Dr Gordon Jones

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected this service on 7 October 2014 as part of our new comprehensive inspection programme. We had previously inspected this service in June 2013 under our former inspection programme. At that time the practice was meeting all standards.

The overall rating for this service is good. We found the practice to be good in the safe, effective, caring responsive and well led domains. We found the practice provided good care to people with long term conditions, families, children and young people and people in vulnerable circumstances, older people, working age people and people experiencing poor mental health.

Our key findings were as follows:

- Patients told us they were satisfied with the appointments system and told us it met their needs.
- Patients were kept safe from the risk and spread of infection as the provider had carried out audits and acted on their findings
- Patients were treated with dignity and respect and spoken to in a friendly manner by all staff
- Systems were in place to keep patients safe by assessing risk and taking steps to reduce this. We saw evidence of learning from previous incidents.
- Patients, their relatives and carers were involved in all aspects of treatment and their opinions were listened to and acted upon.

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 safe. Robust procedures were in place to safeguard children and vulnerable adults from harm. Arrangements were in place to report and investigate any safety incidents. There was an open culture amongst staff which encouraged good communication and learning from these events.

Robust recruitment procedures were in place ensuring all staff had the required checks prior to employment. Arrangements were in place to deal with medical emergencies. Staff had undertaken appropriate training to deal with medical emergencies and emergency medicines and equipment were available and stored securely.

The practice was clean and well maintained. Effective infection prevention and control procedures were in place. Assessments had been carried out to identify and minimise risk of harm to patients and staff using the practice.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence (NICE) guidance is referenced and used routinely. We saw that staff had completed an induction programme and had access to continuing training and development.

Patients were referred to specialists when required and GPs had carried out regular audit cycles to monitor the effectiveness of the service.

There were effective systems in place to monitor the health of people with long term conditions and patients who were unable to attend the practice. Links were established with other healthcare providers to ensure the best outcome for patients, including for people with diabetes, poor mental health and patients receiving end of life care.

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and

Summary of findings

they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness, respect and ensured confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS Englandl Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice and a named GP and continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision and strategy to deliver this. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by the management. The practice had a number of policies and procedures to govern activity and regular governance meeting had taken place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). A PPG is made up of patients of the practice who work with staff to improve the service and the quality of care. We observed how people were being cared for and talked with carers and family members. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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 the practice had good outcomes for conditions commonly found amongst 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, including a community matron. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs and home visits.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. All these patients had a named GP and structured annual reviews to check their health and medication needs were being met. For those people with the most complex needs the named GP worked with the relevant health and care professionals to deliver a multidisciplinary package of care. Individual care plans were in place for patients with long term conditions and regular meetings were held with community matron and district nurse to review care.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk.

Immunisation rates were 100% for all standard childhood immunisations. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Designated children's appointments were available outside of school hours and the premises was suitable for children and babies. We were provided with good examples of joint working with midwives, health visitors and school nurses. Strong links had been established with the local school including class visits to the practice and health promotion lessons. Child and adolescent mental health services were provided at the practice.

Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the 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. For example, practice nurse appointments were offered from 8:00 am and the practice offered late appointments one evening per week. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice reported they did not have patients who were homeless, suffering drug addiction or were travellers. The practice held a register of patients with learning disabilities all of whom had received an annual health check from the GP. The majority of these patients had received a follow-up. The practice offered longer appointments for people with learning disabilities.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector 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 and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia and had a designated community psychiatric nurse attached to the surgery. The practice had in place advance care planning for patients with dementia.

The practice had sign-posted patients experiencing poor mental health to various support groups and other organisations including the Blue Room at the Hartington Unit in Chesterfield. This meant patients could be referred for community psychiatric nurse appointments in less than one week. The practice had a system in

Summary of findings

place to follow up on patients who had attended accident and emergency where there may have been mental health needs. 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

We received 35 comments cards from patients who used Ashover Medical Centre; all 35 contained positive comments. Patients were happy with the care and treatment they received and felt they were treated with dignity and respect by all staff.

Additionally we spoke with six patients on the day of our inspection. All six told us they were able to access appointments when required, they felt they were involved in discussions about their care and were able to make informed decisions.

Patient surveys carried out by the practice in 2013 showed that patients were overwhelmingly happy with the service provided and felt informed and involved with their care. For example, 100% of repondents felt surgery staff were helpful and 75% were able to make an appointment easily. Analysis of the national GP patient survey by NHS North Derbyshire showed that the practice had very high levels of patient satisfaction for all areas of the service.

Dr Gordon Jones

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 a practice manager specialist advisor.

Background to Dr Gordon Jones

Dr. Gordon Jones is the senior GP at Ashover Medical Centre, a rural dispensing practice based in the Derbyshire village of Ashover. The practice has a population of around 2100 patients the majority of whom are over the age of 65.

Parking for patients and staff is available at the practice and the building has level access to aid people with reduced mobility, wheelchair users and parents with pushchairs.

The practice staff consists of a male lead GP, a female salaried GP, six reception staff who are also qualified to work in the dispensary, one female practice nurse, one phlebotomist, a practice manager and a practice secretary. All staff are part time with the exception of the lead GP.

The practice does not provide its own out-of-hours service but arrangements are in place for patients to be seen by the 111 provider Derbyshire Health United (DHU) when the practice is closed.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had been inspected before under our previous methodology and was found to meet all standards.

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.

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:

Detailed findings

- Older people
- People with long-term conditions
- Families, children and young people
- The working-age population and those recently retired (including students)
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 7 October 2014. During our visit we spoke with a range of staff including GP's, a practice manager, a practice nurse, dispensing and reception staff. We also looked at the procedures and systems used and spoke with patients who used the service. We also met with four members of the practice Patient Participation Group (PPG) who gave us examples of their work with the practice. A PPG is made up of patients of the practice who work with staff to improve the service and the quality of care. We observed how people were being cared for and talked with carers and family members.

Good

Are services safe?

Our findings

Safe Track Record

The practice had a robust serious incidents policy in place. Staff we spoke with were aware of the policy and procedure for reporting incidents. Staff told us there was an open culture at the practice and they were happy and confident to report an issue.

We saw that three significant events had been recorded since May 2013. All three were recorded in detail and learning from each incident was recorded. We saw that the incidents, and lessons learnt were discussed at practice meetings to ensure all staff were aware. This showed the practice had managed these consistently over time and so could evidence a safe track record over the long term.

Patients we spoke with told us they felt safe receiving care and treatment at Ashover Medical Centre and did not have any concerns. This was echoed in comments cards received.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last two years and these were made available to us. We saw that significant events were discussed on the practice meetings along with complaints. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

We saw incident forms were available on the practice intranet. Once completed these were sent to the practice manager who showed us the system they used to oversee these was managed and monitored. We tracked four incidents and saw records were completed in a comprehensive and timely manner. We saw examples of incidents recorded and action taken

National patient safety alerts were disseminated by the practice manager to the lead GP and then to practice staff. Staff we spoke with told us alerts were discussed at practice meetings then the alert was initialled by staff to indicate they had read it. This helped to ensure all were aware of any relevant to the practice and where action needed to be taken.

Reliable safety systems and processes including safeguarding

The practice had an effective and appropriate system for safeguarding children and vulnerable adults who may be at risk of abuse and for reporting any concerns. All four staff we spoke with were aware of the safeguarding policy and could describe the signs and types of abuse. We saw that all staff employed at the practice had attended training in safeguarding children and vulnerable adults. The lead GP had attended additional training gaining level 3 qualification. All staff had attended safeguarding training and achieved at least a level one qualification. All were aware of how to raise a concern and told us they had authorisation and confidence to contact the relevant safeguarding authorities. Staff told us they had not raised concerns in the past but felt they would have confidence in the provider and senior staff to deal with any incidents appropriately.

The practice had an appropriate whistleblowing policy which staff were aware of. Whistleblowing is the term used when an employee of an organisation raises concerns about that organisation whilst still employed. All four staff told us they would be happy to raise a concern with their line manager or the lead GP and were confident these concerns would be acted on.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments. Staff demonstrated the process for creating an alert on a record and how this was communicated to other staff. We saw that information on how to raise a concern was available throughout the practice for staff and patients. Additionally safeguarding awareness and procedures were discussed at practice meetings.

A chaperone policy was in place and visible in the waiting room and in consulting rooms. One member of staff had undertaken chaperone training. This staff member then delivered training to all practice staff, including clinical and administrative staff. If nursing staff were not available to act as a chaperone, receptionist staff were available. We saw

that these staff had also undertaken training and understood their responsibilities when acting as chaperones including where to stand to be able to observe the examination. Reception staff told us that although they were aware of the chaperone policy and training they had never been asked to perform that role.

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system, EMIS, which collated all communications about the patient including scanned copies of communications from hospitals. Staff were able to demonstrate how an alert was created on the system to identify patients who were vulnerable, at risk or had other specific requirements. Risks assessments had been completed by the practice to ensure written records were kept secure. All practice staff had successfully completed information governance training and were aware of their duties to protect patient data and confidentiality.

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.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, we saw evidence of audits of prescribing data which showed the practice was better than the Derbyshire average for management of prescription of statins and antibiotics.

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

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance.

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.

Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. If prescriptions were not signed before they were dispensed, staff were able to demonstrate that these were risk assessed and a process was followed to minimise risk. We saw that this process was working in practice.

The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary. Additionally the practice had completed its own survey of patient experience of the dispensary. One hundred and ninety patients responded to the survey which looked at, courtesy of staff, quality of advice of given, confidentiality, ease of ordering repeat prescriptions and time spent waiting for repeat prescriptions. Of the 190 responses the overwhelming majority stated the service was good or excellent.

Records showed that all members of staff involved in the dispensing process had received appropriate training and their competence was checked regularly. All six staff who worked in the dispensary also had reception and administration duties. Staff told us they welcomed this as they had the opportunity to gain skills in a number of areas.

The practice had established a service to deliver prescriptions and medicines to patients who were unable to access the practice or had limited transport availability. The practice is situated in a rural area with very limited public transport.

Cleanliness & Infection Control

Good

Are services safe?

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

The practice manager was the lead for infection control and 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 there after annual updates. We saw evidence the lead had carried out quarterly clinical waste and infection control audits and that any improvements identified for action were completed on time. For example, staff working in the dispensary began wearing gloves when counting medicines. Practice meeting minutes showed the findings of the audits were discussed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these in order to comply with the practice's infection control policy.

Hand hygiene techniques signage was 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 had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy in order to reduce the risk of infection to staff and patients. The practice had contracted an external company to complete regular checks for legionella bacteria. We saw evidence of this and of future review dates.

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 fridge thermometer.

Staffing & Recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service. 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 mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure there was enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave. 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 ensure patients were kept safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

We saw that all new staff had to successfully complete an induction training package. Staff we spoke to told us they found this helpful and felt the training had given them a good insight into the running of the practice. We saw that a Locum Pack had been developed to assist visiting GP's.

Monitoring Safety & 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 as an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed, rated and mitigating actions recorded to reduce

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

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing 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). All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly. In the notes of the practice's significant event meetings, we saw that a medical emergency concerning a patient had been discussed and appropriate learning taken place.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia,(patients going into shock or diabetics having dangerously low blood sugar levels). Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and 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 in the event of failure of the heating system.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken. We saw evidence of learning from fire drills. For example the need to take the signing in sheet and appointment register out of the building during a fire drill was added to the procedure.

Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the practice risk log. We saw an example of this regarding staff travelling to the practice in bad weather and the mitigating actions that had been put in place to manage this.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with confirmed that these meetings took place and that information was passed to them via the senior staff, however we did not see written evidence to confirm this. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as chronic obstructive pulmonary disease (COPD), diabetes, heart disease and asthma and the practice nurses supported this work which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. The review of the clinical meeting minutes confirmed this happened.

Prior to the inspection we saw data from the local Clinical Commissionig Group (CCG) of the practice's performance for antibiotic and statin prescribing which was better than the average for similar practices in the area. The practice had also completed a review of case notes for patients with COPD (Chronic Obstructive Pulmonary Disease, an overarching term for a number of diseases which affect a patients breathing) which showed all were on appropriate treatment and regular review. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes.

National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients requiring additional treatment. Our clinical advisors found these to be timely, well planned and within the agreed timeframes. We saw minutes from meetings where regular review of elective and urgent referrals were made, and that improvements to practise were shared with all clinical staff.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, child protection alerts management and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The practice showed us two clinical audits that had been undertaken in the last year. Both of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, an audit of the management of COPD (Chronic Obstructive Pulmonary Disease, an overarching term for a number of diseases which affect a patients breathing) showed improved practice for medication, self-care and care planning for COPD patients. Other examples of clinical audits included audits to improve outcomes and standardise treatment for patients with acne.

The practice used the information they collected for the Quality Outcome Framework (QOF) and their performance against national screening programmes to monitor outcomes for patients. QOF is a national recording system used to monitor the performance of GP services in a number of areas. For example, 69% of patients had received their annual flu vaccination which was an increase of 17% on the previous year. The practice met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF (or other national) clinical targets.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance

of clinical staff. The staff we spoke with discussed how as a group they reflected upon 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, noting that there was an expectation that all clinical staff should undertake at least one audit per year.

Staff working in the dispensary told us they regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. We saw evidence which confirmed this. The IT system flagged up relevant medicines alerts when the GP went to prescribe medicines. We were shown evidence to confirm that following the receipt of an alert the GPs had reviewed the use of the medicine in question and where they continued to prescribe it, outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. A good skill mix was noted amongst the doctors. 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 every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practice and remain on the performers list with NHS England).

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses, for example all dispensary staff had attended the 'Buttercups Dispensing course'.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, on administration of vaccines, INR near-patient testing. This enables patients on warfarin to have blood tests which check bloodclotting levels at the surgery rather than travel to a hospital. Those with extended roles, for example seeing patients with COPD, were also able to demonstrate they had appropriate training to fulfil these roles. We saw that one member of staff had undertaken a distance learning diploma in treatment of COPD.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and support patients with more complex needs. Blood results, X ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. The GP seeing these documents and results was responsible for the action required. All the staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries which were not followed up appropriately.

The practice was commissioned for the new enhanced service and had a process in place for INR near patient testing. (Enhanced services are services which require an enhanced level of service provision above what is normally required under the core GP contract). We saw that this policy was effective in reducing cancellation of appointments as patients did not have to travel to hospital for the tests.

The practice held multidisciplinary team meetings every two weeks to discuss the needs of complex patents e.g those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, 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 out of hours provider to enable patient data to be shared in a secure and timely

Good

Are services effective?

(for example, treatment is effective)

manner. Electronic systems were also in place for making referrals, and the practice made referrals last year 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). Staff reported that this system was easy to use and patients valued the service.

For emergency patients, there was a practice policy of providing a printed copy of a summary record for the patient to take with them to A&E. One GP showed us how straightforward this task was using the electronic patient record system, and highlighted the importance of this communication with A&E. The practice had signed up to the electronic Summary Care Record and had plans to have this fully operational by 2015. (Summary Care Records provide healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information).

The practice had systems in place to provide staff with the information they needed. An electronic patient record, system one, was used by all staff 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 staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity was an issue, the practice had drawn up a policy to help staff, for example with making do not attempt resuscitation orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

The practice had not had an instance where restraint had been required in the last three years but staff were aware of the distinction between lawful and unlawful restraint.

Health Promotion & Prevention

The practice had met with the Public Health team from the Local Authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant / practice nurse. The GP was informed of all health concerns detected and these were followed-up in a timely manner. We noted a culture amongst the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18-25 and offering smoking cessation advice to smokers.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities all of whom were offered an annual physical health check. The practice had also identified the smoking status of patients over the age of 16 and actively offered nurse led smoking cessation clinics to these patients. Similar mechanisms of identifying at risk groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

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, and again there was a clear policy for following up non-attenders by the named practice nurse. 100% of children registered with the practice had received their immunisations.

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Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey of 2013 , a survey of 56 patients undertaken by the practice's Patient Participation Group (PPG)from 2014 and patient satisfaction questionnaires undertaken by each of the practice's partners in 2014. A PPG is made up of patients of the practice who work with staff to improve the service and the quality of care. We observed how people were being cared for and talked with carers and family members. 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 2014 national patient survey showed the practice was rated 'among the best' for patients rating the practice as good or very good. The practice was also well above average for its satisfaction scores on consultations with doctors and nurses with 100% of practice respondents saying the GP was good at listening to them and100% saying the GP gave them enough time.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 36 completed cards and all comments were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with eight patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

Staff told us 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 they would investigate these and any learning identified would be shared with staff. There was also evidence of learning taking place as staff meeting minutes showed this has been discussed.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The 2014 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 91% of practice respondents said the GP involved them in care decisions and 99% felt the GP was good at explaining treatment and results. Both these results were well above the Clinical Commissioning Group (CCG) area and national averages. Patients we spoke with during our inspection told us they felt involved in and were able to make informed decisions about their care.

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

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the

Good

Are services caring?

practice and rated it well in this area. The patients we spoke to on the day of our inspection and the comment cards we received showed that patients were happy with the support they received and access to care.

Notices in the patient waiting room and patient website also signposted people to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us families who had suffered bereavement were called by their usual GP. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and signposting to the CRUSE bereavement support service. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs. The practice used the Clinical Commissioning Group (CCG) recommended risk tool, which helped doctors detect and prevent unwanted outcomes for patients. This helped to profile patients by allocating a risk score dependent on the complexity of their disease type or multiple comorbidities.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

There had been very little turnover of staff during the last three years which enabled good continuity of care and accessibility to appointments with a GP of choice. Longer appointments were available for patients who needed them and those with long term conditions. This also included appointments with a named GP or nurse. Home visits were made by a named GP to those patients who needed one.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG). For example, the PPG survey identified that patients felt their conversation at receptions could be overheard. The practice introduced a new system for registering arrival of patients which reduced this risk.

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

The practice worked collaboratively with other agencies and regularly shared information (special patient notes) to ensure good, timely communication of changes in care and treatment. The practice held a Multi Disciplinary Team meeting every two weeks to discuss end of life care and patients with additional support needs.

Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services.

For example, appointments were reserved for children at the end of clinics to ensure ease of access.

The practice had access to online and telephone translation services.

The practice provided equality and diversity training via e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events.

The premises and services had been adapted to meet the needs of people with disabilities for example, there was level access to the building, all patient services were on the ground floor and accessible toilets were available.

Access to the service

Appointments were available from 8am to 6pm on weekdays, including until 7:30pm on Thursday evenings. The practice did not close for lunch and appointments were available throughout the day. Appointments at the end of clinics were reserved for children or people in vulnerable circumstances who may require a longer consultation

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 in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Patients were satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another GP if there was a wait to see the GP of their choice.

Comments received from patients showed that patients in urgent need of treatment had often been able to make

Good

Are services responsive to people's needs?

(for example, to feedback?)

appointments on the same day of contacting the practice. One patient we spoke with told us how they needed an urgent appointment on the morning of our inspection and had been able to book one immediately.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Analysis by the practice showed that 100% of the patient population were English speaking, although the practice could cater for speakers of other languages through translation services.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system via the practice information leaflet and website. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

We looked at the one complaint received in the last 12 months and found the practice response was appropriate. The complainant was contacted by the practice and full investigation carried out. The issue was resolved to the complainant's satisfaction.

The practice reviewed complaints on an annual basis to detect themes or trends. We looked at the report for the last review and no themes had been identified, however lessons learnt from individual complaints had been acted upon.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found that all staff were committed to an ethos of the practice to offer a friendly, caring good quality service that was accessible to all patients. Staff we spoke with were proud to work at the practice and felt a sense of ownership.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. Policies and procedures we looked at showed that staff had completed a cover sheet to confirm they had read the policy and when. All policies and procedures we looked at had been reviewed annually and were up to date.

The practice held regular governance meetings. Staff we spoke with told us that performance, quality and risks had been discussed, however we did not see notes of these meetings

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national 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 nurse told us about a local peer support system they took part in with neighbouring GP practices. We saw that practice staff valued this additional support and used the meetings to help benchmark and improve the service.

The practice had completed a number of clinical audits, for example prescribing practices for acne treatment and treatment of chronic obstructive pulmonary disease (COPD)

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us their risk log which addressed a wide range of potential issues, such as; lone working, access to the building, information governance and risk of fall. We saw that the risk log was regularly discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

Leadership, openness and transparency

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

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, induction policy and recruitment policy which were in place to support staff. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through patient surveys, their Patient Participation Group (PPG) and comments cards. We looked at the results of the annual patient survey which showed patients were very satisfied with the service and the care they received.

The practice had an active PPG which had steadily increased in size. The PPG had carried out annual surveys and met every month. The practice manager showed us the analysis of the last patient survey which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available in the practice.

The practice had gathered feedback from staff through 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. One member of staff told us that they had asked for specific training to be given around chaperoning. The member of

Are services well-led?

Good

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

staff received this training and then delivered a training session to all staff. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistle blowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had protected learning time and regular training sessions.

The practice had completed reviews of significant events and other incidents and shared with staff via meetings to ensure the practice improved outcomes for patients. None of the examples we looked at had resulted from actions of the practice or its staff. However we saw that were practice patients had been affected by the actions of other agencies, an investigation was carried out and any learning discussed at practice meetings.