointments were available online, by attending the surgery, or by telephone. The practice also provided text reminder service to try to help reduce the number of patients who did not attend.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for patients who needed them and those with long-term conditions. Longer appointments were also available for patients who were seen by the trainee GP. Home visits were made to local care homes when requested.

We saw from the action plan in response to the patient participation group survey that appointments had been an issue as well as telephone access. We saw that the practice had been actively addressing the issues and implementing changes in response to patient concerns. For example, they had implemented a facility to inform patients of their place in the queue and had released more appointments to be bookable online.

We spoke with patients during our inspection who reported that difficulty in getting an appointment was an issue at times but that it had been improving lately. Patients did confirm that if they need to see a doctor urgently on the day then they could see one, but that it would not necessarily be a doctor of their choice.

The practice's extended opening hours on Tuesdays and Thursday from 7.30am and on Monday up to 7.30pm was

Good

Are services responsive to people's needs?

(for example, to feedback?)

particularly useful to patients with work commitments and those with children who were at school during the day. The practice was also exploring training the nurse practitioner to carry out telephone triage to help prioritise and direct patients more appropriately.

Patients with mental health problems were able to access the mental health link worker who GPs could refer to when appropriate. The link worker attended the practice once a week and could refer on to other services if necessary.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. We saw in the waiting area on the notice board that there was information for patients explaining the complaints procedure. This was also displayed on the practice website.

Patients we spoke with during our inspection had not had cause to complain but told us they knew of the process should they need to. We spoke with a representative from the patient participation group (PPG) who told us that the practice was responsive to patients concerns and complaints and were pro-active when they identified issues which caused patients concern. For example, they told us the practice manager had learned of an issue in the waiting area which caused problems for patients with visual problems and had immediately sought solutions to address this.

They had also responded promptly to concerns regarding privacy for patients approaching the reception area and made changes to rectify this. The PPG member expressed that the practice treated complaints and concerns with openness and transparency and worked well with the group to address issues.

We looked at a selection of complaints received in the last 12 months and found these were all handled satisfactorily and dealt with in a timely way. The practice reviewed complaints annually to detect themes or trends. We saw that the practice had held a meeting to discuss this and that lessons learned had been identified and acted on.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We saw that the practice mission statement was displayed in the waiting room for patients to see. Staff we spoke with told us they were aware of the vision for the practice and felt involved and valued and could see what the practice were striving to achieve. They were aware of what their responsibilities were in relation to the vision and were clear about what the rest of the team were responsible for.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to all staff in a folder and online. We looked at the policy folder and saw that the policies and procedures were in date and there were lead named staff responsible for each area. For example health and safety, fire procedures and safeguarding. The infection control policy identified a lead person who had left the practice and required updating but the practice manager told us that this role would be undertaken by the practice nurse.

Staff we spoke with told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing above the national and CCG standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes. The practice told us they had identified a specific GP who was the lead for the QOF to manage the process and strive to ensure a high achievement.

The GPs told us about local benchmarking data produced by the CCG which was broken down to allow local comparisons which the practice used to determine areas of improvement although we did not see any evidence of peer review during the inspection.

We saw that the practice had undertaken a number of audits which they used to monitor quality and systems to identify where action should be taken. For example, we saw audits for cancer diagnoses to determine whether actions and referral were appropriate and patients taking medication for diabetes. We saw that changes in treatment had been made and lessons learned and discussed as a result of audits undertaken.

The practice had arrangements for identifying, recording and managing risks. The practice did not keep a specific log as a summary of all risks but we saw evidence that all risks were identified on an individual basis and assessed and mitigated appropriately. We saw from minutes of meetings that any risks identified were discussed and addressed and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from minutes that clinical team meetings were held weekly and all staff meetings monthly. Staff we spoke with told us that there was an open and honest culture within the practice and they had the opportunity and were happy to raise issues at any time they needed to. They told us they felt the practice encouraged learning from when things go wrong and a no blame culture was evident. This was also confirmed by the patient participation group who also gave examples of how the practice demonstrated and promoted an open culture and encouraged learning from adverse events.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies such as the induction policy and management of sickness which were in place to support staff. Staff we spoke with told us they had access to all policies and procedures at any time and knew where to find them.

Seeking and acting on feedback from patients, public and staff

We found that the practice had gathered feedback from patients through the patient participation group (PPG), patient surveys, complaints and compliments and comment cards. The practice had been working closely with the PPG to address access to the surgery via the telephone which had been identified as a specific area which concerned patients. The national patient survey and the practice survey concurred with this showing only 48% and 29% respectively of patients found it easy to get through on the phone compared with 70% of the CCG average.

Are services well-led?

Good

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

We saw that the practice had addressed all issues identified following the practice survey and created an action plan. The PPG told us that the practice were working through this and had brought about positive improvements. For example, they had introduced a function to inform patients where they were in the queue, they had changed the message as patients considered it was too complicated and had released more online appointments.

We also noted that the practice had introduced book on the day appointments and changed the seating arrangements in the waiting area in response to patient requests.

The practice had an active patient participation group (PPG) who reported commitment and engagement from the practice. The PPG told us that the practice were encouraging and looked at ways to attract representatives from younger age groups to ensure a more equal representation of patients views. We saw minutes of the PPG meetings and a copy of the practice survey with an action plan of how the practice intended to address the areas identified. The results and actions were also available on the practice website.

The practice had gathered feedback from staff through general staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. The practice had a whistleblowing policy which was available to all staff.

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 two staff files and saw that regular appraisals took place which included a personal development plan. We spoke with staff who told us they felt the appraisal process was a valuable process and allowed them time to reflect and identify future development.

Staff told us that the practice was very supportive of training and that they had protected learning sessions monthly where the practice closed for half a day and staff had an opportunity to identify learning and training needs and discuss practice issues.

The practice had recently been approved as a GP training practice and had introduced their first trainee only two weeks prior to our inspection. We noted that the practice allowed longer appointments for their trainee consultations and that the practice had plans to expand training capacity.

They had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. All staff were aware of the significant event process and demonstrated it was embedded in practice.