Goodrest Croft Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Goodrest Croft Surgery on 15 July 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well led services. It was also good for providing services for the six population groups (older people, people with long-term conditions, families, children and young people, working age people (including those recently retired and students), people whose circumstances may make them vulnerable and people experiencing poor mental health (including people with dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was 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 a clear leadership structure and staff felt supported by management.

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

Importantly the provider should:

Summary of findings

- Improve reporting of significant incidents to ensure they are documented in detail and actions required are clear.
- Ensure audits complete their full audit cycle in order to demonstrate improvements made to patients care and treatment.
- Ensure a consistent approach for signposting bereaved patients to support services.
- Develop systems for monitoring the registration status of professional staff on an ongoing basis to ensure they remain up to date.

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, although we found the reporting and actions from significant events were not always detailed. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were mostly average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' 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 planned to meet these needs. There was evidence of appraisals and personal development plans for staff. Staff worked with multidisciplinary teams. However, clinical audits undertaken to drive improvement were not always completed cycles.

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 for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality although there was no clear and consistent approach for signposting bereaved patients to support available.

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 NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP for continuity of care, with urgent appointments available

Summary of findings

on the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a vision and strategy and staff were aware of their role and responsibilities. There was a clear leadership structure. Individual staff members were valued for their contribution to delivering the service. Staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular meetings in which governance issues were discussed. 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 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 that outcomes for patients for conditions commonly found in older people were consistent with other practices although performance in some areas were better than others. For example, indicators relating to stroke and heart disease were better than the national average, while those relating to chronic obstructive pulmonary disease(COPD) and osteoporosis were below the national average. The practice offered proactive, personalised care to meet the needs of the older people in its population and participated in the unplanned admissions enhanced services for managing those with complex health needs. Regular multidisciplinary team meetings took place to support those with complex and end of life care needs. Support was provided to two local care homes including weekly ward rounds. Positive feedback was received from the care homes and other health professionals about the support provided. The practice offered flu vaccinations to patients in this age group. As part of the CCG led Aspiring for Clinical Excellence (ACE) programme the practice was working with other local practices to develop a scheme aimed at identifying and supporting older patients who may be vulnerable socially and medically.

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 if 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 practice 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 living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available

Summary of findings

outside of school hours and the premises were suitable for children and babies. The practices worked with other health professionals such as midwives and health visitors to provide support to this population group.

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 offered services which 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 including health checks.

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 registers of patients living in vulnerable circumstances such as carers and those with a learning disability. There was some positive work with carers and those identified were given carers pack with useful information and signposting to support available. The practice was less proactive in offering health reviews to patients with learning disabilities but did call patients for reviews as part of quality outcomes framework (QOF). Patients with learning disabilities had also been identified to complete a learning disability passport which identified their preferences. The practice offered services for those with a drug dependency. Twice weekly clinics were held with a Drug Action Team (DAT) worker in conjunction with the lead GP. The practice accessed interpreter services for those with language barriers.

The practice regularly worked with multidisciplinary teams in the case management of vulnerable people with complex needs. 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). Practice data for 2014/15 showed 69% of people experiencing poor mental health had received an annual physical health check and 69% of those with dementia. The practice worked with multidisciplinary teams in the

case management of people experiencing poor mental health, including those with dementia. Care plans were in place for 60% of patients with mental health conditions and actions were in place to improve this. Screening was also available to identify those with possible early stage dementia to enable referral to specialist care.

Summary of findings

What people who use the service say

As part of the inspection we spoke with 12 patients who used the practice. This included two members of the patient participation group (PPG). PPG are a way in which practices can work closely with patients to improve services. We also sent the practice comment cards prior to the inspection inviting patients to tell us about the care they had received. We received 28 completed comment cards. Our discussions with patients and feedback from the comment cards told us that patients were very happy with the service they received. Patients told us that they were treated with dignity and respect and felt listened to. The majority of patients said they could get appointments when they wanted one.

The practice received positive feedback from patients in the latest GP national patient survey 2015. Patients rated the practice similar to and in some areas above the national average for overall experience, access and quality of consultations.

Areas for improvement

Action the service SHOULD take to improve

- Improve reporting of significant incidents to ensure they are documented in detail and actions required are clear.
- Ensure audits complete their full audit cycle in order to demonstrate improvements made to patients care and treatment.
- Ensure a consistent approach for signposting bereaved patients to support services.
- Develop systems for monitoring the registration status of professional staff on an on-going basis to ensure they remain up to date.

Goodrest Croft Surgery

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, practice nurse and an expert by experience (a person who has experience of using this particular type of service, or caring for somebody who has).

Background to Goodrest Croft Surgery

Goodrest Croft Surgery is registered with the Care Quality Commission (CQC) to provide primary medical services. The practice has a general medical service (GMS) contract with NHS England. Under the GMS contract the practice is required to provide essential services to patients who are ill and includes chronic disease management and end of life care.

Goodrest Croft Surgery is part of the NHS Birmingham Cross City Clinical Commissioning Group (CCG). CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

The practice is located in two converted houses adapted to meet the needs of the practice. Based on data available from Public Health England, deprivation in the area served by the practice is higher than the national average. The practice has a registered list size of approximately 7000 patients.

The practice is open 8.30am to 6pm on Monday to Friday. Extended opening hours are available on Saturday morning between 8am and 11.30am. When the practice is closed during the out of hours period (6.30pm to 8am) patients received primary medical services through an out of hours provider (Primecare). When the practice is closed during core hours (between 8am to 8.30am and 6pm to 6.30pm) primary medical service are provided by Southdoc.

The practice has three GP partners (two male and one female) and two salaried GPs (one male and one female). Other practice staff consist of a team of two nurses, a healthcare assistant and phlebotomist, a practice manager and a team of administrative staff. The practice is also a training practice for doctors who are training to be qualified GPs and a teaching practice for medical students.

The practice has not previously been inspected by CQC.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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.

Detailed findings

How we carried out this inspection

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

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

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

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

Before inspecting, 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 July 2015. During our inspection we spoke with a range of staff (GPs, practice nurses, the practice manager, reception and administrative staff) and spoke with patients who used the service. We reviewed how people were being cared for. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and 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. For example, the practice had changed procedures for the administration of a flu vaccination to patients in a care home after a resident of the home received a second vaccination in error.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last seven 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

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records for the five significant events that had occurred during the last 12 months and saw this system was followed appropriately. Significant events were discussed at practice meetings and at an annual meeting dedicated to review actions from past significant events and complaints. 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 at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. We tracked four incidents relating to significant events and found that they were mainly of a clinical nature and were not always very detailed. However, they were completed in a timely manner, there was evidence of a review process and action taken as a result. There was also evidence that the learning had been shared and staff confirmed this. For example, following an incident in which a member of staff had been unhappy to take blood from a young child practice policy was changed. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

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

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. We asked members of medical, nursing and administrative staff about their understanding of safeguarding. 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 record documentation of 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 an appointed dedicated GP leads for safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

A flag system was used to highlight vulnerable patients on the practice's electronic records. This helped ensure staff were made aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. There was engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors. The practice were notified of children with high numbers of

attendances to accident and emergency and those who persistently failed to attend appointments for example, childhood immunisations were followed up with the health visiting team.

There was a chaperone policy, which was visible in the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Only nursing staff and health care assistants undertook chaperoning duties at the practice. We saw that they had undertaken online training to be a chaperone and those we spoke with understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

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 policy for ensuring that medicines were kept at the required temperatures, and described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

Processes were in place to check medicines were within their expiry date and suitable for use. Staff told us this was done on a monthly basis and all medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The practice told us that the local Clinical Commissioning Group (CCG) undertook prescribing audits which enabled comparison with other practices in the area. Data available showed the practices prescribing in areas such as antibiotic, non-steroidal anti-inflammatory and hypnotics were similar to other practices nationally.

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance. Staff were able to describe the systems in place and action they would take on based on the results.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs that were up to date. The health care assistant administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the prescriber. (PGDs and PSDs are written instructions, from a qualified and registered prescriber for a medicine). We saw evidence that nurses and the health care assistant had received appropriate training and been assessed as competent to administer the medicines referred to either under a PGD or in accordance with a PSD from the prescriber.

Cleanliness and infection control

We observed the premises to be visibly 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.

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 so that staff would know the procedure to follow in the event of an injury.

The practice had a lead for infection control who had undertaken infection control training. All staff had access to online infection control training and records showed that the majority of staff had completed this training. We saw evidence that the lead had carried out an infection control audits within the last 12 months and actions identified had been completed.

Good

Are services safe?

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice did not have a specific policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). However, the practice manager told us that they had sought advice sometime ago and as a result were routinely flushing the taps and records were kept of this. Prior to our inspection they had sought advice again and as a result had undertaken testing of the water at the practice and were currently awaiting results of this.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw records which showed that equipment was tested and maintained regularly. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was May 2015. We also saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure monitors and the fridge thermometer.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. The practice had a low turnover of staff and we were told there had only been one new member of staff since the practice had registered with the Care Quality Commission (CQC). We looked at the recruitment records for this member of staff and saw that they 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 the appropriate checks through the Disclosure and Barring Service. However, the practice did not have a robust system in place for monitoring staff registration with their professional body and indemnity on an ongoing basis.

The practice manager 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 which set out the staff that were needed up until the end of August 2015. This helped to ensure that enough staff were on duty and there were appropriate staff available to cover clinics that were running on a particular day. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and to keep patients safe.

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 regular 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.

Health and safety audits took place on a monthly basis and we saw examples of these. The practice manager told us that any actions required would be assessed to identify whether they needed to be carried out immediately or added to the budget plan if not urgent.

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 in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date.

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

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 assessed and mitigating actions

Good

Are services safe?

recorded to reduce and manage the risk. Risks identified included power failure, loss of computer system, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of gas, electric or water companies in the event of an emergency. The plan was last reviewed in May 2015.

The practice had carried out a fire risk assessment in December 2012. No actions had been required although the practice manager explained that there had been actions which they had addressed from the previous risk assessments to maintain fire safety. Records showed that staff were up to date with fire training and that the named fire marshals had received additional training. Records showed that alarms were tested weekly and annual fire drills took place. Fire equipment had been maintained to ensure they were in good working order.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Staff told us that new guidance was discussed at practice meetings.

Staff described how they carried out assessments of patients' health needs. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes had regular health checks. Feedback from patients with long term health conditions confirmed they underwent regular reviews to ensure their health needs were met.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with felt they were well supported.

The practice had identified patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and their needs were being met to assist in reducing the need for them to go into hospital. There were processes in place to follow up these patients after they were discharged from hospital to ensure that all their needs continued to be met.

Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patients' age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

The practice showed us four clinical audits that had been undertaken in the last 12 months. None of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. Audits undertaken included an audit to assess the management of patients with gout against National Institute for Health and Care Excellence (NICE) guidance. Other examples included audits to confirm that the GPs who undertook minor surgical procedures, contraceptive implants and the insertion of intrauterine contraceptive devices were doing so in line with their registration and NICE guidance.

The practice also used the information collected for the Quality Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions such as diabetes and implementing preventative measures. The results are published annually). The practice was performing in line with the national average in most QOF areas although was an outlier for mental health care plans. It achieved 90% of the total QOF target in 2014, which was below the national average of 94%. Specific examples to included:

- Performance for diabetes related indicators was similar to the national average at 85%.
- The percentage of patients with hypertension having regular blood pressure tests was similar to the national average at 80%.
- Performance for mental health related indicators was similar to the national average at 88%.
- The dementia diagnosis rate was comparable to the national average.

The practice was aware of all the areas where performance was not in line with national figures. They explained that the mental health care plans were developed by the mental health trust but there were problems entering this information onto their system. They had identified action to improve the performance in this area. All other QOF indicators relating to mental health care were in line with other practices in the CCG area.

The practice's prescribing rates were slightly higher than the national average for antibiotic, hypnotic and non-steroidal anti-inflammatory). There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. Patients on repeat prescriptions confirmed they received reviews of their medicines. They also checked all routine health checks were completed for long-term conditions such as diabetes. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

Good

Are services effective?

(for example, treatment is effective)

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

All staff undertook annual appraisals that identified their learning needs. The practice manager explained that training request would be discussed with the GP partners. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example one practice nurse was undertaking training for chronic obstructive pulmonary disease (COPD). The practice was a training practice for qualified doctors who were training to be GPs but the practice had temporarily suspended placements after the training lead GP had left. However, the practice had appointed another training lead and were planning to start taking trainee GPs again in August 2015.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles for example, those seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

The practice had a low turnover of staff. The practice manager explained to us how they managed poor performance and had taken appropriate action to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet patients' 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. Staff were aware of their individual responsibilities for passing on, reading and acting on any issues arising from these communications and felt the system worked well. The GPs we spoke with told us that they were up to date in actioning information received. There was no evidence of any instances identified within the last year of any results or discharge summaries that were not followed up.

Emergency hospital admission rates for the practice were higher than the national average. For example the number of emergency admissions for 19 ambulatory care sensitive conditions per 1,000 population was 20.7 compared to the national average of 14.4 but were unable to explain why this might be. (Ambulatory care sensitive conditions are those that can be effectively treated in the primary care setting). The practice was commissioned for the unplanned admissions 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).

The practice held regular multidisciplinary team meetings to discuss patients with complex needs. For example, those with multiple long term conditions, palliative care needs and vulnerable patients. These meetings were attended by district nurses, health visitors and palliative care nurses. We spoke with two health professionals that worked closely with the practice in the care of patients with complex needs. Both were positive about the working relationship with the practice.

We spoke with the managers from two care homes supported by the practice. They were both positive about the support their residents received from the home.

Information sharing

The practice had systems in place to communicate with other providers. For example, the practice used Choose and Book for referrals where this was available. (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). Appropriate information was also shared with the local GP out-of-hours provider for patients who may need to use this service.

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to

Good

Are services effective?

(for example, treatment is effective)

Accident and Emergency. The practice had also signed up to the electronic Summary Care Record and had this operational. (Summary Care Records provide 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 to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

The staff we spoke with were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation. We spoke with the managers from two care which included patients with dementia, they were happy that the practice understood capacity and explained how they would speak with the family before signing any do not attempt resuscitation orders. Information was also readily available to patients on advance directives about a patients future wishes for medical care and treatment if there came a time when they lacked capacity to make decisions.

All clinical staff interviewed demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

There were processes in place for documenting consent for specific interventions. For example, for all minor surgical procedures. Staff showed us a copy of the consent for them used in which potential risks and benefits of the procedure.

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. The practice also undertook NHS health checks on patients aged 40 to 75 years. Practice data showed that 24.3% of eligible patients had been invited to attend a health check and 9.5% of those had taken up the offer. The practice nurse told us that the GP would be informed of any health concerns detected and would review the results from blood tests undertaken.

The practice had many ways of identifying patients who needed additional support, and offered additional help. For example, data available to us from 2013/14 showed the practice had identified the smoking status in 82% of its patients over the age of 15 and had actively offered health care assistant-led smoking cessation clinics to 71% of those eligible. This was slightly lower than CCG and national figures. However, the practice was able to show us their latest data which showed improvement with 87% of eligible patients offered smoking cessation advice of which 67.9% had stopped smoking as a result. Nursing staff told us that Patients who would benefit were also referred to health weight management and exercise support.

The practice's performance for the cervical screening programme was 82%, which was at the national average of 82%. There were processes in place to follow up patients who did not attend for their cervical screening test.

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 was similar or above average for the majority of immunisations where comparative data was available. For example:

- Flu vaccination rates for the over 65s were 45%, and at risk groups 69%. These were similar to CCG averages.
- Childhood immunisation rates for the vaccinations given to under twos ranged from 88% to 100% and five year olds from 91% to 100%. These were above the CCG averages.

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 (2014/15), a survey of 121 patients undertaken in conjunction with the practice's patient participation group (PPG) and results from the friends and family test introduced in 2014. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was average for its satisfaction scores on consultations with doctors and nurses. For example:

- 87% said the GP was good at listening to them compared to the CCG average of 87% and national average of 87%.
- 82% said the GP gave them enough time compared to the CCG average of 85% and national average of 85%.
- 96% said they had confidence and trust in the last GP they saw compared to the CCG average of 91% and national average of 91%

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 28 completed cards and all were positive about the service experienced. Patients were very happy with the service they received, they gave examples of care they and their families had received and told us they felt well looked after. Staff were described as efficient, helpful and caring. They said staff treated them with dignity and respect. There were no negative comments about the care received and only one person commented that they had difficulty making an appointment. We also spoke with 12 patients on the day of our inspection. All told us they were happy with the care provided by the practice and that their dignity and privacy were respected.

We saw that consultations and treatments were carried out in the privacy of a consulting room. None of the patients raised privacy or dignity as an issue. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. Calls to patients were made away from the front desk to avoid conversations being overheard. There was a notice at the reception desk advising patients to let reception staff know if they wished to speak in private. Additionally, 97% said they found the receptionists at the practice helpful compared to the CCG average of 83% and national average of 87%.

Patients were kept informed about what was going on at the practice through the patient newsletter.

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:

- 83% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 82% and national average of 82%.
- 75% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 75% and national average of 74%.

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

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

Good

Are services caring?

Care plans were in place for all patients who had been identified with complex care needs. Although the QOF data for the practice had identified that they were below the national average for mental health care planning at 60% and had identified actions to improve this figure.

Patient/carer support to cope emotionally with care and treatment

The patient survey (2014/15) information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

- 83% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 82% and national average of 82%.
- 72% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 76% and national average of 77%.

The patients we spoke with on the day of our inspection and the comment cards we received were also positive and consistent with the patient responses to the national patient survey. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Information available in the patient waiting room and patient website also told patients how to access a number of support groups and organisations. The practice had a carers' register and was actively inviting patients who were carers to identify themselves through notices and information in the waiting area. An information pack was available for carers to ensure they understood the various avenues of support available to them.

The clinicians were spoke with told us that they did contact families to offer advice at times of bereavement to offer support for families who had suffered a bereavement. However the practice did not have a clear and consistent approach for signposting families who had suffered a bereavement to other support services available.

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 patients' 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. For example, the practice was above Clinical Commissioning Group (CCG) and national average for levels of satisfaction for the service and access.

The NHS England Area Team and 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. The practice was participating in the CCG led Aspiring to Clinical Excellence (ACE) programme aimed at driving standards and consistency in primary care and we saw a copy of the practice's report which showed they were engaged and making good progress. Through the ACE programme they were also working closely with other practices in their local commissioning network to identify local priorities and initiatives. For example, the practice was offering ambulatory blood pressure monitoring at home to aid the correct diagnosis of hypertension in line with NICE guidance on the diagnosis of hypertension.

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). We spoke with members of the patient participation group who told us how the practice had introduced twitter accounts and telephone appointments following feedback.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients who needed them. The practice was inclusive in registering patients which needed support. As part of the CCG priorities the practice was working to identify and develop the registers for patients with learning disabilities and carers. The majority of the practice population were English speaking patients but access to translation services were available. Staff we spoke with knew how to access the translation services and told us that they had done in the past.

The premises and services had been adapted to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also suitable for patients with mobility difficulties and there were accessible toilets and baby changing facilities. There was a bell to alert staff if a patient needed any assistance into the premises and a low section to the reception desk which enabled patients who used a wheelchair to speak more easily to staff. There was sufficient space for wheelchairs and prams which made movement around the practice easier and helped to maintain patients' independence.

A hearing loop was available for those with difficulties hearing. Although the practice did not routinely use texting as a means to communicate with patients they did use this to support patients with difficulty hearing.

Staff told us that there were patients who were of 'no fixed abode' registered at the practice and they were registered at a 'care of' address which enabled them to be vigilant if any post which needed to be sent to the patient.

There were male and female GPs in the practice which enabled patients to choose a male or female doctor for their health problem.

The practice provided equality and diversity training through e-learning. Records showed that most staff had completed this training within the last 12 months.

Access to the service

The surgery was open from 8:30am to 6pm Monday to Friday. When the practice was closed during core hours 8am to 8.30pm and 6pm to 6.30pm cover was provided through another provider (South Doc). Patients were able to arrange appointments up to six weeks in advance and could see their preferred GP if they were willing to wait. Urgent appointments were available on a daily basis and some routine appointments could also be booked on the same day. Telephone consultations were also available.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

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, patients were able to request these if they felt they needed one and this was advertised on the practice website. GPs at their discretion may also request patients to book a longer appointment as appropriate. The practice carried out weekly ward rounds at one care home every Tuesday. Home visits were also made to patients in local care homes and managers from two care homes we spoke with told us that the practice was quick to help and flexible when needed.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example:

- 78% were satisfied with the practice's opening hours compared to the CCG average of 72% and national average of 75%.
- 87% described their experience of making an appointment as good compared to the CCG average of 67% and national average of 74%.
- 82% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 62% and national average of 65%.
- 89% said they could get through easily to the surgery by phone compared to the CCG average of 60% and national average of 71%.

The practice offered extended opening hours on a Saturday morning between 8am and 11.30am. Appointments could also be made online. This helped to provide more convenient appointments for those who worked or had other commitments during the week.

Patients we spoke with were satisfied with the appointments system and found access generally easy. They confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. Comments received from patients also showed that the appointment system was generally working well.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. Information was displayed in the entrance to the practice, website and new patient information pack. Patients we spoke with were aware of the process to follow if they wished to make a complaint. Where patients told us they had raised a concern the practice was open to their comments and that they were satisfied with how the situation had been managed.

We looked at four complaints received in the last 12 months and found these had been satisfactorily handled. Although the complaints leaflet provided details as to where patients should escalate their complaint if they were dissatisfied with the practice's response this information was not routinely included on all response letters.

The practice had reviewed complaints and significant events received within the last year. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result.

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. During the presentation the practice shared with us their short and long term vision for the practice. This had been recorded within their Aspiring to Clinical Excellence (ACE) appraisal document. ACE is a CCG led programme aimed at driving standards and consistency in primary care and supporting innovation.

Although, practice staff we spoke with were not aware of the specific visions and values of the practice they told us that they were kept informed and wanted to do their best for their patients. Feedback from patients and our observations during the inspection confirmed this was the case.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at several policies and procedures, staff confirmed that they were aware of these if they needed to refer to them. The majority of policies and procedures we looked at were up to date.

There was a clear leadership structure with 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 nine members of clinical and non-clinical members of staff and they were all clear about their own roles and responsibilities. It was evident that staff respected each other and their contribution to delivering the service. Staff members 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 (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing in line with most national standards. Individual staff took responsibility for monitoring different areas of QOF in order to meet targets.

The practice held weekly clinical meetings and quarterly practice meetings in which governance issues were discussed. It also underwent annual appraisals from the CCG in relation to performance against the ACE programme.

The practice manager was responsible for human resource policies and procedures. There was an induction programme for new staff to the practice and a staff handbook. We reviewed the staff hand book which contained policies to support staff for example disciplinary procedures, equal opportunity policy, harassment and bullying at work policy. The practice also had a whistleblowing policy in place. Staff we spoke with knew where to find these policies if required.

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and supportive. Staff told us that they were kept informed about what was going on in the practice.

We saw from minutes that practice meeting were held three monthly. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues with senior staff when needed and felt supported if they did. Staff felt respected, valued and supported, particularly by the GP partners in the practice.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), NHS choices and complaints received. It had an active PPG. The PPG had tried to increase membership and improve representation from different population groups by introducing a virtual patient group. We spoke with two members of the PPG and they were very positive about the role they played and told us they felt engaged with the practice. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care). Patient feedback about the service in general from all sources reviewed was very positive including the national GP patient survey.

The practice had also gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us

Are services well-led?

Good

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

they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us about issues they had raised with senior staff and how these had been addressed.

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 several 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. Staff were able to attend networking meetings with other practices and were supported to undertake additional training such as chronic disease management where it met the needs of the practice and patients. One GP at the practice was able to show us research undertaken that had been published in medical journals.

The practice was a teaching practice for medical students. We saw that the senior partner had students on the day of our inspection and was consistently available to support the students. The practice was also a GP training practice and had recruited a new lead GP dedicated to support trainee GPs at the practice from August 2015.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients. For example, policy changes for taking blood for testing on very young children.